

**CHAPTER 1181. NURSING FACILITY CARE**

Subchap.	Sec.
A. NURSING FACILITY CARE .....	1181.1
B. MANUAL FOR ALLOWABLE COST REIMBURSEMENT FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES .....	1181.201
C. [Reserved] .....	1181.301
D. NURSING HOME REFORM—STATEMENT OF POLICY .....	1181.501

**Source**

The provisions of this Chapter 1181 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610, unless otherwise noted.

**Notes of Decisions**

The MA Program provides cost-related reimbursement on behalf of eligible individuals whose institutional care for skilled nursing home or intermediate care in a licensed nonpublic facility is prescribed by a physician. *Harston Hall Nursing and Convalescent Home, Inc. v. Department of Public Welfare*, 513 A.2d 1097 (Pa. Cmwlth. 1986).

Nursing facility not entitled to reimbursement from Department of Public Welfare under medical assistance program for accrued employee vacation costs for year facility converted from cash to accrual accounting of employee vacation pay; based on Department's rules, allowable accrued vacation expense was calculated by subtracting accrued vacation costs from prior year from accrued vacation costs for the reporting year, and facility did not include accrued vacation costs for either fiscal year in the cost report submitted to the Department. *Cambria City Home and Hospital v. Department of Public Welfare*, 907 A.2d 661, 667, 668 (Pa. Cmwlth. 2006).

**Cross References**

This chapter cited in 55 Pa. Code § 1101.31 (relating to scope); 55 Pa. Code § 1101.95 (relating to conflicts between general and specific provisions); 55 Pa. Code § 1151.48 (relating to noncompensable services and items); 55 Pa. Code § 1163.59 (relating to noncompensable services, items and outlier days); 55 Pa. Code § 1163.455 (relating to noncompensable services and items); and 55 Pa. Code § 1187.113b (relating to capital cost reimbursement waivers—statement of policy).

**Subchapter A. NURSING FACILITY CARE****GENERAL PROVISIONS**

Sec.	
1181.1.	Policy.
1181.2.	Definitions.

**SCOPE OF BENEFITS**

1181.21.	Scope of benefits for the categorically needy.
1181.22.	Scope of benefits for the medically needy.
1181.23.	Scope of benefits for State Blind Pension recipients.
1181.24.	Scope of benefits for qualified Medicare beneficiaries.
1181.25.	Scope of benefits for General Assistance recipients.

**PROVIDER PARTICIPATION**

- 1181.41. Provider participation requirements.
- 1181.41a. Dual participation requirements for Medicare and MA Programs— statement of policy.
- 1181.42. Additional participation requirements for hospital-based nursing units.
- 1181.43. Additional participation requirements for intermediate care facilities for the mentally retarded.
- 1181.44. Additional participation requirements for State-operated nursing facilities other than intermediate care facilities for the mentally retarded.
- 1181.45. Ongoing responsibilities of providers.

**PAYMENT FOR NURSING FACILITY CARE**

- 1181.51. General payment policy.
- 1181.52. Payment conditions.
- 1181.53. Payment conditions related to the recipient's initial need for care.
- 1181.54. Payment conditions related to the recipient's continued need for care.
- 1181.55. General limitations on payment.
- 1181.56. Limitations on payment for reserved beds.
- 1181.56a. Limitations on payment for reserved beds—statement of policy.
- 1181.56b. Charges for bed hold days—statement of policy.
- 1181.56c. Reimbursement for hospital reserved bed days during a Medicare benefit period—statement of policy.
- 1181.57. Limitations on payment for prescription drugs.
- 1181.58. Limitations on payment during strike or disaster situations requiring patient evacuation.
- 1181.58a. [Reserved].
- 1181.59. Payment to a nursing facility for heavy care/intermediate services or intermediate care provided in a dually certified skilled bed.
- 1181.60. Utilizing Medicare as a resource.
- 1181.61. Services included in the interim per diem rate.
- 1181.61a. Nurse-aide programs—statement of policy.
- 1181.62. Noncompensable services.
- 1181.63. Method of payment.
- 1181.64. Cost reporting.
- 1181.65. Cost-finding.
- 1181.66. Setting ceilings on allowable net operating costs.
- 1181.67. Setting interim per diem rates.
- 1181.68. Upper limits of payment.
- 1181.69. Annual adjustment.

**REPORTING AND AUDITING REQUIREMENTS**

- 1181.71. Annual reporting.
- 1181.72. Interim reporting.

- 1181.73. Final reporting.
- 1181.74. Auditing requirements related to cost reports.
- 1181.75. Auditing requirements related to patient fund management.

### UTILIZATION CONTROL

- 1181.81. Scope of claims review procedures.
- 1181.82. Review of need for admission.
- 1181.83. Inspections of care.
- 1181.84. Facility course of action.
- 1181.85. Facility utilization review requirements.
- 1181.86. Provider misutilization.

### ADMINISTRATIVE SANCTIONS

- 1181.91. Failure to file a cost report.
- 1181.92. Failure to maintain adequate records.
- 1181.93. Failure to correct deficiencies.
- 1181.94. Failure to adhere to certification requirements.
- 1181.95. Failure to adhere to medical evaluation requirements.
- 1181.96. Failure to comply with requirements of maintaining patient's funds.

### FACILITY RIGHT TO APPEAL

- 1181.101. Facility's right to a hearing.

*(Editor's Note: This subchapter does not apply to ICFs/MR and ICFs/ORC. See 24 Pa.B. 5523 (October 29, 1994).)*

#### Cross References

This subchapter cited in 55 Pa. Code § 1181.201 (relating to scope); 55 Pa. Code § 1181.211 (relating to cost reimbursement principles and methods); and 55 Pa. Code § 1181.231 (relating to standards for general and selected costs).

### GENERAL PROVISIONS

#### § 1181.1. Policy.

(a) This subchapter applies to psychiatric transitional facilities that are enrolled in the MA Program. To the extent that this subchapter is inconsistent with Subchapter B (relating to manual for allowance cost reimbursement for skilled nursing and intermediate care facilities), Subchapter B prevails for psychiatric transitional facilities.

(b) The MA Program provides payment for psychiatric transitional facility services provided to eligible recipients by enrolled providers. Payment for ser-

vices is made subject to this subchapter, Subchapter B for psychiatric transitional facilities, and Chapter 1101 (relating to general provisions). The upper limit of payment of the MA Program is specified in § 1181.68 (relating to upper limits of payment).

(c) Any section of this subchapter may not be applied or interpreted out of context.

(d) Extensions of time will be as follows:

(1) The time limits established by this chapter for the filing of an application, cost report, waiver request or appeal cannot be extended except as provided in this section.

(2) Extensions of time in addition to the time otherwise prescribed for providers by this chapter with respect to the filing of an application, cost report, waiver request or appeal may be permitted only if required because of a breakdown in Department procedures justifying relief *nunc pro tunc* or because of an intervening natural disaster making timely compliance impossible or unsafe.

(3) This subsection supersedes 1 Pa. Code § 31.15 (relating to extensions of time).

#### Source

The provisions of this § 1181.1 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended May 3, 1985, effective retroactively as of July 1, 1984, 15 Pa.B. 1629; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005; amended October 13, 1995, effective January 1, 1996, 25 Pa.B. 4477. Immediately preceding text appears at serial pages (196497) to (196498).

### § 1181.2. Definitions.

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

*Certified registered nurse practitioner*—A registered nurse licensed in this Commonwealth who is currently certified by the State Board of Medicine and the State Board of Nursing as a certified registered nurse practitioner as defined at 42 CFR 481.2(b).

*County nursing facility*—A nursing facility controlled and totally funded by the County Institution District or by the county if no County Institution District exists. “Totally funded,” as used in this definition, means that the county funds costs which are not reimbursed by liable third parties, such as MA, Medicare or other health insurance programs. “Controlled,” as used in this definition, means that the county government directs the actions and policies of the facility. The term does not include intermediate care facilities for the mentally retarded controlled or totally funded by a County Institution District or county government.

*Distinct part*—A designated part or unit of a health care facility licensed or approved by the appropriate State agency to provide a specific level of care, either skilled nursing, intermediate care or intermediate care for the mentally retarded.

*General nursing facility*—A skilled nursing or intermediate care facility, including special rehabilitation and hospital-based facility, that is owned by an individual, partnership, association or corporation and may be operated on a profit or nonprofit basis. The term does not include intermediate care facilities for the mentally retarded, psychiatric transitional facilities, State-owned facilities or county nursing facilities.

*HIM-15*—The Medicare Provider Reimbursement Manual, Health Insurance Manual-15.

*Heavy care/intermediate services*—Health related care and services, provided to a patient in a dually certified skilled bed, which are not as inherently complex as skilled nursing services, which meet the criteria in Appendix F (relating to heavy care/intermediate services) and which are:

- (i) Ordered by and provided under the direction of a physician.
- (ii) Needed in the context of a planned program of health care management due to the degree of functional impairment.
- (iii) Provided to a patient requiring 24-hour supervision on an inpatient basis.

*Hospital-based nursing facility*—A distinct part skilled nursing or intermediate care unit that is:

- (i) Located physically within or on the immediate grounds of a hospital.
- (ii) Operated or controlled by the hospital.
- (iii) Licensed or approved by the Department of Health and meets the requirements of 28 Pa. Code § 101.31 (relating to hospital requirements) and shares support services and administrative costs of the hospital.

*Interim per diem rate*—The rate established by the Department for the purpose of making interim payments to the facility pending a year-end cost settlement. The interim per diem rate is based on the facility's latest approved reported costs, and is limited by the upper limits of payment specified in § 1181.68 (relating to upper limits of payment).

*Intermediate care*—A level of care provided by a facility that is licensed by the Department of Health to provide intermediate care. Intermediate care shall be ordered by, and provided under the direction of a physician. It is available on a continuous 24-hour basis to a person who does not require the degree of care and treatment provided in a hospital or skilled nursing facility. Because of a mental or physical disability, the person does, however, require nursing and related health and medical services in the context of a planned program of health care and management. The term does not include intermediate care for the mentally retarded.

*Intermediate care for the mentally retarded*—A level of care provided by a State-operated or non-State-operated facility licensed as an ICF/MR facility by the Department. Care is specially designed to meet the needs of persons who are mentally retarded, or persons with related conditions, who require specialized health and rehabilitative services; that is, active treatment provided by an intermediate care facility for the mentally retarded.

*Nursing facility*—A general descriptive term that includes general nursing facilities, hospital-based nursing facilities, county-operated nursing facilities, intermediate care facilities for the mentally retarded, psychiatric transitional facilities and special rehabilitation facilities.

*Physician assistant*—An individual currently certified as a physician assistant by the State Board of Medicine or by the State Board of Osteopathic Medicine and who meets the qualifications for a physician assistant as defined at 42 CFR 481.2(d).

*Psychiatric transitional facility*—A private or public facility which provides skilled nursing or intermediate care services primarily to individuals who have been discharged from institutions for mental diseases and who require nursing services for a limited period of time to prepare them to function independently in a community setting. The psychiatric transitional facility shall exclusively serve this population group and must give the Department control over intake decisions.

*Skilled nursing facility services*—Skilled nursing and rehabilitation services which are provided in accordance with the Medicare requirements and which meet the criteria in Appendix E (relating to skilled nursing care) by a facility or distinct part of a facility that is licensed to provide skilled care and is certified to meet the requirements for participation as a provider in the MA Program.

*Special rehabilitation facility*—A facility with skilled or intermediate care patients more than 80% of whom are so severely physically disabled that they require intensive services thereby necessitating facility staffing at the levels specified in § 1181.242(b) (relating to nursing staff allowance).

#### Authority

The provisions of this § 1181.2 amended under sections 403(a) and (b) and 443.1(2) and (3) of the Public Welfare Code (62 P.S. §§ 403(a) and (b) and 443.1(2) and (3)); amended under section 443.1(2) and (3) of the Public Welfare Code (62 P.S. § 443.1(2) and (3)).

#### Source

The provisions of this § 1181.2 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended July 2, 1982, effective July 1, 1982, 12 Pa.B. 2070; amended January 7, 1983, effective January 8, 1983, 13 Pa.B. 148; amended May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; amended September 5, 1986, effective July 1, 1985, 16 Pa.B. 3294; amended March 10, 1989, effective immediately and applies retroactively to February 23, 1988, 19 Pa.B. 999; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial pages (117410) to (117412).

#### 1181-6

**SCOPE OF BENEFITS****§ 1181.21. Scope of benefits for the categorically needy.**

Categorically needy recipients are eligible for medically necessary skilled nursing care, intermediate care, and intermediate care for the mentally retarded, subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to general provisions).

**Source**

The provisions of this § 1181.21 codified July 24, 1981, effective July 25, 1981.

**§ 1181.22. Scope of benefits for the medically needy.**

Medically needy recipients are eligible for medically necessary skilled nursing care, intermediate care and intermediate care for the mentally retarded, subject to the conditions and limitations established in this chapter and Chapter 1101 (relating to general provisions).

**Source**

The provisions of this § 1181.22 codified July 24, 1981, effective July 25, 1981.

**§ 1181.23. Scope of benefits for State Blind Pension recipients.**

State Blind Pension recipients are not eligible for nursing facility care under the MA Program. Blind and visually impaired individuals are, however, eligible for nursing facility services if they qualify as categorically or medically needy recipients.

**Source**

The provisions of this § 1181.23 codified July 24, 1981, effective July 25, 1981.

**§ 1181.24. Scope of benefits for qualified Medicare beneficiaries.**

Qualified Medicare beneficiaries only are not eligible for nursing facility care under the MA Program. Qualified Medicare beneficiaries are eligible for nursing facility services if they qualify as categorically or medically needy recipients.

**Source**

The provisions of this § 1181.24 adopted December 14, 1990, effective immediately and apply retroactively to January 1, 1989, 20 Pa.B. 6172.

**§ 1181.25. Scope of benefits for General Assistance recipients.**

General Assistance recipients, age 21 to 65, whose MA benefits are funded solely by State funds, are eligible for medically necessary basic health care benefits as defined in Chapter 1101 (relating to general provisions). See § 1101.31(e) (relating to scope).

**Source**

The provisions of this § 1181.25 adopted December 11, 1992, effective January 1, 1993, 22 Pa.B. 5995.

**PROVIDER PARTICIPATION****§ 1181.41. Provider participation requirements.**

In addition to the participation requirements established in Chapter 1101 (relating to general provisions), nursing facilities shall meet the following requirements:

- (1) Skilled nursing care and intermediate care facilities shall be licensed by the Department of Health.
- (2) Intermediate care facilities for the mentally retarded shall be licensed by the Department.
- (3) Nursing facilities shall abide by applicable Federal, State and local statutes and regulations, including, but not limited to, Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396q), sections 443.1—443.6 of the Public Welfare Code (62 P. S. §§ 443.1—443.6) and applicable licensing statutes. Nursing facilities shall conform with the requirements specified in Title XIX of the Social Security Act and the regulations promulgated thereunder which are necessary for the Department to receive Federal financial participation for nursing services rendered by the facilities.
- (4) A facility with more than 60 licensed beds shall be enrolled and participating in the Medicare Program. This paragraph does not apply to a facility that has no beds certified to provide skilled care.

**Source**

The provisions of this § 1181.41 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial pages (133589) to (133590).

**Notes of Decisions**

Court rejected petitioner's contention that Department of Public Welfare's regulations regarding classification of nursing care as skilled or intermediate were inconsistent with Department of Health's regulations. The Department of Public Welfare has been named as the single state agency to administer and supervise the medicare program and the Department of Health is merely in charge of licensing skilled and intermediate care facilities. *Barnett v. Department of Public Welfare*, 491 A.2d 320 (Pa. Cmwlth. 1985).

**Cross References**

This section cited in 55 Pa. Code § 1181.41a (relating to dual participation requirements for Medicare and MA Programs—statement of policy); 55 Pa. Code § 1181.42 (relating to additional participation requirements for hospital-based nursing units); 55 Pa. Code § 1181.43 (relating to additional participation requirements for intermediate care facilities for the mentally retarded); 55 Pa. Code § 1181.44 (relating to additional participation requirements for State-operated nursing facilities other than intermediate care facilities for the mentally retarded); 55 Pa. Code § 1181.504 (relating to back-



ground); 55 Pa. Code § 1181.511 (relating to provider conditions of participation); and 55 Pa. Code Chapter 1181 Appendix O (relating to OBRA sanctions).

**§ 1181.41a. Dual participation requirements for Medicare and MA Programs—statement of policy.**

(a) As a result of the multiple changes to § 1181.41(4) (relating to provider participation requirements), a facility providing skilled care, enrolled in the MA Program with more than 60 licensed beds, shall also be enrolled in the Medicare program to the extent that it has sufficient beds to accommodate Medicare eligible residents. This does not preclude a facility with a bed complement of under 60 beds from enrolling in the Medicare program.

(b) A facility certified to participate in the Medicare program shall have sufficient beds to accommodate its Medicare eligible residents. Payment will be based on criteria found in § 1181.51(b) (relating to general payment policy).

(c) If a facility has a total bed complement of more than 60 licensed beds and is not enrolled in the Medicare Program, the Department of Health should be contacted to enroll the skilled beds. Medicare enrollment forms may be requested from and returned to: Department of Health, Division of Long Term Care, Room 526, Health and Welfare Building, Harrisburg, Pennsylvania 17108, (717) 787-1816.

(d) Failure to be enrolled and certified in the Medicare Program will result in denial of claims for a recipient with both Medicare and MA coverage.

**Source**

The provisions of this § 1181.41a adopted April 20, 1990, effective July 1, 1990, 20 Pa.B. 2200; amended October 5, 1990, effective October 6, 1990, and apply retroactively to July 1, 1990, 20 Pa.B. 5054; corrected October 19, 1990, effective July 1, 1990, 20 Pa.B. 5296. Immediately preceding text appears at serial page (146849).

**§ 1181.42. Additional participation requirements for hospital-based nursing units.**

In addition to the participation requirements listed in §§ 1181.41 and 1181.45 (relating to provider participation requirements; and ongoing responsibilities of providers), hospital-based nursing units shall meet the following requirements:

(1) The nursing unit shall be composed of former acute care hospital beds that have been converted to and certified for skilled nursing or intermediate care.

(2) The need for the beds shall have been approved by the local health planning agency.

(3) The distinct part unit may not exceed 50% of the facility's total licensed or approved bed complement for acute hospital care. A facility will, however, be granted an exception to the 50% bed limit if it submits written documentation to the Office of MA, Bureau of Long Term Care Programs, substantiating that all of the following criteria have been met:

- (i) Beds operated in excess of the 50% limit have been approved by the Department of Health, Division of Need Review.
- (ii) The unit is located in an area underserved or lacking long term care beds under an approved local health plan.
- (iii) More than 50% of the unit's licensed long term care beds are occupied by MA patients.

**Source**

The provisions of this § 1181.42 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

**§ 1181.43. Additional participation requirements for intermediate care facilities for the mentally retarded.**

- (a) In addition to §§ 1181.41 and 1181.45 (relating to provider participation requirements; and ongoing responsibilities of providers), intermediate care facilities for the mentally retarded shall enter into a written provider agreement with the Office of MA.
- (b) State-operated intermediate care facilities for the mentally retarded shall submit budgets on Department forms to the Office of Mental Retardation.
- (c) Non-State operated intermediate care facilities for the mentally retarded shall submit cost reports, or budgets if a waiver is granted in accordance with Subchapter C (Reserved), to the Office of Mental Retardation.
- (d) The Office of Mental Retardation is responsible for approving projected operating costs and budgets for intermediate care facilities for the mentally retarded.

**Source**

The provisions of this § 1181.43 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629. Immediately preceding text appears at serial page (62932).

**§ 1181.44. Additional participation requirements for State-operated nursing facilities other than intermediate care facilities for the mentally retarded.**

In addition to the participation requirements in §§ 1181.41 and 1181.45 (relating to provider participation requirements; and ongoing responsibilities of providers), psychiatric transitional facilities and other State-operated nursing facilities other than intermediate care facilities for the mentally retarded shall also submit budgets to the Office of Fiscal Management and the Office of MA, Bureau of Long Term Care Programs, for review and approval 60 days prior to July 1 of each year.

**Source**

The provisions of this § 1181.44 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial page (117415).

**§ 1181.45. Ongoing responsibilities of providers.**

(a) In addition to the ongoing responsibilities established in Chapter 1101 (relating to general provisions), a nursing facility shall, as a condition of participation:

(1) Submit a Utilization Review Plan to the Office of MA for approval.

(2) Have in operation a system for managing patients' funds that, at a minimum, fully complies with the Medicare long term care certification requirements established at 42 CFR 405.1121(k)(6) (relating to conditions of participation—governing body and management).

(i) The facility in which a qualified Medical Assistance recipient dies may, under the circumstances described in this subparagraph, make payment of funds, if any remain in the patient's care account, for the decedent's burial expenses. Payment may be made only to a qualified funeral director and may not exceed \$1,000. The payment may be made whether or not a personal representative has been appointed.

(ii) Subparagraph (i) applies only in circumstances where there is no will, if this is ascertainable, and if no relative or friend of the deceased patient takes responsibility for the burial. Under 20 Pa.C.S. (relating to Probate, Estates and Fiduciaries Code) a facility making such a payment is released from responsibility to the same extent as if payment had been made to an appointed personal representative of the decedent and the facility is not required to oversee the manner in which the funeral director applies the payment.

(3) File an acceptable cost report with the Department within the time limit specified in § 1181.64 (relating to cost reporting) if the facility is continuing its participation in the MA Program or within the time limit specified in § 1181.73 (relating to final reporting) if the facility is sold, transferred by merger or consolidation, terminated or withdraws from participation in the MA Program. An acceptable cost report is one that meets the requirements of § 1181.66(a)(1)(i)—(iv) (relating to setting ceilings on allowable net operating costs).

(4) Except for non-State operated intermediate care facilities for the mentally retarded, if making initial application for participation, submit a projected MA 11 cost report to the Bureau of Long Term Care Programs for the purpose of establishing an interim per diem rate.

(5) Undergo at least an annual onsite inspection of care by the Department's Inspection of Care Team and within 30 days of receipt of the team's report, submit a written response, if required by the Department.

(6) Submit to the Bureau of Long Term Care Programs changes in ownership of persons having a direct or indirect interest of 5% or more in the nursing facility and, if a corporation, changes in the name or address of corporate officers.

(7) Have a written transfer agreement with one or more general hospitals to provide needed diagnostic and other medical services to patients of the nursing facility, and under which acutely ill patients may be transferred to ensure timely admission. Hospital based units are exempt from this requirement.

(b) If the facility changes ownership and the new owner wishes the facility to participate in MA, the facility shall submit a written request for participation to the Bureau of Long Term Care Programs. The agreement in effect at the time of the ownership change will be assigned to the new owner subject to applicable statutes and regulations and to the terms and conditions under which it was originally issued.

#### Source

The provisions of this § 1181.45 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial pages (117415) to (117417).

#### Notes of Decisions

Nursing care facilities must file a "cost report" with the Department within 90 days of the close of each fiscal year in order to be eligible for cost reimbursement. *Harston Hall Nursing and Convalescent Home, Inc. v. Department of Public Welfare*, 513 A.2d 1097, 1099 (Pa. Commw. 1986).

#### Cross References

This section cited in 55 Pa. Code § 1181.42 (relating to additional participation requirements for hospital-based nursing units); 55 Pa. Code § 1181.43 (relating to additional participation requirements for intermediate care facilities for the mentally retarded); and 55 Pa. Code § 1181.44 (relating to additional participation requirements for State-operated nursing facilities other than intermediate care facilities for the mentally retarded).

## PAYMENT FOR NURSING FACILITY CARE

### § 1181.51. General payment policy.

(a) Payment for nursing facility care is subject to the following conditions and limitations:

(1) This chapter and Chapter 1101 (relating to general provisions).

(2) The applicable per diem ceilings established under § 1181.66 (relating to setting ceilings on allowable net operating costs) and announced by the submission of a notice for recommended publication in the *Pennsylvania Bulletin* and suggested codification in the *Pennsylvania Code* as an annex to § 1181.66 for the location of the facility, level of care, type of facility and date of service

involved. Heavy care/intermediate services shall be paid at the higher of a facility's applicable rates for skilled or intermediate care, as limited by the ceilings.

(b) Payment will not be made for long term care if full payment, at the medical assistance interim per diem rate, is available from another public agency, another insurance or health program, or the patient's resources.

#### Authority

The provisions of this § 1181.51 amended under sections 201 and 443.1(2) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(2)).

#### Source

The provisions of this § 1181.51 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; amended September 6, 1985, effective September 7, 1985, except that the groups and ceilings shall be effective and apply at audit to costs of services rendered from July 1, 1984 through December 31, 1985, 15 Pa.B. 3181; amended March 10, 1989, effective immediately and applies retroactively to February 23, 1988, 19 Pa.B. 999. Immediately preceding text appears at serial pages (117417) to (117418).

#### Cross References

This section cited in 55 Pa. Code § 1181.41a (relating to dual participation requirements for Medicare and MA Programs—statement of policy); and 55 Pa. Code § 1181.52 (relating to payment conditions).

### § 1181.52. Payment conditions.

For payment to be made to a nursing facility for covered services the applicable conditions of §§ 1181.51—1181.69 (relating to payment for nursing facility care) shall be met. Payment shall be subject to the sanctions in this chapter and as otherwise provided by law.

#### Source

The provisions of this § 1181.52 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1010. Immediately preceding text appears at serial page (117418).

### § 1181.53. Payment conditions related to the recipient's initial need for care.

(a) *Certification of need for care.* For skilled, heavy care/intermediate, intermediate and intermediate care for the mentally retarded levels of care, a physician, or a nurse practitioner or clinical nurse specialist who is not an employe of the facility but is working in collaboration with a physician, shall certify in writing on the medical record that the applicant or recipient needs skilled, heavy care/intermediate, intermediate care or intermediate care for the mentally retarded as applicable. The certification shall be signed and dated by a physician, or a nurse practitioner or clinical nurse specialist who is not an employe of the facility but is working in collaboration with a physician, not more than 30 days prior to the

admission of an applicant or recipient to a facility, or, if an individual applies for assistance while in a facility before the Department authorizes payment for nursing facility care or intermediate care for the mentally retarded.

(b) *Medical evaluation.* The medical evaluation shall consist of the following:

(1) Before admission to a facility for skilled nursing care or before authorization of payment, the attending physician shall make a medical evaluation of the applicant's or recipient's need for skilled nursing care.

(2) Before the latter of the admission of an applicant or recipient to a skilled nursing facility or the Department's authorization of payment for skilled nursing care, an applicant or recipient shall be determined to be medically eligible for skilled nursing care in accordance with the criteria specified in Appendix E (relating to skilled nursing care). Skilled Nursing Care Assessment forms which are designed to enable the Department to determine whether the criteria specified in Appendix E are met by a recipient, will be supplied by the Department. The form shall be completed by a physician.

(3) Before admission to a facility for heavy care/intermediate, intermediate care or intermediate care for the mentally retarded, or before authorization for payment, an interdisciplinary team of health professionals shall make a comprehensive medical and social evaluation and, when appropriate, a psychological evaluation of each applicant's or recipient's need for heavy care/intermediate, intermediate care or intermediate care for the mentally retarded. In an intermediate care facility for the mentally retarded, the team shall also make a psychological evaluation of need for care.

(4) The following criteria shall be met before a person qualifies for an intermediate care facility for the mentally retarded level (ICF/MR) of care:

(i) The applicant or recipient has a diagnosis of mental retardation.

(ii) The applicant or recipient requires active treatment.

(iii) The applicant or recipient is recommended for an ICF/MR level of care based on medical evaluation as specified in Appendix Q (Reserved).

(5) The evaluations required in this subsection shall be recorded on the patient's medical record and on forms issued by the Department and forwarded to the Department for review and assessment. The Department's Review Team will evaluate the need for admission and authorize payment for the appropriate level of care.

(6) The Department will send a written notice of the authorization or denial of payment to the nursing facility and the patient.

(7) The notice will indicate the effective date of coverage and the amount of money the patient has available to contribute toward the interim per diem rate. Obtaining the patient's share of the interim per diem rate is the responsibility of the nursing facility.

(c) *Plan of care.* Before admission to a skilled nursing facility, intermediate care facility or intermediate care facility for the mentally retarded, or before authorization for payment, the attending physician shall establish a written plan

of care for each applicant or recipient. The plan of care shall indicate time-limited and measurable care objectives and goals to be accomplished and who is to give each element of care.

#### Authority

The provisions of this § 1181.53 amended under sections 403(a) and (b), 443.1(2) and (3) and 443.6 of the act of June 13, 1967 (P. L. 31, No. 21) (62 P. S. §§ 403(a) and (b), and 443.1(2) and (3) and 443.6).

#### Source

The provisions of this § 1181.53 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended January 7, 1983, effective January 8, 1983, 13 Pa.B. 148; amended November 30, 1984, effective December 1, 1984, 14 Pa.B. 4370, and by approval of the court of a joint motion for modification of a consent agreement dated February 11, 1985 in *Turner v. Beal, et al.*, C.A. No. 74-1680 (E.D. Pa. 1975); amended May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; amended March 10, 1989, effective immediately and applies retroactively to February 23, 1988, 19 Pa.B. 999; amended June 29, 1990, effective June 30, 1990, 20 Pa.B. 3595. Immediately preceding text appears at serial pages (135888) to (135889).

#### Cross References

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions); 55 Pa. Code § 1181.54 (relating to payment conditions related to the recipient's continued need for care); 55 Pa. Code § 1181.83 (relating to inspections of care); 55 Pa. Code § 1181.94 (relating to failure to adhere to certification requirements); and 55 Pa. Code § 1181.95 (relating to failure to adhere to medical evaluation requirements).

### **§ 1181.54. Payment conditions related to the recipient's continued need for care.**

#### (a) *Recertification of continued need for care.*

(1) A physician, a physician assistant under the supervision of a physician or a nurse practitioner or clinical nurse specialist who is not an employe of the facility but is working in collaboration with a physician shall enter into the recipient's medical record a signed and dated statement that the recipient continues to need skilled, heavy care/intermediate or intermediate level of care, as applicable. For a certification for the skilled level of care to be considered valid, the physician, physician assistant, nurse practitioner or clinical nurse specialist shall certify that the criteria specified in Appendix E (relating to skilled nursing care) have been met. For a certification for the heavy care/intermediate level of care to be considered valid, the physician, physician assistant, nurse practitioner or clinical nurse specialist shall certify that the criteria in Appendix F (relating to heavy care/intermediate services) have been met.

(2) Recertification of the need for care of a recipient receiving care in an ICF/MR shall be made at least once every 365 days after the initial certification as specified in Appendix Q (Reserved).

(3) Recertification of the need for care of a recipient receiving skilled nursing facility services shall be made as follows:

- (i) At least 30 days after the date of the initial certification.
- (ii) At least 60 days after the date of the initial certification.
- (iii) At least 90 days after the date of the initial certification and every 60 days thereafter.

(4) Recertification of the need for care of a recipient receiving heavy care/intermediate or intermediate care services shall be made as follows:

- (i) At least 60 days after the date of the initial certification.
- (ii) At least 180 days after the date of the initial certification.
- (iii) At least 12 months after the date of the initial certification.
- (iv) At least 18 months after the date of the initial certification.
- (v) At least 24 months after the date of the initial certification and every 12 months thereafter.

(b) *Continued stay reviews by the Utilization Review Committee.*

(1) The Utilization Review Committee of a facility shall document in the medical record of the recipient the continued stay review date and need determination of the Committee.

(2) If the Utilization Review Committee recommends that a recipient's continued stay at the skilled level of care is needed, the Committee shall complete the Skilled Nursing Care Assessment form substantiating that the recipient meets the minimum medical requirements for skilled level of care specified in § 1181.53(b)(2) (relating to payment conditions related to the recipient's initial need for care). The Skilled Nursing Care Assessment form shall be completed each time the Utilization Review Committee recommends that the recipient's continued stay be at the skilled level of care. The form shall be signed by the Utilization Review Committee chairperson and retained in the medical record of the recipient. If the Utilization Review Committee recommends that a recipient's level of care be changed to or from the skilled level of care, the original of the Skilled Nursing Care Assessment form shall accompany the Committee's notification (Utilization Review Request for Change Summary) to the Department. Copies of the forms shall be retained in the recipient's medical record.

(3) If the Utilization Review Committee recommends that a recipient's level of care be changed to intermediate care from skilled or heavy care/intermediate, the Committee shall notify the Department of the Committee's recommendation on the Utilization Review Request for Change Summary form. A copy of the form shall be retained in the recipient's medical record.

(4) If the Utilization Review Committee recommends that a recipient's level of care be changed to heavy care/intermediate from skilled or intermediate, the Committee shall notify the Department of the Committee's recommendation on the Utilization Review Request for Change Summary form. A copy of the form shall be retained in the recipient's medical record. The Committee



shall also submit documentation to the Department to substantiate that the recipient meets the minimum medical requirements for the heavy care/intermediate level of care specified in Appendix F (relating to heavy care/intermediate services).

(5) If the Utilization Review Committee recommends that a recipient not continue to receive the level of care for which payment is authorized, the Committee shall notify the Department of the Committee's recommendation on the Utilization Review Request for Change Summary form. A copy of the form shall be retained in the recipient's medical record.

(c) *Adverse decisions by the Inspection of Care team.* If the Department's Inspection of Care team determines that a recipient no longer needs the level of care for which payment is authorized, the Inspection of Care team shall direct the Department to take action to authorize payment for alternate care.

(d) *Recipient notice of adverse decisions.* Upon notification of the recommended change in the level of care, the Department will notify the recipient and facility of its decision. If the recipient or the representative of the recipient appeals the decision within 10 calendar days from the date the notice is mailed, payment for the present level of care will continue pending the outcome of the hearing. If the recipient does not respond to the notice within 10 calendar days, the Department will deny payment in a case where care is no longer needed or authorize payment for the appropriate level of care no earlier than 10 calendar days from the date the notice was mailed to the recipient.

(e) *Continued review of plan of care.* The plan of care shall comply with the following:

(1) For recipients receiving skilled nursing care, the attending or staff physician and other personnel involved in the care of the recipient shall review each plan of care at least every 60 days and document the date of the review in the record of the patient.

(2) For recipients receiving intermediate, heavy care/intermediate or intermediate care for the mentally retarded, the interdisciplinary team shall review each plan of care at least every 90 days and document the date of the review in the record of the recipient.

(f) *Attending physician decision on level of care.*

(1) In response to changes in the recipient's medical condition, the attending physician may order a change in the recipient's level of care which is different from the level of care for which payment is authorized.

(2) If the attending physician recommends a change in the recipient's level of care to or from the skilled level of care, the attending physician shall document the change in the recipient's medical record and sign a completed Skilled Nursing Care Assessment form which substantiates that the recipient meets or does not meet the minimum medical criteria for skilled level of care specified in § 1181.53(b)(2). The attending physician shall sign and date the entry in the medical record. The original of the Skilled Nursing Care Assessment form shall

accompany the Attending Physician Request for Change Summary form to the Department. Copies of the forms shall be retained in the recipient's medical record. The facility shall make the change immediately and notify the Department of the change. The Department will issue a Confirming Notice to the recipient or the person acting on behalf of the recipient and to the nursing facility.

(3) If the attending physician recommends a change in the recipient's level of care to the intermediate level of care, the attending physician shall document the change in the recipient's medical record and notify the Department of the level of care change on the Attending Physician Request for Change Summary form. A copy of the form shall be retained in the recipient's medical record.

(4) If the attending physician recommends a change in the recipient's level of care to the heavy care/intermediate level of care, the attending physician shall document the change in the recipient's medical record. The facility shall notify the Department of the level of care change on the Attending Physician Request for Change Summary form. A copy of the form shall be retained in the recipient's medical record. The facility shall also submit documentation to the Department to substantiate that the recipient meets the minimum medical requirements for the heavy care/intermediate level of care in Appendix F.

(5) If the recipient's level of care is changed as a result of a determination by the Department's Inspection of Care team as described in subsection (c), the attending physician may order a change in the recipient's level of care only if the recipient's medical condition changes subsequent to the date of the Inspection of Care team's determination and the change in the recipient's medical condition warrants another level of care. The physician shall date and sign the documentation of the change in the medical condition and state the alternate care recommendation in the recipient's record.

(i) If ordering the skilled level of care, the attending physician shall sign and date a completed Skilled Nursing Care Assessment form substantiating that the recipient meets the minimum medical requirements for skilled level of care specified in § 1181.53(b)(2). The original of the Skilled Nursing Care Assessment form substantiating the recipient's medical eligibility shall accompany the Attending Physician Request for Change Summary form to the Department. Copies of the forms shall be retained in the recipient's medical record.

(ii) If ordering the intermediate level of care, the attending physician shall complete an Attending Physician Request for Change Summary form, and the original copy shall be sent to the Department. A copy of the form shall be retained in the recipient's medical record.

(iii) If ordering the heavy care/intermediate level of care, the attending physician shall complete an Attending Physician Request for Change Summary form. The original of the Attending Physician Request for Change Summary form and documentation to substantiate that the recipient meets the

minimum medical requirements for the heavy care/intermediate level of care in Appendix F, shall be sent to the Department. A copy of the form shall be retained in the recipient's medical record.

(g) *Payment pending appeal.* If the recipient or the person or the nursing facility acting on behalf of the recipient appeals an action of the Department to change the level of care for which payment is authorized within the time period specified on the advance notice issued by the Department, the Department will make payment to the facility for the level of care the recipient is presently receiving pending the outcome of the hearing under § 275.4(a)(3)(iii) (relating to procedures). If the Department is sustained in its action, the Department will recover from the facility payments in excess of the amount that would have been made if the action of the Department had not been appealed. The period for which the Department will recover excess payment runs from the effective date specified on the advance notice to the date that the appropriate change in the level of care for which payment is authorized is made.

#### Authority

The provisions of this § 1181.54 amended under sections 403(a) and (b) and 443.1(2) and (3) of the Public Welfare Code (62 P. S. §§ 403(a) and (b) and 443.1(2) and (3)).

#### Source

The provisions of this § 1181.54 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended July 2, 1982, effective July 1, 1982, 12 Pa.B. 2070; amended January 7, 1983, effective January 8, 1983, 13 Pa.B. 148; amended May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; amended March 10, 1989, effective immediately and applies retroactively to February 23, 1988, 19 Pa.B. 999; amended June 29, 1990, effective June 30, 1990, 20 Pa.B. 3595. Immediately preceding text appears at serial pages (135889) to (135894).

#### Notes of Decisions

This section is not arbitrary and capricious and furthers the Commonwealth's interest in maintaining a solvent Medicaid Program. *Centennial Spring Health Care Centers v. Department of Public Welfare*, 541 A.2d 806 (Pa. Cmwlth. 1988).

It is not unreasonable for the Department of Public Welfare to recoup overpayments made for services actually rendered following a provider or recipient appeal when the Department of Public Welfare's reclassifications are sustained. *Centennial Spring Health Care Centers v. Department of Public Welfare*, 541 A.2d 806 (Pa. Cmwlth. 1988).

#### Cross References

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions); 55 Pa. Code § 1181.83 (relating to inspections of care); and 55 Pa. Code § 1181.94 (relating to failure to adhere to certification requirements).

### § 1181.55. General limitations on payment.

The payment limits specified in this section apply to payment to nursing facilities for nursing facility care.

**Source**

The provisions of this § 1181.55 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions).

**§ 1181.56. Limitations on payment for reserved beds.**

The Department will make payment to a nursing facility for a reserved bed when the recipient is absent from the facility for a continuous 24-hour period because of hospitalization or therapeutic leave. Each reserved bed for therapeutic leave shall be recorded on the facility's daily census record and invoice. If a bed is being reserved for a recipient who has been hospitalized and that bed is being temporarily occupied by another recipient, the occupied bed shall be recorded on the facility's daily census record and the invoice. A reserved bed shall be available for the recipient upon the recipient's return to the facility. The following limits on payment for reserved bed days apply:

(1) *Hospitalization.* A recipient receiving skilled nursing care, intermediate care or intermediate care for the mentally retarded—except a recipient in a State-operated intermediate care facility for the mentally retarded—is eligible for a maximum 15 consecutive reserved bed days per hospitalization. The Department will pay a facility at a rate of one-third of the facility's current interim per diem rate on file with the Department for a hospital reserved bed day.

(2) *Therapeutic leave.* Payment for therapeutic leave days is limited as follows:

(i) A recipient receiving skilled nursing care is eligible for a maximum of 15 days per calendar year for therapeutic leave outside the facility if the leave is included in the individual's plan of care and is ordered by the attending physician.

(ii) A recipient receiving intermediate care is eligible for a maximum of 30 days per calendar year of therapeutic leave outside the facility if the leave is included in the individual's plan of care and is ordered by the attending physician.

(iii) A recipient receiving intermediate care for the mentally retarded is eligible for a maximum of 75 days per calendar year for therapeutic leave outside the facility.

(iv) A recipient receiving both skilled and intermediate level of care during the calendar year is eligible for a maximum of 30 days per calendar year for therapeutic leave.

**Authority**

The provisions of this § 1181.56 amended under section 443.1(2) and (3) of the Public Welfare Code (62 P. S. § 443.1(2) and (3)).

**Source**

The provisions of this § 1181.56 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended July 2, 1982, effective July 1, 1982, 12 Pa.B. 2070; corrected July 2, 1982, effective July 1, 1982, 12 Pa.B. 2290; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial pages (133591) to (133592).

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions); 55 Pa. Code § 1181.56a (relating to limitations on payment for reserved beds—statement of policy); 55 Pa. Code § 1181.62 (relating to noncompensable services); and 55 Pa. Code § 6211.62 (relating to computing the minimum occupancy rate).

**§ 1181.56a. Limitations on payment for reserved beds—statement of policy.**

(a) *Interpretation.* The Department interprets § 1181.56 (relating to limitations on payments for reserved beds) to mean that for each continuous 24-hour period the patient is absent from the facility, the nursing home should bill the Department for a hospital or therapeutic leave day, under the limitations set forth in this chapter. Furthermore, when the cycle—continuous 24-hour period—is broken, the home will bill the Department for a facility day.

(b) *Discussion.* The Department has seen evidence that some nursing homes are not following the interpretation set forth in subsection (a) of how to bill for reserved days. The following examples should serve as guidelines to help nursing homes bill for reserved days properly.

(1) *Example 1.* A nursing home resident leaves the facility May 4, 1987 at 2:30 p.m. and returns to the facility May 5, 1987 at 10:30 a.m. May 4, 1987 should be billed as a facility day and May 5, 1987 should also be billed as a facility day because the patient was not absent from the facility for a continuous 24-hour period.

(2) *Example 2.* A nursing home resident leaves the facility on May 4, 1987 at 11 a.m. and returns to the facility May 5, 1987 at 1 p.m. May 4, 1987 should be billed as a reserve bed day and May 5, 1987 should be billed as a facility day. The patient was absent from the facility for a continuous 24-hour period from May 4, 1987 at 11 a.m. to May 5, 1987 at 11 a.m.

(3) *Example 3.* A nursing home resident leaves the facility on May 4, 1987 at 9 a.m. and returns to the facility May 11, 1987 at 12 noon. May 4, 1987 through May 10, 1987 should be billed as reserve bed days. May 11, 1987 should be billed as a facility day.

(4) *Example 4.* A nursing home resident leaves the facility May 1, 1987 at 10 a.m. and returns to the facility May 16, 1987 at 1 p.m. May 1, 1987 through May 15, 1987 should be billed as reserve bed days and May 16, 1987 should be billed as a facility day.

**Source**

The provisions of this § 1181.56a adopted February 5, 1988, effective February 12, 1988, 18 Pa.B. 596.

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions).

**§ 1181.56b. Charges for bed hold days—statement of policy.**

(a) Under the Omnibus Budget Reconciliation Act of 1987, if a nursing facility resident is transferred to a hospital, the resident shall be permitted to return to the nursing facility immediately upon the first availability of a bed in a semiprivate room in the facility if, at the time of readmission, the resident requires the services provided by the facility.

(b) If a nursing facility resident indicates in writing a desire to pay the nursing facility to keep the resident's bed vacant in anticipation of the resident's return to the facility after the 15-day bed hold, the nursing facility may charge the resident to hold the bed the resident occupied prior to transferring to the hospital.

(c) The nursing facility may not charge the resident more than the MA rate paid for the resident's care prior to the resident's transfer to the hospital.

(d) The nursing facility may not charge the resident to hold a bed other than the bed the resident occupied prior to the resident's transfer to the hospital.

(e) Nursing facilities enrolled in the MA Program shall adhere to this chapter.

**Source**

The provisions of this § 1181.56b adopted May 1, 1992, effective upon publication and applies retroactively to May 1, 1992, 22 Pa.B. 2357.

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions).

**§ 1181.56c. Reimbursement for hospital reserved bed days during a Medicare benefit period—statement of policy.**

(a) Effective with dates of service on and after January 1, 1992, an MA eligible nursing facility resident that is in a Medicare benefit period, fully paid days or coinsurance days, or both, is eligible for a maximum of 15 consecutive reserved bed days per hospitalization. The Department will reimburse a nursing facility at 1/3 of the facility's current interim per diem rate on file with the Department, for a hospital reserved bed day when a resident is hospitalized during a Medicare benefit period.

(b) Nursing facilities should follow the billing instructions under the billing section of the Long Term Care Services Provider Handbook when invoicing the Department for hospital reserved bed days.

**Source**

The provisions of this § 1181.56c adopted May 1, 1992, effective upon publication and applies retroactively to January 1, 1992, 22 Pa.B. 2358.

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions).

**§ 1181.57. Limitations on payment for prescription drugs.**

The Department's interim per diem rate for nursing facility care does not include prescription drugs. Prescribed drugs for categorically needy are reimbursable directly to a licensed pharmacy according to regulations contained in Chapter 1121 (relating to pharmaceutical services).

**Source**

The provisions of this § 1181.57 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions).

**§ 1181.58. Limitations on payment during strike or disaster situations requiring patient evacuation.**

Payment may continue to be made to a facility that has temporarily transferred patients, as the result or threat of a strike or disaster situation, to the closest medical institution able to meet the patients' needs, if the institution receiving the patients is licensed and certified to provide the required level of care. If the facility transferring the patients can demonstrate that there is no certified facility available for the safe and orderly transfer of the patients, the payments may be made so long as the institution receiving the patients is certifiable and licensed to provide the required level of care. If the facility to which the patients are transferred has a different interim per diem rate, the transferring facility will be reimbursed at the lower rate. The facility shall immediately notify the Department, Office of Medical Assistance Programs, in writing of an impending strike or a disaster situation and follow with a listing of MA patients and the facility to which they will be or were transferred.

**Source**

The provisions of this § 1181.58 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial pages (133593) and (117425).

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions); and 55 Pa. Code Chapter 1181 Appendix O (relating to OBRA sanctions).

**§ 1181.58a. [Reserved].****Source**

The provisions of this § 1181.58a adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; deleted August 19, 1983, effective July 1, 1983, 13 Pa.B. 2554.

**§ 1181.59. Payment to a nursing facility for heavy care/intermediate services or intermediate care provided in a dually certified skilled bed.**

(a) Payment may be made to a nursing facility for intermediate care provided in a bed which is dually certified for skilled and intermediate care, subject to the following conditions:

(1) The costs of services to the intermediate care (ICF) patients in dually certified beds, including services to heavy care/intermediate patients, shall be included in the determination of the skilled nursing facility (SNF) payment rate.

(2) The SNF payment rate shall be based on the costs of care of all patients served in dually-certified and SNF-only certified beds.

(3) Except as provided in subsection (b), payments for ICF patients in the dually-certified beds will be determined by the facility's rate for ICF-only certified beds, or, where the facility has no ICF-only certified beds, by combining the facility's SNF rate components for depreciation and interest on capital indebtedness with the lower of one of the following:

(i) The facility's SNF net operating cost rate component.

(ii) The applicable ceiling on ICF net operating costs.

(4) The facility has contacted the Department, prior to invoicing for intermediate care in the bed, to designate the bed as an intermediate care bed for MA program payment purposes.

(5) Payment will not be made for services to an ICF patient in a bed which is not certified to provide intermediate care.

(b) Payment may be made to a nursing facility for heavy care/intermediate services when a recipient's level of care changes to heavy care/intermediate if that recipient is in a dually certified skilled bed. The nursing facility shall be reimbursed for heavy care/intermediate services at the higher of the facility's applicable rates for skilled or intermediate care, as limited by the ceilings.

**Authority**

The provisions of this § 1181.59 amended under sections 201 and 443.1(2) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(2)).

**Source**

The provisions of this § 1181.59 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended August 5, 1983, effective January 1, 1983, 13 Pa.B. 2402; amended September 6, 1985, effective September 7, 1985, except that the groups and ceilings shall be effective and apply to costs



of services rendered from July 1, 1984 through December 31, 1984, 15 Pa.B. 3181; amended March 10, 1989, effective immediately and applies retroactively to February 23, 1988, 19 Pa.B. 999. Immediately preceding text appears at serial page (117425).

#### Cross References

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions).

### § 1181.60. Utilizing Medicare as a resource.

(a) An eligible recipient who is a Medicare beneficiary, is receiving care in a Medicare certified facility and is authorized by the Medicare Program to receive skilled nursing care benefits shall utilize these benefits before payment will be made by the MA Program. For each benefit period, the Medicare Program makes full payment for the first 20 days of skilled nursing care and pays all but a specified coinsurance amount for days 21 through 100. If the Medicare payment for days 21 through 100 is less than the facility's MA interim per diem rate for skilled nursing care, the Department will participate in payment of the coinsurance charge to the extent that the total of the Medicare payment and the Department's coinsurance payment does not exceed the MA skilled interim per diem rate for the facility. The Department will not pay more than the maximum coinsurance amount.

(b) The facility may not seek or accept payment from a source other than Medicare for any portion of the Medicare coinsurance amount that is not paid by the Department on behalf of an eligible recipient because of the limit of the facility's MA skilled interim per diem rate.

(c) The Medicare payment will be recognized as payment in full for each day that a Medicare payment is made during the first 20 days of a benefit period.

(d) If a recipient either has purchased Medicare Part B coverage or the coverage has been purchased for the recipient, the facility shall use available Medicare Part B resources for Medicare Part B services.

(e) The amendments to this section as published in Annex A at 20 Pa.B. 6175 (December 15, 1990), and corrected at 21 Pa.B. 228 (January 19, 1991), required by the Medicare Catastrophic Coverage Act of 1988 (Pub. L. No. 100-360 (Repealed)) are in effect for the period from January 1, 1989 to December 31, 1989.

#### Source

The provisions of this § 1181.60 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; deleted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended August 19, 1983, effective July 1, 1983, 13 Pa.B. 2554; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005; amended December 14, 1990, effective immediately and apply retroactively to January 1, 1989, 20 Pa.B. 6172; amended December 14, 1990, effective immediately and apply retroactively to January 1, 1990, 20 Pa.B. 6172; corrected December 21, 1990, effective immediately and apply retroactively to January 1, 1990, 20 Pa.B. 6269; corrected January 18, 1991, effective immediately and apply retroactively to January 1, 1990, 21 Pa.B. 228. Immediately preceding text appears at serial page (135899).

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions).

**§ 1181.61. Services included in the interim per diem rate.**

The Department's interim per diem rate of reimbursement for long term care provided eligible recipients in participating facilities includes allowable costs for routine services. Services include but are not limited to:

- (1) Regular room, dietary and nursing services, social services and other services required to meet certification standards, medical and surgical supplies, and the use of equipment and facilities.
- (2) General nursing services, including but not limited to administration of oxygen and related medications, handfeeding, incontinency care, tray service and enemas.
- (3) Items furnished routinely and relatively uniformly to all patients, such as patient gowns, water pitchers, basins and bedpans.
- (4) Items furnished, distributed or used individually in small quantities such as alcohol, applicators, cotton balls, bandaids, antacids, aspirin (and other nonlegend drugs ordinarily kept on hand), suppositories and tongue depressors.
- (5) Items used by individual patients but which are reusable and expected to be available, such as ice bags, bedrails, canes, crutches, walkers, wheelchairs, traction equipment and other durable medical equipment.
- (6) Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician.
- (7) Laundry services other than for personal clothing, except for intermediate care facilities for the mentally retarded in which laundry services including the laundering of resident's personal clothing are allowable.
- (8) Other special medical services of a rehabilitative, restorative or maintenance nature, designed to restore or sustain the patient's physical and social capacities.

**Source**

The provisions of this § 1181.61 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629. Immediately preceding text appears at serial pages (85073) to (85074).

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions).

**§ 1181.61a. Nurse-aide programs—statement of policy.**

As a result of provisions contained in the Federal Omnibus Budget Reconciliation Act of 1987 (42 U.S.C.A. § 1396r(b)(5)) regarding nurse aide training and testing fees, the Department will reimburse nursing facilities the reasonable and appropriate costs for State-approved nurse aide training programs that meet Fed-

eral requirements and are completed by individuals employed or offered employment within 12 months of completing the Nurse Aide Training and Competency Evaluation Program (NATCEP) or a Competency Evaluation Program (CEP).

**Source**

The provisions of this § 1181.61a adopted April 1, 1995, effective April 6, 1995, 25 Pa.B. 1169.

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions).

**§ 1181.62. Noncompensable services.**

Payment will not be made to a nursing facility for:

- (1) Services provided to a recipient who no longer requires the level of care for which payment is authorized by the County Assistance Office.
- (2) Reserved bed days that exceed the limits set for the different levels of care in § 1181.56 (relating to limitations on payment for reserved beds).
- (3) Services provided to a recipient occupying a bed which is not certified for the level of care for which payment is authorized by the County Assistance Office.
- (4) Services covered but disallowed by Medicare.
- (5) Services rendered by a provider that do not meet the conditions for payment established by this chapter and Chapter 1101 (relating to general provisions).

**Source**

The provisions of this § 1181.62 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended March 10, 1989, effective immediately and applies retroactively to February 23, 1988, 19 Pa.B. 999; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial page (117427).

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions).

**§ 1181.63. Method of payment.**

Payment for nursing facility care is made in accordance with the provisions of the Medicaid State Plan and this chapter.

**Source**

The provisions of this § 1181.63 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions).

**§ 1181.64. Cost reporting.**

Each facility shall submit a cost report to the Department within 90 days following the close of each fiscal year as designated by the facility in accordance with § 1181.71 (relating to annual reporting). The report shall be prepared using the accrual basis of accounting and must cover a fiscal period of 12 consecutive months. Facilities beginning operations during a fiscal period will prepare a report from the date of approval for participation to the end of the facility's fiscal year. The cost report shall identify costs of services, facilities and supplies furnished by organizations related to the provider by common ownership or control.

**Source**

The provisions of this § 1181.64 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

**Cross References**

This section cited in 55 Pa. Code § 1181.45 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1181.52 (relating to payment conditions); and 55 Pa. Code § 1181.91 (relating to failure to file a cost report).

**§ 1181.65. Cost-finding.**

(a) A nursing facility shall use the direct allocation method of cost-finding. The costs of ancillary and administrative services shall be apportioned directly to the appropriate level of care based on appropriate statistical data.

(b) A facility's direct or indirect allowable costs related to patient care will be considered in the finding and allocation of costs to the MA Program for its eligible recipients. Total allowable costs of a facility shall be apportioned between third-party payors and other patients so that the share borne by MA is based upon actual services and costs related to MA patients. For purposes of MA reimbursement, the return on net equity and net worth is not reimbursable.

(c) The Department will recognize depreciation and interest as an allowable cost for general and county nursing facilities subject to the following conditions:

(1) Depreciation and interest on new or additional beds is an allowable cost only if one of the following applies:

(i) The facility was issued either a Section 1122 approval or letter of nonreviewability under 28 Pa. Code Chapter 301 (relating to limitation on Federal participation for capital expenditures) or a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 (relating to Certificate of Need Program) for the project by the Department of Health no later than August 31, 1982.

(ii) The facility was issued a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 for the construction of a nursing facility, and there was no nursing facility, including county, private or hospital-based, located within the county.

(2) The Department will not recognize depreciation and interest as allowable costs if the facility does not substantially implement the project as defined at 28 Pa. Code § 401.5(m)(3) (relating to Certificate of Need) within the effective period of the original Section 1122 approval or the original Certificate of Need.

(3) Depreciation and interest on replacement beds is an allowable cost only if the facility was issued a Certificate of Need or a letter of nonreviewability by the Department of Health.

(4) Allowable depreciation and interest on capital indebtedness will be recognized on debt service incurred to finance a maximum cost per bed of \$22,000. The \$22,000 per bed limit does not include the cost of movable equipment. Allowable depreciation and interest will be calculated by the straight line method of accounting.

(d) Allowable operating costs for a general nursing facility including hospital-based and special rehabilitation facilities, shall be determined subject to the following:

(1) The Department's Manual for Allowable Cost Reimbursement for Skilled Nursing and Intermediate Care Facilities.

(2) The HIM-15, except that if the Department's Manual and the HIM-15 differ, the Department's Manual applies.

(3) The MSA or non-MSA group ceilings if applicable.

(e) Allowable operating costs for a county nursing facility will be determined under the following:

(1) The Department's *Manual for Allowable Cost Reimbursement for Skilled Nursing and Intermediate Care Facilities* is used for cost-finding.

(2) HIM-15 will be used as a supplement to the Department's *Manual for Allowable Cost Reimbursement for Skilled Nursing and Intermediate Care Facilities* with respect to allowable costs. HIM-15 may not be construed to recognize an allowable cost which otherwise is not included or is excluded in the Department's *Manual for Allowable Cost Reimbursement for Skilled Nursing and Intermediate Care Facilities*.

(3) The facility's net operating per diem is subject to the MSA or non-MSA group ceiling for county facilities.

(4) The Department will deduct from the State share of the allowable operating costs of county facilities the administrative expense the Department incurs in determining the allowable operating costs of a county facility.

(f) Allowable costs for an intermediate care facility for the mentally retarded shall be determined as follows:

(1) For State-operated intermediate care facilities for the mentally retarded, allowable costs are determined by HIM-15.

(2) For non-State-operated intermediate care facilities for the mentally retarded, allowable costs are determined by Subchapter C (Reserved).

(g) The allowable costs of a psychiatric transitional facility and other State-operated nursing facility other than an intermediate care facility for the mentally retarded will be determined in accordance with the HIM-15 and within the limits of their approved budgets.

(h) For a nursing facility, the Department's reimbursement for depreciation, interest and other costs related to the negotiation or settlement of the sale or purchase of a capital asset that undergoes a transfer of ownership either on or after July 18, 1984, will be determined under paragraphs (1) and (2). Paragraph (1) does not apply to an asset that undergoes a transfer of ownership either on or after July 18, 1984 under an enforceable agreement that was entered into prior to July 18, 1984.

(1) The cost basis that will be used to establish the allowable depreciation and interest for an asset that undergoes a transfer of ownership on or after July 18, 1984 will be the lesser of the remaining allowable cost basis of the asset to the owner of record on or after July 18, 1984, or, in the case of an asset not in existence as of that date, the first owner of record of the asset after that date, or the allowable cost basis of the asset to the new owner.

(2) The Department will not recognize as allowable, a cost including legal fees, travel costs and the costs of feasibility studies, attributable to the negotiation or settlement of the sale or purchase of a capital asset—by acquisition or merger—for which a payment has previously been made under Title XVIII of the Social Security Act (42 U.S.C.A. §§ 1395—1395xx).

#### Authority

The provisions of this § 1181.65 amended under sections 201 and 443.1 of the Public Welfare Code (62 P. S. §§ 201 and 443.1).

#### Source

The provisions of this § 1181.65 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended July 2, 1982, effective July 1, 1982, 12 Pa.B. 2070; amended August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; corrected August 19, 1983, effective February 12, 1983, 13 Pa.B. 2553; amended February 17, 1984, effective July 1, 1983, 14 Pa.B. 546; corrected August 24, 1984, effective March 24, 1984, 14 Pa.B. 3091; amended May 3, 1985, effective retroactively to July 1984, 15 Pa.B. 1629; amended September 6, 1985, effective September 7, 1985, except that the groups and ceilings shall be effective and apply at audit to costs of services rendered from July 1, 1984 through December 31, 1985, 15 Pa.B. 3181; corrected January 24, 1986, effective September 7, 1985, 16 Pa.B. 249; amended February 28, 1986, effective March 1, 1986, 16 Pa.B. 600; amended March 10, 1989, effective immediately and applies retroactively to February 23, 1988, 19 Pa.B. 999; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial pages (117428) to (117430).

#### Notes of Decisions

##### *Conflicting Authorities*

When a conflict as to allowable operating costs arose between the state and federal manual, the State manual controlled. *Western Reserve Convalescent Home v. Department of Public Welfare*, 660 A.2d 1312 (Pa. 1995).

Federal manual establishing offset rules applies where State manual is silent. *Northwood Nursing and Convalescent Home v. Department of Public Welfare*, 567 A.2d 1385 (Pa. 1989).

#### Cross References

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions); and 55 Pa. Code § 1181.259 (relating to depreciation allowance).

### § 1181.66. Setting ceilings on allowable net operating costs.

(a) The Department will establish maximum group per diem rate ceilings for allowable net operating costs for each level of care for general and county operated nursing facilities. Effective April 1, 1988, these ceilings will be based on 115% of the median of year-end reported costs excluding depreciation and interest. Facilities will not be reimbursed for net operating costs above the maximum group per diem rate ceilings. Costs which are not reimbursed within the established ceilings for a fiscal year may not be carried forward or backward to other fiscal years. The ceilings for general and county operated nursing facilities will be established as follows:

(1) The Department will use only year-end cost reports that cover a period of at least 180 days, are acceptable and received at least 90 days prior to the implementation date of the new ceilings. An acceptable cost report is one in which the following requirements are met:

(i) Applicable items are fully completed in accordance with the instructions incorporated in the Department's cost report, including the necessary original signatures on the required number of copies.

(ii) Computations carried out on the form are accurate and consistent with other related computations.

(iii) The treatment of costs conforms to the applicable requirements of this subchapter and Subchapters B and C (relating to manual for allowable cost reimbursement for skilled nursing and intermediate care facilities; and Reserved).

(iv) Required documentation is included.

(2) In establishing net operating ceilings, the data from the provider's latest acceptable cost report will be brought forward to a common date by using multipliers developed by the Department based on the most current revised urban wage earners and clerical workers consumer price index (CPI-W, 1967 = 100, all items, all cities, United States average). This factor will adjust for inflation for the period from the end-date of each cost report to the common date.

(3) To account for the period from the common date to the end date for which these ceilings will be in effect, the Department will again utilize a combination of inflation factors. If actual inflation factors are available, CPI-W will be utilized. If actual CPI-W is not available, the Department will take into account projected economic indicators, such as CPI-W. During Fiscal Years



1992-1993, 1993-1994 and 1994-1995, the Department will utilize CPI-W plus an amount equal to the difference between CPI-W and the DRI McGraw-Hill Health Care Costs-Nursing Home Market Basket applied to the full year ceiling setting period applicable to the last day of the second quarter of the calendar year, as the inflation factor under this paragraph. The Department will also increase the ceilings so calculated by an additional factor equal to 2.5%.

(4) The inflation factors used, the common date and the number of cost reports by facility year utilized will be published in the notice in the *Pennsylvania Bulletin* which establishes each new ceiling.

(5) Metropolitan Statistical Area (MSA) group ceilings for allowable net operating costs for county nursing facilities and general nursing facilities, excluding hospital-based and special rehabilitation facilities, will be established at least annually by the Department. Effective April 1, 1988, these ceilings will be based on 115% of the median of year-end reported costs excluding depreciation and interest. The groups used by the Department will be based on the classification levels announced by the Federal Office of Management and Budget no later than 90 days before the implementation date of the new ceilings. The Department will establish a separate ceiling for general nursing facilities, excluding hospital-based and special rehabilitation facilities, in counties which are located in Level A statistical areas, for those in Level B statistical areas, for those in Level C statistical areas and for those in nonstatistical areas under the Federal system. The Department will establish a separate ceiling for county nursing facilities in counties located in either Level A or Level B statistical areas and one for county nursing facilities in counties located in either Level C statistical areas or in nonstatistical areas under the Federal system.

(6) The Department will announce, by notice submitted for recommended publication in the *Pennsylvania Bulletin* and suggested codification in the *Pennsylvania Code* as an appendix to this section, the classification levels and the applicable per diem ceilings for the location of the facility, level of care, type of facility and date of service involved. A fiscal note, as required by section 612 of The Administrative Code of 1929 (71 P. S. § 232), will accompany the notice.

(b) Statewide ceilings for allowable net operating costs will be established at least annually by the Department under the method in subsection (a)(1)—(4) and (6) for hospital-based nursing facilities. Effective April 1, 1988, these ceilings will be based on 115% of the median of year-end reported costs excluding depreciation and interest.

(c) Statewide ceilings for allowable net operating costs will be established at least annually by the Department under the method in subsection (a)(1)—(4) and (6) for special rehabilitation facilities. Effective April 1, 1988, these ceilings will be based on 115% of the median of year-end reported costs excluding depreciation and interest.



(d) State-operated intermediate care facilities for the mentally retarded are reimbursed actual allowable costs under Medicare principles, subject to MA regulations. NonState-operated intermediate care facilities for the mentally retarded are reimbursed actual, allowable, reasonable costs under Subchapter C and other applicable MA Regulations.

(e) Psychiatric transitional facilities are reimbursed actual allowable costs under Medicare principles and within the limits of their budgets.

#### Authority

The provisions of this § 1181.66 amended under sections 201, 403 and 443.1(2) and (3) of the Public Welfare Code (62 P. S. §§ 201, 403 and 443.1 (2) and (3)).

#### Source

The provisions of this § 1181.66 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended July 2, 1982, effective July 1, 1982, 12 Pa.B. 2070; amended May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; amended September 6, 1985, effective September 7, 1985, except that the groups and ceilings shall be effective and apply at audit to costs of services rendered from July 1, 1984 through December 31, 1985, 15 Pa.B. 3181; corrected January 24, 1986, effective September 7, 1985, 16 Pa.B. 249; amended September 5, 1986, effective July 1, 1985, 16 Pa.B. 3294; amended June 29, 1990, effective immediately and apply retroactively to April 1, 1988, 20 Pa.B. 3593; amended July 21, 1995, effective immediately and apply retroactively to July 1, 1992, and sunset on June 30, 1995, 25 Pa.B. 2893. Immediately preceding text appears at serial pages (196505) to (196507). (**Editor's Note:** See 22 Pa.B. 3749 (July 18, 1992) for nursing home pooling provisions.)

#### Notes of Decisions

The General Assembly lacked the authority to specify the starting date on which a raised ceiling for nursing home cost reimbursements would commence. *Wesbury United Methodist Community v. Department of Public Welfare*, 597 A.2d 271 (Pa. Cmwlth. 1991).

#### Cross References

This section cited in 55 Pa. Code § 1181.45 (relating to ongoing responsibilities of providers); 55 Pa. Code § 1181.51 (relating to general payment policy); 55 Pa. Code § 1181.52 (relating to payment conditions); 55 Pa. Code § 1181.73 (relating to final reporting); 55 Pa. Code § 1181.74 (relating to auditing requirements related to cost reports); and 55 Pa. Code § 1181.217 (relating to establishing ceilings for allowable net operating costs).

**APPENDIX A  
CEILINGS ON NET OPERATING  
COST REIMBURSEMENT FOR  
GENERAL AND COUNTY NURSING  
FACILITIES**

**Editor's Note:** The following document was published in the *Pennsylvania Bulletin* as a Notice and is codified under 1 Pa. Code § 3.1(9) (relating to contents of *Code*) as a document which the Legislative Reference Bureau finds to be general and permanent in nature.

**Annex A  
GENERAL NURSING FACILITIES**  
(Excluding Hospital-Based and Special Rehabilitation Facilities)

	<i>*Skilled Nursing Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>	<i>*Intermediate Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>
<b>1. LEVEL A</b>		
Philadelphia		
Bucks	\$133.39	\$110.54
Chester	\$133.39	\$110.54
Delaware	\$133.39	\$110.54
Montgomery	\$133.39	\$110.54
Philadelphia	\$133.39	\$110.54
Pittsburgh		
Allegheny	\$133.39	\$110.54
Beaver	\$133.39	\$110.54
Butler	\$133.39	\$110.54
Fayette	\$133.39	\$110.54
Washington	\$133.39	\$110.54
Westmoreland	\$133.39	\$110.54
<b>2. LEVEL B</b>		
Allentown—Bethlehem—Easton		
Carbon	\$117 .20	\$ 98.00
Lehigh	\$117 .20	\$ 98.00
Northampton	\$117 .20	\$ 98.00
Erie		
Erie	\$117 .20	\$ 98.00

	<i>*Skilled Nursing Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>	<i>*Intermediate Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>
Harrisburg—Lebanon—Carlisle		
Cumberland	\$117.20	\$ 98.00
Dauphin	\$117.20	\$ 98.00
Lebanon	\$117.20	\$ 98.00
Perry	\$117.20	\$ 98.00
Lancaster		
Lancaster	\$117.20	\$ 98.00
Newburgh		
Pike	\$117.20	\$ 98.00
Reading		
Berks	\$117.20	\$ 98.00
Scranton—Wilkes-Barre—Hazleton		
Columbia	\$117.20	\$ 98.00
Lackawanna	\$117.20	\$ 98.00
Luzerne	\$117.20	\$ 98.00
Wyoming	\$117.20	\$ 98.00
York		
York	\$117.20	\$ 98.00
3. LEVEL C		
Altoona		
Blair	\$115.67	\$ 91.37
Johnstown		
Cambria	\$115.67	\$ 91.37
Somerset	\$115.67	\$ 91.37
Sharon		
Mercer	\$115.67	\$ 91.37
State College		
Centre	\$115.67	\$ 91.37
Williamsport		
Lycoming	\$115.67	\$ 91.37

	<i>*Skilled Nursing Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>	<i>*Intermediate Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>
4. Non-MSA		
Adams	\$105.51	\$ 86.15
Armstrong	\$105.51	\$ 86.15
Bedford	\$105.51	\$ 86.15
Bradford	\$105.51	\$ 86.15
Cameron	\$105.51	\$ 86.15
Clarion	\$105.51	\$ 86.15
Clearfield	\$105.51	\$ 86.15
Clinton	\$105.51	\$ 86.15
Crawford	\$105.51	\$ 86.15
Elk	\$105.51	\$ 86.15
Forest	\$105.51	\$ 86.15
Franklin	\$105.51	\$ 86.15
Fulton	\$105.51	\$ 86.15
Greene	\$105.51	\$ 86.15
Huntingdon	\$105.51	\$ 86.15
Indiana	\$105.51	\$ 86.15
Jefferson	\$105.51	\$ 86.15
Juniata	\$105.51	\$ 86.15
Lawrence	\$105.51	\$ 86.15
McKean	\$105.51	\$ 86.15
Mifflin	\$105.51	\$ 86.15
Monroe	\$105.51	\$ 86.15
Montour	\$105.51	\$ 86.15
Northumberland	\$105.51	\$ 86.15
Potter	\$105.51	\$ 86.15
Schuylkill	\$105.51	\$ 86.15
Snyder	\$105.51	\$ 86.15
Sullivan	\$105.51	\$ 86.15
Susquehanna	\$105.51	\$ 86.15
Tioga	\$105.51	\$ 86.15
Union	\$105.51	\$ 86.15
Venango	\$105.51	\$ 86.15
Warren	\$105.51	\$ 86.15
Wayne	\$105.51	\$ 86.15

\*Does not include depreciation and interest.

## HOSPITAL-BASED NURSING FACILITIES

	<i>*Skilled Nursing Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>	<i>*Intermediate Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>
Statewide per diem ceilings	\$202.80	\$135.08

\*Does not include depreciation and interest.

## SPECIAL REHABILITATION FACILITIES

	<i>*Skilled Nursing Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>	<i>*Intermediate Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>
Statewide per diem ceilings	\$310.29	\$231.97

\*Does not include depreciation and interest.

## COUNTY NURSING FACILITIES

	<i>*Skilled Nursing Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>	<i>*Intermediate Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>
1. LEVEL A and B		
Philadelphia		
Bucks	\$145.04	\$125.96
Chester	\$145.04	\$125.96
Delaware	\$145.04	\$125.96
Montgomery	\$145.04	\$125.96
Philadelphia	\$145.04	\$125.96
Pittsburgh		
Allegheny	\$145.04	\$125.96
Beaver	\$145.04	\$125.96

	<i>*Skilled Nursing Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>	<i>*Intermediate Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>
Butler	\$145.04	\$125.96
Fayette	—	—
Washington	\$145.04	\$125.96
Westmoreland	\$145.04	\$125.96
Allentown—Bethlehem—Easton		
Carbon	\$145.04	\$125.96
Lehigh	\$145.04	\$125.96
Northampton	\$145.04	\$125.96
Erie		
Erie	\$145.04	\$125.96
Harrisburg—Lebanon—Carlisle		
Cumberland	\$145.04	\$125.96
Dauphin	\$145.04	\$125.96
Perry	—	—
Lebanon	\$145.04	\$125.96
Lancaster		
Lancaster	\$145.04	\$125.96
Newburgh		
Pike	—	—
Reading		
Berks	\$145.04	\$125.96
Scranton—Wilkes-Barre—Hazleton		
Columbia	—	—
Lackawanna	\$145.04	\$125.96
Luzerne	\$145.04	\$125.96
Wyoming	—	—
York		
York	\$145.04	\$125.96

	<i>*Skilled Nursing Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>	<i>*Intermediate Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>
2. LEVEL C and Non-MSA		
Altoona		
Blair	\$125.90	\$103.12
Johnstown		
Cambria	\$125.90	\$103.12
Somerset	\$125.90	\$103.12
Sharon		
Mercer	\$125.90	\$103.12
State College Centre	\$125.90	\$103.12
Williamsport Lycoming	—	—
All Non-MSA		
Adams	\$125.90	\$103.12
Armstrong	\$125.90	\$103.12
Bedford	—	—
Bradford	\$125.90	\$103.12
Cameron	—	—
Clarion	—	—
Clearfield	—	—
Clinton	\$125.90	\$103.12
Crawford	\$125.90	\$103.12
Elk	—	—
Forest	—	—
Franklin	\$125.90	\$103.12
Fulton	—	—
Greene	\$125.90	\$103.12
Huntingdon	—	—
Indiana	\$125.90	\$103.12
Jefferson	—	—
Juniata	—	—

	<i>*Skilled Nursing Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>	<i>*Intermediate Care Net Operating Ceilings Effective July 1, 1995 thru December 31, 1995</i>
Lawrence	\$125.90	\$103.12
McKean	\$125.90	\$103.12
Mifflin	—	—
Monroe	\$125.90	\$103.12
Montour	—	—
Northumberland	\$125.90	\$103.12
Potter	—	—
Schuylkill	\$125.90	\$103.12
Snyder	—	—
Sullivan	—	—
Susquehanna	—	—
Tioga	—	—
Union	—	—
Venango	\$125.90	\$103.12
Warren	\$125.90	\$103.12
Wayne	—	—

\*Does not include depreciation and interest.

#### Source

The provisions of these ceilings on net operating costs, amended September 5, 1986, effective July 1, 1985, 16 Pa.B. 3350; amended September 5, 1986, effective October 1, 1985, 16 Pa.B. 3354; amended October 17, 1986, effective July 1, 1986, 16 Pa.B. 3996; amended September 18, 1987, effective July 1, 1987, 17 Pa.B. 3784; amended October 14, 1988, effective July 1, 1988, 18 Pa.B. 4716; amended November 17, 1989, effective July 1, 1989, 19 Pa.B. 4974; amended September 21, 1990, effective July 1, 1990, 20 Pa.B. 4901; amended April 17, 1992, effective for services rendered from July 1, 1991 through June 30, 1992, 22 Pa.B. 1956; amended September 24, 1993, effective for services rendered from July 1, 1992 through June 30, 1993, 23 Pa.B. 4581; amended July 8, 1994, effective July 1, 1993, 24 Pa.B. 3406; amended April 7, 1995, effective for services rendered from July 1, 1994, through June 30, 1995, 25 Pa.B. 1348; amended January 19, 1996, effective for services rendered from July 1, 1995, through December 31, 1996, 26 Pa.B. 259. Immediately preceding text appears at serial pages (201404) to (201410).



**§ 1181.67. Setting interim per diem rates.**

The Department establishes interim per diem rates on the basis of the following methods and in accordance with § 1181.68 (relating to upper limits of payment):

(1) For general and county nursing facilities, interim per diem rates within the ceilings on net operating costs will be established by the Department based on the latest adjusted reported net operating cost of the facility plus an allowance for depreciation and interest. For the period July 1, 1995, through December 31, 1995, the interim rate will be calculated in this manner, except that if the interim rate for a nursing facility (excluding depreciation and interest) is less than the ceiling on net operating costs to be applied during this period, the interim rate for the nursing facility will be increased by 2% to reflect inflation up to the upper limits on payment as stated in § 1181.68.

(2) For State-operated intermediate care facilities for the mentally retarded, interim per diem rates will be established by the Department based on the latest adjusted reported costs and approved budgets. For non-State intermediate care facilities for the mentally retarded, interim per diem rates will be established by the Department based on the latest adjusted cost report plus an inflationary factor, or a submitted budget if a waiver is granted in accordance with Subchapter C (Reserved).

(3) For psychiatric transitional facilities, interim per diem rates will be established by the Department based on latest adjusted reported costs and approved budgets.

(4) For facilities entering the program and for facilities in the programs with changes of ownership, except for intermediate care facilities for the mentally retarded, the facility's projected MA-11 cost report will be used to set the interim rate for MA during the initial period of operation pending the filing of the first year-end cost report.

**Authority**

The provisions of this § 1181.67 amended under sections 201, 403 and 443.1(2) and (3) of the Public Welfare Code (62 P. S. §§ 201, 403 and 443.1(2) and (3)).

**Source**

The provisions of this § 1181.67 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended May 3, 1985, effective retroactively as of July 1, 1984, 15 Pa.B. 1629; amended July 21, 1995, effective immediately and apply retroactively to July 1, 1992, and sunsetted on June 30, 1995, 25 Pa.B. 2893; amended August 23, 1996, effective immediately and apply to the time period from July 1, 1995, to December 31, 1995, 26 Pa.B. 4086. Immediately preceding text appears at serial pages (209183) and (201411). (**Editor's Note:** See 22 Pa.B. 3749 (July 18, 1992) for nursing home pooling provisions.)

**Cross References**

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions); and 55 Pa. Code § 1181.101 (relating to facility's right to a hearing).

**§ 1181.68. Upper limits of payment.**

(a) *Maximum rate of payment.* Except as provided in this section, the Department's maximum rate of payment to an enrolled facility will be the lower of the following:

- (1) The facility's lowest charge to private pay patients for the same level of care.
- (2) The facility's Medicare rate, which is either of the following:
  - (i) As compared to the facility's Medical Assistance interim per diem rate, the facility's Medicare interim per diem rate that is in effect on the date the facility's request for an interim per diem rate is postmarked or, if hand delivered, the date the request is received by the Department as documented by the Department's date stamp.
  - (ii) As compared to the facility's Medical Assistance final rate, the Medicare interim per diem rate in effect on the day of the facility's exit conference.
- (3) The facility's Medical Assistance final per diem rate.

(b) *Established ceilings.* The established ceilings on net operating costs as published by notice in the *Pennsylvania Bulletin* are the upper limit, as applicable, on the net operating costs of county and general nursing facilities.

(c) *Waiver of application.*

(1) A facility participating in Medicare may obtain a waiver of the application of subsection (a)(2) when the following apply:

(i) The facility demonstrates to the Department that the applicable Medicare interim per diem rates are lower than the facility's Medical Assistance per diem rate.

(ii) The grant of the waiver will not cause the Department's estimated aggregate payment for long-term care facility services for the fiscal year involved to exceed the amount that the Department could reasonably estimate would be paid for these services under Medicare principles of reimbursement.

(2) A waiver will not be granted from the application of subsection (a)(2) unless the request for the waiver is received by the Department prior to the expiration of the time limit established by § 1101.84 (relating to provider right of appeal) for filing an appeal of the interim rate or audit report with respect to which the waiver is sought. Additionally, no request for a waiver received after the issuance of an audit report shall stay the collection of any overpayments resulting from the determinations of the audit report pending the adjudication of the waiver request.

(d) *Upper limits for State-operated facilities.* The upper limits of payment for State-operated intermediate care facilities for the mentally retarded are the full allowable costs as specified in the HIM-15.

(e) *Upper limits for non-State operated facilities.* The upper limits of payment for non-State operated intermediate care facilities for the mentally retarded are the total projected operating cost or if a waiver is granted under Subchapter C (Reserved) an approved budget level as specified in Subchapter C.

**Authority**

The provisions of this § 1181.68 amended under sections 201 and 443.1(2) of the Public Welfare Code (62 P. S. §§ 201 and 443.1 (2)).

**Source**

The provisions of this § 1181.68 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended July 2, 1982, effective July 1, 1982, 12 Pa.B. 2070; amended August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; amended September 6, 1985, effective September 7, 1985, except the groups and ceilings shall be effective and apply at audit to costs of services rendered from July 1, 1984 through December 31, 1984; corrected August 7, 1987, effective September 7, 1985, 17 Pa.B. 3327; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial pages (131059) to (131060) and (125799).



**Cross References**

This section cited in 55 Pa. Code § 1181.1 (relating to policy); 55 Pa. Code § 1181.2 (relating to definitions); 55 Pa. Code § 1181.52 (relating to payment conditions); 55 Pa. Code § 1181.67 (relating to setting interim per diem rates); 55 Pa. Code § 1181.68 (relating to upper limits of payment); 55 Pa. Code § 1181.69 (relating to annual adjustment); 55 Pa. Code § 1181.91 (relating to failure to file a cost report); 55 Pa. Code § 1181.211 (relating to cost reimbursement principles and method); 55 Pa. Code § 1181.221 (relating to determining the interim per diem rate); 55 Pa. Code § 1181.224 (relating to final per diem rate); and 55 Pa. Code § 1181.231 (relating to standards for general and selected costs).

**§ 1181.69. Annual adjustment.**

(a) An annual payment adjustment will be made by the Department or facility based on total audited costs related to the total Department interim claims for services for the fiscal year and any interim cost settlement for the fiscal years paid under subsection (c).

(b) For cost reporting periods ending on or after October 1, 1985, if the total amount of MA payment for interim claims for services during the fiscal year exceeds the total audited costs, the Department will recover the overpaid amount from the provider under § 1101.69(b) (relating to overpayment—underpayment).

(c) During Fiscal Years 1992-1993, 1993-1994 and 1994-1995, the Department will pay facilities interim cost settlements on acceptable year-end cost reports as follows:

(1) A facility's interim cost settlement will be equal to 90% of the amount by which the facility's total adjusted allowable costs for MA reported in the facility's acceptable fiscal year-end cost report exceed the amount of MA interim payments received by the facility attributable to the fiscal period covered by the cost report.

(2) For the purpose of paragraph (1), "adjusted allowable costs" means the facility's total reported costs for MA as adjusted for the following limitations:

(i) The applicable ceiling on net operating costs, as stated in § 1181.68(b) (relating to upper limits of payment).

(ii) The per bed ceiling on allowable depreciation and interest costs as stated in §§ 1181.259(s) and 1181.260(k) (relating to depreciation allowance; and interest allowance) in effect on February 1, 1993, or in effect during the cost report period, whichever is greater.

(iii) The moratorium on reimbursement of depreciation and interest costs as stated in §§ 1181.259(r) and 1181.260(a).

(iv) The Medicare rate and private pay rate upper limitations on payment, as stated in § 1181.68(a)(1) and (2). In adjusting the facility's reported costs for the Medicare rate and the private pay rate limitations, the Department will apply the facility's most recent Medicare and private pay rates reported on the MA 58 form filed with the fiscal year end cost report on which the interim cost settlement is based.

(3) Interim cost settlements will not be paid on the basis of interim or final cost reports.

(4) An interim cost settlement will not be paid to a facility which has filed an interim cost report for the fiscal period covered by the interim cost settlement unless the facility waives its rights to a revised interim rate for the fiscal period.

#### Authority

The provisions of this § 1181.69 amended under sections 201, 403 and 443.1(2) and (3) of the Public Welfare Code (62 P. S. §§ 201, 403 and 443.1(2) and (3)).

#### Source

The provisions of this § 1181.69 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended February 5, 1988, effective February 6, 1988, 18 Pa.B. 556; amended July 21, 1995, effective immediately and apply retroactively to July 1, 1992, and sunsetted on June 30, 1995, 25 Pa.B. 2893. Immediately preceding text appears at serial page (193425). (**Editor's Note:** See 22 Pa.B. 3749 (July 18, 1992) for nursing home pooling provisions.)

#### Cross References

This section cited in 55 Pa. Code § 1181.52 (relating to payment conditions); and 55 Pa. Code § 1181.101 (relating to facility's right to a hearing).

## REPORTING AND AUDITING REQUIREMENTS

### § 1181.71. Annual reporting.

(a) The fiscal year for purposes of MA payments for skilled nursing and intermediate care facilities will be either January 1 through December 31 or July 1 through June 30 as designated by the facility.

(b) The fiscal year, for purposes of MA payments for intermediate care facilities for the mentally retarded, will be July 1 through June 30.

#### Source

The provisions of this § 1181.71 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended May 3, 1985, effective retroactively as of July 1, 1984, 15 Pa.B. 1629. Immediately preceding text appears at serial page (85080).

#### Notes of Decisions

##### *Cost Report*

Nursing care facilities must file a "cost report" with the Department of Public Welfare within 90 days of the close of each fiscal year in order to be eligible for cost reimbursement. *Harston Hall Nursing and Convalescent Home, Inc. v. Department of Public Welfare*, 513 A.2d 1097 (Pa. Cmwlth. 1986).

#### Cross References

This section cited in 55 Pa. Code § 1181.64 (relating to cost reporting).

**§ 1181.72. Interim reporting.**

Except for intermediate care facilities for the mentally retarded, a facility may file an interim cost report as justification for an interim rate change. However, the interim report may not be filed prior to January 1 (a report received prior to that date will be returned), and shall cover a 6-month period. If an interim report is filed, a 12-month report covering the facility's fiscal year shall still be filed.

**Source**

The provisions of this § 1181.72 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended May 3, 1985, effective retroactively as of July 1, 1984, 15 Pa.B. 1629. Immediately preceding text appears at serial page (85080).

**Notes of Decisions**

A corporation which merged with a Medicare health provider and the provider's parent company could challenge interim reimbursement rates effective after the merger, since the provider did file "final cost reports" for the beginning of the facilities fiscal year. *Manor Health Care Corporation v. Department of Public Welfare*, 551 A.2d 628 (Pa. Cmwlth. 1988).

**§ 1181.73. Final reporting.**

(a) A facility that enters into a termination agreement or an agreement of sale, or is withdrawing or being terminated as a provider, or is otherwise undergoing a change of ownership is required to file an acceptable final cost report and outstanding annual cost reports with the Department within 45 days of the effective date of the termination, transfer, withdrawal or change of ownership and is required to provide financial records to the Department for auditing. An acceptable cost report is one that meets the requirements of § 1181.66(a)(1)(i)—(iv) (relating to setting ceilings on allowable net operating costs).

(b) Except for an intermediate care facility for the mentally retarded, a facility may request an extension to file its final cost reports as required by subsection (a) of up to 30 days from the date the cost reports are due if the facility's request is received by the Department prior to the expiration of the 30th day of the 45-day period specified in subsection (a), specifies the reasons for the extension request and the amount of time requested and is for reasons beyond the control of the provider. No further extensions will be granted. The denial of a request shall be an adverse action appealable under § 1101.84(c) (relating to provider right of appeal). Failure to timely appeal a denial shall preclude any attack on the denial in another proceeding.

**Source**

The provisions of this § 1181.73 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended May 3, 1985, effective retroactively as of July 1, 1984, 15 Pa.B. 1629; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial page (125801).

#### Notes of Decisions

A corporation which merged with a Medicare health provider and the provider's parent company could challenge interim reimbursement rates effective after the merger, since the provider did file "final cost reports" for the beginning of the facilities fiscal year. *Manor Health Care Corporation v. Department of Public Welfare*, 551 A.2d 628 (Pa. Cmwlth. 1988).

This section requiring a facility to submit a final cost report to DPW makes no provision for permitting or prohibiting a grant of an extension to file the report, and therefore the Department's decision not to grant an extension based on no authority was arbitrary and capricious. *Department of Public Welfare v. Overlook Medical Clinic, Inc.*, 544 A.2d 935 (Pa. Cmwlth. 1988).

The Department's determination that this section precluded total life care facility from receiving reimbursement for depreciation and interest on capital indebtedness was incorrect, and in conflict with other Department regulations. *Twining Village v. Department of Public Welfare*, 523 A.2d 1199 (Pa. Cmwlth. 1987).

This section must be interpreted in context with other regulations which demonstrate a consistent policy of differentiating between operating costs, and depreciation and interest. *Twining Village v. Department of Public Welfare*, 523 A.2d 1199 (Pa. Cmwlth. 1987).

The Department of Public Welfare may terminate a facility's provider agreement under § 1181.91 where the facility's cost report is not filed on time, and may make a final cost settlement based on the facility's last final, audited *per diem* rate under § 1181.73 where the final cost report is filed late, but, the regulations do not authorize the Department to impose a zero allowable cost as a sanction for the late filing. *Mansion Nursing and Convalescent Home, Inc. v. Department of Public Welfare*, 506 A.2d 1343 (Pa. Cmwlth. 1986).

The word "not" in subsection (b) means "not within 30 days" when read with subsection (a) and is interpreted as "not timely" rather than "never." *Michael Manor, Inc. v. Department of Public Welfare*, 490 A.2d 957 (Pa. Cmwlth. 1985).

#### Cross References

This section cited in 55 Pa. Code § 1181.45 (relating to ongoing responsibilities of providers); and 55 Pa. Code § 1181.91 (relating to failure to file a cost report).

### § 1181.74. Auditing requirements related to cost reports.

(a) Except in cases of provider delay or delay requested by State or Federal agencies investigating possible criminal or civil fraud, the Department will audit each cost report within 1 year of the latter of its receipt in acceptable form, as defined in § 1181.66 (relating to setting ceilings on allowable net operating costs) or, if the facility participates in Medicare and has reported home office costs to the Department on its cost report, the Department's receipt of the facility's Medicare home office audit, to verify, to the extent possible, that the facility has complied with:

- (1) This chapter.
- (2) Chapter 1101 (relating to general provisions).
- (3) The limits established in Subchapters B and C (relating to manual for allowable cost reimbursement for skilled nursing and intermediate care facilities; and Reserved).
- (4) The instructions attached to the Financial and Statistical Report for Skilled Nursing and Intermediate Care facilities.



(5) The HIM-15, for State-operated intermediate care facilities for the mentally retarded.

(b) An onsite field audit will be performed on a periodic basis at reporting facilities. Participating facilities will receive a field audit or a desk audit each year. Full scope field audits will be conducted in accordance with auditing requirements set forth in Federal regulations and generally accepted auditing standards.

(c) An auditor may validate the costs and statistics of the annual report by an onsite visit to the facility. The auditors will then certify to the Department the allowable cost for the facility as a basis for calculating a per diem and an annual adjustment. Based on the certification and total interim payments received by the facility, the Department will compute adjustments due the facility or due the Department for the fiscal year. The Department will notify the facility of the annual adjustment due after the annual cost report is audited.

(d) A nursing facility shall make financial and statistical records to support cost reports available to State and Federal agents upon request.

#### Authority

The provisions of this § 1181.74 amended under section 443.1(2) and (3) of the Public Welfare Code (62 P. S. § 443.1 (2) and (3)).

#### Source

The provisions of this § 1181.74 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended July 2, 1982, effective July 1, 1982, 12 Pa.B. 2070; amended through May 3, 1985, effective retroactively as of July 1, 1984, 15 Pa.B. 1629; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial pages (125801) to (125802).

#### Notes of Decisions

The responsibility to claim reimbursement for allowable costs rests with a facility and not with the Department of Public Welfare auditors. *Quincy United Methodist Home v. Department of Public Welfare*, 530 A.2d 1026 (Pa. Cmwlth. 1987).

### § 1181.75. Auditing requirements related to patient fund management.

Nursing facilities are required to maintain records relating to the facility's management of MA patients' personal funds for a minimum of 4 years and make them available to Federal and State representatives upon request. MA patients' fund accounts will be audited at the time the annual cost reports are validated for a facility. If discrepancies are proven and the facility is found to be at fault, the facility will be required to make restitution to the patients for funds improperly handled, accounted for, or disbursed. The facility has the right of appeal in accordance with § 1181.101 (relating to facility's right to a hearing).

#### Source

The provisions of this § 1181.75 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

**UTILIZATION CONTROL****§ 1181.81. Scope of claims review procedures.**

All claims submitted for payment under the Medical Assistance Program are subject to the utilization review procedures established in Chapter 1101 (relating to general provisions). In addition, the Department will perform the reviews specified in these sections for controlling the utilization of nursing facility services.

**Source**

The provisions of this § 1181.81 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

**§ 1181.82. Review of need for admission.**

The Department's Review Team will evaluate each applicant's or recipient's need for admission by reviewing and assessing the appropriate departmental form completed by the attending physician or interdisciplinary team as required for the specifically prescribed level of care needed. The facility and recipient will be notified of the decision on forms designated by the Department.

**Authority**

The provisions of this § 1181.82 amended under sections 403(a) and (b) and 443.6 of the Public Welfare Code (62 P. S. §§ 403(a) and (b) and 443.6).

**Source**

The provisions of this § 1181.82 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended November 30, 1984, effective December 1, 1984, 14 Pa.B. 4370, and by approval of the court of a joint motion for modification of a consent agreement dated February 11, 1985 in *Turner v. Beal, et al.*, C.A. No. 74-1680 (E.D. Pa. 1975). Immediately preceding text appears at serial page (96155).

**§ 1181.83. Inspections of care.**

(a) *Inspection team.* The Department's Inspection of Care team will inspect the care and services provided to each recipient in a participating nursing facility at least annually. The Department will not give the facility more than 48 hours notice of the time and date of the scheduled arrival of the team. The facility shall make readily available to the team the patient's complete medical records for the year since the last review of the team. The team's inspection will include:

(1) Personal contact with and observation of each recipient in a skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

(2) Review of each recipient's medical record. The record must include timely certification and recertifications by the physician that the services are needed and a written individual plan of care developed either by an interdisciplinary team or the attending or staff physician, whichever is applicable. The

plan of care must indicate time limits and measurable care objectives and goals to be accomplished and who is to give each element of care.

(b) *Determination of inspection.* The team will determine in its inspection whether:

(1) The services are available and adequate to meet the recipient's health needs.

(2) It is medically necessary and desirable for the recipient to remain in the facility.

(3) Recipients receiving skilled care meet the minimum medical requirements for skilled nursing care specified in § 1181.53(b)(2) (relating to payment conditions related to the recipient's initial need for care).

(4) It is feasible for the facility to meet the recipient's health needs and, in an ICF, the recipient's rehabilitative needs or whether the recipient's needs could be met through alternative institutional or noninstitutional services.

(5) Each recipient in an intermediate care facility for the mentally retarded is receiving active treatment.

(6) The medical evaluation including any required psychological or social evaluations and the plan of care are complete and current, are followed, and all ordered services are provided and recorded.

(7) The recipient receives adequate services based on personal observations, that is, the recipient is clean, bedsores are absent, there is absence of signs of malnutrition or dehydration and there is apparent maintenance of maximum physical, mental and psychosocial function.

(8) In an ICF, there is evidence of a planned activities program to prevent regression and there is progress toward meeting goals of the plan of care.

(9) Service needs are met by the facility or by outside arrangements.

(10) Recipient needs continued placement in the facility or there is an appropriate plan to transfer to an alternate level of care.

(c) *Reports on inspections of care.*

(1) The Inspection of Care team will develop a summary report at the conclusion of its inspection of each facility. The report will include:

(i) The alternate care determinations.

(ii) Findings of the adequacy and quality of care rendered by the facility. The findings will specify that the care rendered is acceptable or in need of improvement.

(2) Within 45 days following the conclusion of the inspection, two copies of the summary report will be forwarded to the administrator of the facility. The administrator shall forward one copy of the summary report to the Utilization Review Committee chairperson. On the second copy of the summary report, the administrator will give written responses to each area identified as deficient and all narrative recommendations.

(3) In advance of forwarding the summary report to the facility, the Inspection of Care team will notify the County Assistance Office and the facility of any alternate care determinations made by the team.

(d) *Recipient right of appeal of alternate care determinations.* The recipient or the person or the nursing facility acting on the behalf of the recipient, in accordance with Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings), has 30 days in which to appeal the Inspection of Care team's alternate care determination. Neither the facility, the facility's Utilization Review Committee, nor the recipient's attending physician has the right to appeal the alternate care determination on their own behalf. If the recipient or the person or the facility acting on behalf of the recipient appeals the decision within 10 calendar days from the date the County Assistance Office issues the advance notice, payment for the present level of care will continue pending the outcome of the hearing subject to the provisions of § 1181.54(g) (relating to payment conditions related to the recipient's continued need for care).

#### Authority

The provisions of this § 1181.83 amended under sections 403(a) and (b) and 443.1(2) and (3) of the Public Welfare Code (62 P. S. §§ 403(a) and (b) and 443.1(2) and (3)).

#### Source

The provisions of this § 1181.83 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended January 7, 1983, effective January 8, 1983, 13 Pa.B. 148. Immediately preceding text appears at serial pages (62948) to (62949).

#### Notes of Decisions

DPW Inspection of Care procedural regulations at 55 Pa. Code § 1181.83(b) are in conformance with federal regulations at 42 CFR 456.600—456.614. *Fifty Residents of Park Pleasant Nursing Home v. Commonwealth*, 503 A.2d 1057 (Pa. Cmwlth. 1986).

#### Cross References

This section cited in 55 Pa. Code Chapter 1181 Appendix O (relating to OBRA sanctions).

### § 1181.84. Facility course of action.

(a) The nursing facility shall return a copy of the summary report with appropriate corrective actions written thereon to the Department within 30 days of the control date indicated on the summary report. The facility's planned course of corrective action shall include proposed time frames for correcting findings of deficient care or services and narrative recommendations.

(b) The Inspection of Care team may conduct a follow-up visit to determine if the deficiencies and recommendations are corrected and report to the Bureau of Long Term Care Programs.

**Authority**

The provisions of this § 1181.84 amended under sections 403(a) and (b) and 443.1(2) and (3) of the Public Welfare Code (62 P. S. §§ 403(a) and (b) and 443.1(2) and (3)).

**Source**

The provisions of this § 1181.84 adopted July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended January 7, 1983, effective January 8, 1983, 13 Pa.B. 148. Immediately preceding text appears at serial page (62950).

**§ 1181.85. Facility utilization review requirements.**

(a) Each enrolled nursing facility furnishing services to eligible MA recipients shall have in effect a written Utilization Review Plan that provides for review of each recipient's need for the services.

(b) If the Utilization Review Committee of a facility finds that the continued stay of a recipient at a specific level of care is not needed, the committee shall request additional information as follows:

(1) If the recipient is receiving care in a skilled nursing facility, the committee shall request additional information from the attending physician who shall respond within 7 days. Two physician members of the committee shall review the additional information and make the final recommendation. If the attending physician does not respond to the committee's request within 7 days, the committee's recommendation shall be deemed final.

(2) If the recipient is receiving care in an intermediate care facility, the committee shall, within 1 working day of its decision, request additional information from the recipient's attending physician, who shall respond within 2 working days. A physician member of the committee, in cases involving a medical determination, or the Utilization Review Committee, in cases not involving a medical determination, shall review the additional information and make the final recommendation. If the attending physician does not respond to the committee's request within 2 working days, the committee's recommendation shall be deemed final.

(3) If the recipient is receiving care in an intermediate care facility for the mentally retarded, the committee shall, within 1 working day of its decision, request additional information from the recipient's qualified mental retardation professional, who shall respond within 2 working days. A physician member of the committee, in cases involving a medical determination, or the Utilization Review Committee, in cases not involving a medical determination, shall review the additional information and make the final recommendation. If the additional information is not received within 2 working days, the committee's decision will be deemed final.

(c) The Utilization Review Committee will send written notice of any adverse final decisions on the need for continued stay to:

(1) The nursing facility administrator.

- (2) The attending physician of a recipient in a skilled nursing or intermediate care facility or the qualified mental retardation professional of a recipient in an intermediate care facility for the mentally retarded.
- (3) The County Assistance Office.
- (d) The County Assistance Office will notify the recipient or the person acting on behalf of the recipient and the facility of the recommended change in the level of care. The recipient has the right of appeal in Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings). Neither the facility nor the attending physician may appeal the decision of the Utilization Review Committee on their own behalf.

#### Authority

The provisions of this § 1181.85 amended under sections 403(a) and (b) and 443.1(2) and (3) of the Public Welfare Code (62 P. S. §§ 403(a) and (b) and 443.1(2) and (3)).

#### Source

The provisions of this § 1181.85 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended January 7, 1983, effective January 8, 1983, 13 Pa.B. 148. Immediately preceding text appears at serial page (62950).

### § 1181.86. Provider misutilization.

Nursing facilities determined to have billed for services inconsistent with Medical Assistance Program regulations, to have provided services outside the scope of customary standards of practice, or to have otherwise violated the standards set forth in the provider agreement, are subject to the sanctions described in this chapter and Chapter 1101 (relating to general provisions).

#### Source

The provisions of this § 1181.86 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

## ADMINISTRATIVE SANCTIONS

### § 1181.91. Failure to file a cost report.

(a) Failure to file a cost report, other than a final cost report, and annual cost reports due along with a final cost report, when due, may result in termination of the provider agreement and shall result in the suspension of interim payments to the provider until the reports are filed in acceptable form. If the reports are not filed by the end of the fifth month after the due date established by § 1181.64 (relating to cost reporting), including extensions of that date granted by the Department, the Department may either determine payment for the cost reporting period involved on the basis of the method established with respect to untimely final cost reports in subsection (b) or may seek injunctive relief to require proper filing, as the Department may deem is in the best interest of the efficient and economic administration of the Program.

(b) Failure to file a final cost report and outstanding annual cost reports, when due, under § 1181.73 (relating to final reporting) shall result in payment to the provider for all cost reporting periods involved being determined on the basis of the lowest audited rate for a provider, including a rate limited by § 1181.68 (relating to upper limits of payment) for the same level of care (SNF, ICF or ICF/MR) without regard to the type of provider—for example, hospital-based or county facility—for services rendered during the 6 months immediately preceding the beginning of the fiscal periods involved. No payment will be made for depreciation expenses incurred by the provider with respect to services during the 365 days preceding the effective date of the event described in § 1181.73(a) which required the final cost report to be filed. Interim payments or payments after audit of the depreciation expenses shall be offset against payments due to the provider or shall be repaid to the Department by the provider if no payment is due.

#### Source

The provisions of this § 1181.91 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial page (117448).

#### Notes of Decisions

The Department of Public Welfare may terminate a facility's provider agreement under this section where the facility's cost report is not filed on time, and may make a final cost settlement based on the facility's last final, audited *per diem* rate under § 1181.73 where the final cost report is filed late, but, the regulations do not authorize the Department to impose a zero allowable cost as a sanction for the late filing. *Mansion Nursing and Convalescent Home, Inc. v. Department of Public Welfare*, 506 A.2d 1343 (Pa. Cmwlth. 1986).

#### Cross References

This section cited in 55 Pa. Code § 1181.215 (relating to efficiency incentive); 55 Pa. Code § 1181.216 (relating to depreciation and interest reimbursement); and 55 Pa. Code § 1181.224 (relating to final per diem rate).

### § 1181.92. Failure to maintain adequate records.

When the Department determines that the nursing facility has not maintained financial and statistical records in accordance with the Department's regulations, thus preventing the Department from conducting an audit of the facility's records, the facility will be notified, by certified mail, that it has 60 days to correct the problem. The facility will be advised further that for failure to comply with the Department's notice, the Department will terminate the Medical Assistance Provider Agreement, unless the problem is corrected within the 60-day period.

#### Source

The provisions of this § 1181.92 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

**Cross References**

This section cited in 55 Pa. Code § 1181.215 (relating to efficiency incentive); 55 Pa. Code § 1181.216 (relating to depreciation and interest reimbursement); and 55 Pa. Code § 1181.224 (relating to final per diem rate).

**§ 1181.93. Failure to correct deficiencies.**

If the facility fails to correct a deficiency cited by the Department's Inspection of Care Team or causes delay in the review process which results in a penalty being imposed by the Department of Health and Human Services (DHHS) on the Department of Human Services the penalty will be imposed on the facility. Failure to correct gross deficiencies in patient care and services within 6 months following the receipt of report of Inspection of Care team's review will result in the termination of the facility's Medical Assistance Provider Agreement.

**Source**

The provisions of this § 1181.93 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

**Cross References**

This section cited in 55 Pa. Code § 1181.215 (relating to efficiency incentive); 55 Pa. Code § 1181.216 (relating to depreciation and interest reimbursement); and 55 Pa. Code § 1181.224 (relating to final per diem rate).

**§ 1181.94. Failure to adhere to certification requirements.**

If the facility's failure to comply with the requirements that the physician certify and recertify the need for care as described under §§ 1181.53 and 1181.54 (relating to payment conditions related to the recipient's initial need for care; and payment conditions related to the recipient's continued need for care), results in a penalty being imposed by DHHS on the Department, the penalty will be imposed on the facility.

**Source**

The provisions of this § 1181.94 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

**Cross References**

This section cited in 55 Pa. Code § 1181.215 (relating to efficiency incentive); 55 Pa. Code § 1181.216 (relating to depreciation and interest reimbursement); and 55 Pa. Code § 1181.224 (relating to final per diem rate).

**§ 1181.95. Failure to adhere to medical evaluation requirements.**

If the facility fails to comply with the requirements that the physician perform a medical evaluation before admission or before authorization for payment, as described under § 1181.53 (relating to payment conditions related to the recipient's initial need for care), which results in a penalty being imposed by DHHS on the Department, the penalty will be imposed on the facility.



**Source**

The provisions of this § 1181.95 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

**Cross References**

This section cited in 55 Pa. Code § 1181.215 (relating to efficiency incentive); 55 Pa. Code § 1181.216 (relating to depreciation and interest reimbursement); and 55 Pa. Code § 1181.224 (relating to final per diem rate).

**§ 1181.96. Failure to comply with requirements of maintaining patient's funds.**

In the event discrepancies are identified by audit and the facility fails to make restitution to the patient, the Department may terminate the provider agreement for cause.

**Source**

The provisions of this § 1181.96 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610.

**Cross References**

This section cited in 55 Pa. Code § 1181.215 (relating to efficiency incentive); 55 Pa. Code § 1181.216 (relating to depreciation and interest reimbursement); and 55 Pa. Code § 1181.224 (relating to final per diem rate).

**FACILITY RIGHT TO APPEAL****§ 1181.101. Facility's right to a hearing.**

(a) A nursing facility has a right to appeal and have a hearing if dissatisfied with the Department's decision regarding:

(1) The interim per diem rate established by the Department, unless a change in the interim per diem rate is made by the Department based on a revision to the net operating portion of the rate as a result of a revision to the applicable net operating cost reimbursement ceiling, in which case the facility may appeal only as to the issue of whether or not the ceiling used to revise the interim per diem rate is in fact the established ceiling for the facility's geographical grouping and level of care.

(2) The findings of the auditors in the annual audit report.

(3) The determination by the comptroller of the difference between the allowable costs certified by the auditors in the annual audit report, and the total allowance amount as shown on the interim billing.

(4) The denial or nonrenewal of a provider agreement.

(i) A skilled nursing facility that has been either denied an MA Provider Agreement or renewal of the agreement or whose agreement has been terminated in whole or in part by the Department prior to its expiration date, has the right to a full evidentiary hearing before a hearing officer to contest the action.

(ii) Facilities participating in Medicare and the MA Program that are denied renewal of an MA Provider Agreement or have the agreement terminated by the Department because of termination or nonrenewal by Medicare are entitled to the review procedures specified for Medicare facilities in 42 CFR Part 498 (relating to appeals procedures for determinations that affect participation in the Medicare Program). The final decision entered as a result of the Medicare review procedures is binding for the purposes of participation in the MA Program.

(5) The MA Program enhancement payment consisting of the 2% inflation adjustment of the interim rate or interim cost settlement made by the Department for Fiscal Years 1992-1993, 1993-1994 and 1994-1995.

(i) The facility's right to appeal shall be limited to the issue of whether:

(A) Its MA Program enhancement payment consisting of 2% inflation adjustment of the facility's interim rate was calculated in accordance with §§ 1181.67(1) and 1181.211 (relating to setting interim per diem rates; and cost reimbursement principles and method).

(B) Its interim cost settlement was calculated in accordance with § 1181.69(c) (relating to annual adjustment).

(ii) This paragraph does not otherwise limit a facility's right to file an appeal under § 1101.84 (relating to provider right of appeal) or this section from interim rates established under § 1181.221 (relating to determining the interim per diem rate) or established as a result of a revision to the ceilings on net operating costs, or from audit findings or final cost settlement issued with respect to which an interim cost settlement is paid.

(6) The MA Program enhancement payment consisting of the 2% inflation adjustment of the interim rate made by the Department for the period July 1, 1995, through December 31, 1995. The nursing facility's right to appeal shall be limited to the issue of whether its MA Program enhancement payment consisting of the 2% inflation adjustment of the nursing facility's interim rate was calculated in accordance with §§ 1181.67(1) and 1181.211.

(b) A nursing facility appeal is subject to § 1101.84.

(c) An appeal shall be taken within 30 days of the date that the facility is notified of the decisions in subsection (a). Findings contained in a facility's audit report which are not appealed by the facility within the 30-day limit will not be considered as part of subsequent appeal proceedings.

(d) An appeal shall be mailed to the Executive Director, Office of Hearings and Appeals, Department of Human Services, Post Office Box 2675, DHS Complex, 6th Floor, Harrisburg, Pennsylvania 17105, with a copy to the Office of Legal Counsel. The appeal request shall specify the issues presented for review.

(e) The Audit Division of the Bureau of Long Term Care Programs may reopen a prior year's audit if an appeal is filed.

(f) For cost reporting periods ending prior to October 1, 1985, if an analysis of the facility's audit report by the Office of the Comptroller discloses that an overpayment has been made to the facility, the facility will be bound by § 1101.84(b)(4) and (5).

#### Authority

The provisions of this § 1181.101 amended under sections 201, 403 and 443.1(2) and (3) of the Public Welfare Code (62 P. S. §§ 201, 403 and 443.1(2) and (3)).

#### Source

The provisions of this § 1181.101 codified July 24, 1981, effective July 25, 1981, 11 Pa.B. 2610; amended February 5, 1988, effective February 6, 1988, 18 Pa.B. 556; corrected July 8, 1988, effective February 6, 1988, 18 Pa.B. 3051; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005; corrected March 31, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1405; amended July 17, 1992, effective immediately and applies retroactively to May 5, 1991, 22 Pa.B. 3749; amended July 21, 1995, effective immediately and apply retroactively to July 1, 1992, 25 Pa.B. 2893; amended August 23, 1996, effective immediately and apply to the time period from July 1, 1995, to December 31, 1995, 26 Pa.B. 4086. Immediately preceding text appears at serial pages (201425) to (201427).

#### Notes of Decisions

No basis existed to allow Medical Assistance program provider to pursue separate appeals regarding disputed audit findings of Department of Public Welfare's final cost settlement report regarding reimbursement claims; dismissal of appeal transferred from Board of Claims to Bureau of Hearings and Appeals was warranted since provider had other appeal before Bureau which provided adequate remedy to seek relief and the transferred appeal challenged same cost adjustments. *Lancaster v. Department of Public Welfare*, 916 A.2d 707, 712 (Pa. Cmwlth. 2006).

Thirty-day appeal rule for audit reports only applies in subsequent appeal proceedings for prior fiscal years. *Twining Village v. Department of Public Welfare*, 564 A.2d 1335 (Pa. Cmwlth. 1989).

A facility is not, in order to preserve an interim rates issue, required to file an appeal both from the final audit and settlement and from the interim rate establishment. *Twining Village v. Department of Public Welfare*, 564 A.2d 1335 (Pa. Cmwlth. 1989).

Petitioner's identification of the issue for review as "Audit Report for the Fiscal Period Ended June 30, 1983" and failure to specifically identify the reimbursement issue regarding the zero-cost determination in its notice of appeal was not fatal since a zero-cost determination was the only issue of contention. *Beverly Enterprises, Inc. v. Department of Public Welfare*, 556 A.2d 995 (Pa. Cmwlth. 1989).

A corporation which merged with Medicare health provider and the provider's parent company preserved the right to the interim rates by following the Department's instruction to resubmit MA-11 reports using original cost bases for each facility prior to the stock purchase. *Manor Health Care Corporation v. Department of Public Welfare*, 551 A.2d 628 (Pa. Cmwlth. 1988).

This section authorizes Department of Public Welfare's audit division to reopen any prior year's audit if an appeal is filed. *Quincy United Methodist Home v. Department of Public Welfare*, 530 A.2d 1026 (Pa. Cmwlth. 1987).

While this section establishes an appeals procedure or State rate determinations for medicaid provider claims under 42 CFR 447.258, the Federal regulation does not prohibit a separate cause of action for breach of contract under State Law. *Department of Public Welfare v. Divine Providence Hospital*, 516 A.2d 82 (Pa. Cmwlth. 1986).

Nursing care facilities have the right to appeal any adjustments made by the Department based on audits performed after the facility filed its annual "cost report." *Harston Hall Nursing and Convalescent Home, Inc. v. Department of Public Welfare*, 513 A.2d 1097 (Pa. Cmwlth. 1986).

**Cross References**

This section cited in 55 Pa. Code § 1101.69a (relating to establishment of a uniform period for the recoupment of overpayments from providers (COBRA)); and 55 Pa. Code § 1181.75 (relating to auditing requirements related to patient fund management).

**Subchapter B. MANUAL FOR ALLOWABLE COST  
REIMBURSEMENT FOR SKILLED NURSING  
AND INTERMEDIATE CARE FACILITIES**

**GENERAL PROVISIONS**

- Sec.  
1181.201. Scope.  
1181.202. Definitions.

**REIMBURSEMENT PRINCIPLES**

- 1181.211. Cost reimbursement principles and methods.  
1181.212. General principles.  
1181.213. Cost reporting.  
1181.214. Cost apportionment and allocation.  
1181.215. Efficiency incentive.  
1181.216. Depreciation and interest reimbursement.  
1181.217. Establishing ceilings for allowable net operating costs.

**RATE DETERMINATIONS**

- 1181.221. Determining the interim per diem rate.  
1181.222. Determining a cost-related prospective rate for certain facilities.  
1181.223. Determining the interim per diem rate for a new facility or a facility with a change of ownership.  
1181.224. Final per diem rate.

**ALLOWABLE COSTS**

- 1181.231. Standards for general and selected costs.  
1181.232. Changing the basis for allocating cost centers.  
1181.232a. Bed changes during a cost reporting period—statement of policy.  
1181.233. Bed occupancy allowance.  
1181.234. General administration allowance.

**SALARY COSTS AND STAFFING STANDARDS**

- 1181.241. General administration salaries.  
1181.242. Nursing staff allowance.  
1181.243. Social service staff.

**OTHER COST ITEMS**

- 1181.251. Contracted management services.
- 1181.252. Volunteer and donated services of individuals.
- 1181.253. Pastoral services.
- 1181.254. Medicare Part B type services.
- 1181.254a. Medicare Part B adjustments—statement of policy.
- 1181.255. Recreational services.
- 1181.256. Other practitioner services.
- 1181.257. Drug services.
- 1181.257a. Clarification of the term “written”—statement of policy.
- 1181.258. Utilization, medical review and program audits.
- 1181.259. Depreciation allowance.
- 1181.259a. Elimination of funded depreciation—statement of policy.
- 1181.260. Interest allowance.
- 1181.261. Bad debt expense.
- 1181.262. Fund raising expenses.
- 1181.263. Costs of related parties.
- 1181.264. Rental of property and plant.
- 1181.265. Prudent buyer concept.

**EXPENSES AND REVENUE ITEMS NOT ALLOWABLE IN DETERMINING NET OPERATING COSTS**

- 1181.271. Excluded expenses and revenues.
- 1181.272. Costs related to revenue producing items.
- 1181.273. Income that will reduce allowable costs.
- 1181.274. Direct provider payments not includable in costs.

**Cross References**

This subchapter cited in 55 Pa. Code § 1181.1 (relating to policy); 55 Pa. Code § 1181.66 (relating to setting ceilings on allowable net operating costs); and 55 Pa. Code § 1181.74 (relating to auditing requirements related to cost reports).

**GENERAL PROVISIONS****§ 1181.201. Scope.**

(a) This subchapter, under applicable Federal and State statutes and regulations, sets forth principles for determining the allowable costs of general and county skilled and intermediate care facilities. This subchapter governs MA payments to general and county skilled nursing and intermediate care facilities on the basis of the Commonwealth’s approved State Plan for reimbursement.

(b) The Medicare Provider Reimbursement Manual (HIM-15) and the Federal regulations appropriate to the reimbursement of nursing facility care under the Medicare program are a supplement to this subchapter. If a cost is included in this subchapter as allowable, then the HIM-15 and applicable Federal regulations will be used as a source of more detailed information on that cost. The HIM-15 and

applicable Federal regulations will not be used for any cost that is determined to be nonallowable either by a statement to that effect in this subchapter or by virtue of the fact that the cost is not being addressed in this subchapter, nor will the HIM-15 or applicable Federal regulations be used to alter the treatment of any cost provided for in this subchapter.

(c) This subchapter is adopted under section 443.1(2) and (3) of the Public Welfare Code (62 P. S. § 443.1(2) and (3)) and supplements Subchapter A (relating to nursing facility care). To the extent that this subchapter is inconsistent with the definitions and provisions of Subchapter A, the provisions and definitions of this subchapter will control. No section of this subchapter may be applied or interpreted out of context.

#### Source

The provisions of this § 1181.201 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

#### Notes of Decisions

##### *Underpayments*

The Department of Public Welfare is not required to pay MA providers interest on underpayments of reimbursements for nursing home services. The appeal process in the Federal manual, which includes an interest provision, does not govern MA provider appeals since the State manual has its own appeal provisions. *Western Reserve Convalescent Home v. Department of Public Welfare*, 660 A.2d 1312 (Pa. 1995).

#### § 1181.202. Definitions.

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

*Accrual basis*—An accounting method by which revenue is recorded in the period when it is earned, regardless of when it is collected, and expenses are recorded in the period when they are incurred, regardless of when they are paid.

*Actual time method*—An accounting method used for determining depreciation which counts the number of months an asset is owned in both the year of acquisition and the year of disposal.

*Allowable cost*—Costs which are necessary and reasonable to the proper care of Medical Assistance patients and which are identified in this subchapter.

*Annual adjustment notice*—The notice from the Department comptroller of underpayment or overpayment stating the difference between the total of the interim payments to a facility and the total certified costs for the facility's audit year.

*Average per diem cost*—The facility's total allowable costs for a level of care divided by the total actual patient days for the same level of care for a reporting period.

*Bad debts*—Amounts considered to be uncollectable from accounts and notes receivable that were created or acquired in providing services.

*Cash basis*—An accounting method by which cash is recorded when it is received, regardless of when it is earned and expenses are recorded when they are paid, regardless of when they are incurred.

*Certified cost*—The amount of reimbursement due after the application of group ceilings and other adjustments due a facility for an audit period as certified to the Department comptroller by the Department auditors or their agents.

*Common ownership*—A business arrangement wherein an individual, partnership, association or corporation has equity and, thereby, an association or affiliation in both the nursing facility and an organization which does business with the facility.

*Facility*—A county or general nursing facility that is enrolled in the Medical Assistance Program.

*Fair market value*—The value at which an asset could be sold in the open market in a transaction between unrelated parties.

*Final per diem rate*—The rate established by the Department after completion of an audit of the facility's year-end cost report, comprised of the facility's allowable net operating per diem rate and an efficiency incentive, if appropriate, which are subject to the limitation of the applicable group ceiling, plus rates for allowable depreciation and interest.

*Group ceiling*—The maximum per diem cost, excluding depreciation and interest on capital indebtedness, that may be reimbursed by the Medical Assistance Program for a facility in a specified group.

*Half-year method*—An accounting method used for determining depreciation which counts 1/2 year's depreciation in the year in which an asset is acquired, plus 1/2 year's depreciation in the year in which the asset is disposed of, regardless of when the asset was acquired or disposed of during the year.

*Interest*—The direct actual cost incurred for the use of borrowed funds.

*Interest on capital indebtedness*—The direct cost incurred for funds borrowed for capital purposes. Examples are acquisition of facilities, equipment and capital improvements. Generally, loans for capital purposes are long term loans.

*Interest on current indebtedness*—The direct cost incurred for funds borrowed for current operating expenses or working capital.

*Interim payment*—Reimbursement for MA patients by the Department to the facility based on the interim per diem rate.

*Investment income*—Actual or imputed income available to or accrued by a facility from funds which the facility invest or lends or which are held by others for the benefit of the facility.

*Leasehold improvement*—The improvements made by the owners of a facility to the leased land, buildings or equipment, with amortization taken over the useful life of the asset.

*Medicare Part B service*—A service for which reimbursement may be made to a facility under this subchapter and Medicare Part B.

*Medicare Part B type service*—A service for which reimbursement may be made to a facility under this subchapter and would be made under Medicare Part B if the service were rendered to a Medicare Part B eligible beneficiary.

*Net operating cost*—The total allowable cost less depreciation and interest on capital indebtedness.

*Patient day*—Care of one patient during a day of service. In maintaining statistics, the day of admission is counted as a day of patient care but the day of discharge is not counted as a day of patient care.

*Per diem rate*—A comprehensive rate of payment for the costs of covered services for a patient day.

*Private pay patient*—An individual for whom payment for services is made with his own resources, private insurance or funds from liable third parties but not by the MA Program.

*Private pay rate*—The lowest rate for a semiprivate room charged by a facility to a private pay patient for a day of care, consisting of either a comprehensive charge or the sum of a flat rate of routine services plus the result of the total annual allowable cost for ancillary services for private pay patients which would be recognized as allowable by the MA Program for MA patients divided by the total annual private pay patient days.

*Prudent buyer concept*—An accounting term used to refer to the price paid for items by a prudent buyer in the open market under competitive conditions.

*Related party*—An individual or organization that is associated or affiliated with, or has control of or is controlled by, the provider. “Control,” as used in this definition, means the power to influence or direct the actions or policies of another.

#### Source

The provisions of this § 1181.202 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial pages (131064) to (131067).

#### Notes of Decisions

##### *Interest Income*

Income from a charitable trust paid by a trustee bank to a religious organization for the maintenance of a particular nursing home under the direction of the settlor fell within the definition of investment income as defined by this regulation. *Sycamore Manor Health Ctr. v. Department of Public Welfare*, No. 1625, C. D. 1994, No. 2460 C. D. 1994, 1995 Pa. Cmwlth. LEXIS 349 (July 27, 1995).

Interest income earned by a skilled nursing facility on an Endowment Fund and an Annuity Fund was investment income. *Messiah Village v. Department of Public Welfare*, 545 A.2d 956 (Pa. Cmwlth. 1988).

Definitions of “final per diem rate” and “group ceiling,” when considered with other Department of Public Welfare regulations, demonstrated a consistent policy of treating depreciation and interest separate from net operating costs. *Twining Village v. Department of Public Welfare*, 523 A.2d 1199 (Pa. Cmwlth. 1987).



*Investment Income*

Although unrestricted gifts to a home of income from funds held for that purpose are “investment income” of the home office under this regulation, to be allocated on the same basis as home office costs, gifts restricted to use for components of that home that did not claim Medicaid reimbursement were not investment income of a provider or part of the home office investment income that was available for offset. *Sycamore Manor Health Ctr. v. Department of Public Welfare*, No. 1625 C. D. 1994, No. 2460 C. D. 1994, 1995 Pa. Cmwlth. LEXIS 349 (July 27, 1995).

*Net Operating Costs*

A nursing home’s investment income from a trust was “income available to the nursing home held by others for the benefit of the facility” and therefore was properly used to offset its interest expense. *Sfang Crest Home v. Department of Public Welfare*, 538 A.2d 87 (Pa. Cmwlth. 1988).

**REIMBURSEMENT PRINCIPLES****§ 1181.211. Cost reimbursement principles and method.**

(a) Subject to the limitations and sanctions specified in Subchapter A (relating to nursing facility care), a facility will be reimbursed its allowable net operating costs, plus allowable depreciation and interest on capital indebtedness.

(b) The amount of MA reimbursement for allowable operating costs, excluding depreciation and interest, will not exceed the level of net operating costs the Department determines to be reasonable and adequate to meet the costs that an efficiently and economically operated facility incurs in meeting applicable State and Federal laws and quality and safety standards.

(c) Costs that are not recognized as allowable costs in a fiscal year may not be carried forward or backward to other fiscal years for inclusion in allowable costs.

(d) Long-term care disproportionate share allowance payments are made according to a formula established by the Department to general nongovernmental long-term care facilities in which skilled and intermediate Medicaid funded patient days account for at least 90% of total patient days. Payment of the long-term care disproportionate share allowance is contingent upon the express appropriation by the General Assembly, of funds designated to make payments of this allowance.

(e) County nursing facility disproportionate share payments are made according to a formula established by the Department to county nursing facilities, in which Medicaid funded resident days account for at least 80% of the facility’s total resident days and the number of certified MA beds is greater than 270 beds. Payment of the county nursing facility disproportionate share payment for the period July 1, 1995, through December 31, 1995, is contingent upon the determination by the Department that there are sufficient State and Federal funds appropriated to make these allowance payments. County nursing facility disproportionate share payments will not be limited to or affected by any ceilings or net operating costs, charges to private pay residents, peer group or facility-specific payment limits under the MA Program.

(f) For the period July 1, 1995, through December 31, 1995, the Department will make program enhancement payments to general and county nursing facilities participating in the MA Program as follows. The Department will increase the interim per diem rate for the nursing facility to reflect inflation by 2% up to the ceilings on allowable net operating costs and subject to the upper limits on payments in accordance with § 1181.68 (relating to upper limits of payment).

**Authority**

The provisions of this § 1181.211 amended under sections 201, 403 and 443.1(2) and (3) of the Public Welfare Code (62 P. S. §§ 201, 403 and 443.1(2) and (3)).

**Source**

The provisions of this § 1181.211 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005; amended May 4, 1990, effective May 5, 1990 and apply retroactively to June 30, 1989; amended July 21, 1995, effective immediately and apply retroactively to July 1, 1992, and sunsetted June 30, 1995, 25 Pa.B. 2893; amended August 23, 1996, effective immediately and apply to the time period from July 1, 1995, to December 31, 1995, 26 Pa.B. 4086. Immediately preceding text appears at serial pages (201433) to (201434). (**Editor's Note:** See 22 Pa.B. 3749 (July 18, 1992) for nursing home pulling provisions.)

**Cross References**

This section cited in 55 Pa. Code § 1181.101 (relating to facility's right to a hearing).

**§ 1181.212. General principles.**

(a) A facility's direct or indirect allowable costs related to patient care will be considered in the finding and allocation of costs to the MA Program for its eligible recipients.

(b) Total allowable costs of a facility will be apportioned between third-party payors and other patients so that, within the limits of this subchapter, the share borne by MA under Title XIX of the Public Health Service Act, 42 U.S.C. Chapter 6A, Subchapter XIX is based upon those actual services and costs related to MA recipients.

(c) Within the limits of this subchapter, allowable costs include those costs necessary to provide skilled or intermediate care. These may include costs related to all of the following:

- (1) Dietary and food.
- (2) Laundry.
- (3) Housekeeping.
- (4) Plant operation and maintenance.
- (5) Nursing.
- (6) Director of nursing.
- (7) Related clerical staff.
- (8) Practitioners.
- (9) Medical director.
- (10) Utilization and medical review.
- (11) Social services.

- (12) Patient activities.
- (13) Volunteer services.
- (14) Over-the-counter drugs.
- (15) Medical supplies.
- (16) Physical, occupational and speech therapy.
- (17) Oxygen.
- (18) Rent.
- (19) Amortization.
- (20) Other interest.
- (21) Insurance.
- (22) Real estate taxes.
- (23) Equipment rental.
- (24) Depreciation.
- (25) Interest on capital indebtedness.

(d) In certain cases under MA principles, there may be more than one method for handling a cost item. In these cases the method initially elected by the provider shall be followed consistently in subsequent reporting periods except as provided in this subchapter.

**Source**

The provisions of this § 1181.212 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**Notes of Decisions**

Insurance premiums paid on liability policies for the protection of directors and officers of a facility were not “renumeration” but were related to patient care and therefore could be allowed as a reimbursement cost under Medicaid. *Mercury-Douglass Center, Inc. v. Department of Public Welfare*, 601 A.2d 913 (Pa. Cmwlth. 1992).

**§ 1181.213. Cost reporting.**

(a) The facility shall identify for cost finding allowable direct, indirect, ancillary and related organization costs that apply to patient care for each certified level of care.

(b) The facility shall submit a cost report (Financial and Statistical Report, MA-11) to the Department in accordance with Departmental requirements. The cost report shall be based on financial and statistical records maintained by the facility. The cost information contained in the cost report and in the facility’s records shall be current, accurate, and in sufficient detail to support the claim for cost reimbursement. The Financial and Statistical Report (MA-11) outlines the expenses and revenues to be included in the cost report for MA.

(c) The facility shall maintain adequate financial records and statistical data for proper determination of costs payable under the MA Program. The financial records shall include all ledgers, books, records, and original evidence of cost (purchase requisitions, purchase orders, vouchers, vendor invoices, requisitions for supplies, inventories, time cards, payrolls, bases for apportioning costs, and the like) which pertain to the determination of reasonable costs and are auditable. The facility is required to maintain the records pertaining to each cost report for a period of not less than 4 years following the date the facility submits the cost

report to the Department. No cost will be allowed unless it is adequately documented to the extent that it is capable of being audited.

#### Notes of Decisions

##### *Auditability*

Department of Public Welfare's interpretation of this section as requiring a per se disallowance of all cash receipts and cancelled check claims unaccompanied by invoices was plainly erroneous, where testimony indicated that the disallowed receipts were not per se incapable of being audited. *Nipple v. Department of Public Welfare*, 692 A.2d 590 (Pa. Cmwlth. 1997).

#### § 1181.214. Cost apportionment and allocation.

The allowable costs for skilled nursing and intermediate care will be apportioned to the Medical Assistance Program by multiplying the average per diem cost for each level of care by the number of Medical Assistance patient days for that level of care.

#### Source

The provisions of this § 1181.214 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

#### § 1181.215. Efficiency incentive.

Subject to the sanctions specified in §§ 1181.91—1181.96 (relating to administrative sanctions), an efficiency incentive will be allowable for a nonpublic facility if the facility's audited net operating per diem costs are less than the applicable group ceiling. In determining the efficiency incentive, the following limitations apply:

- (1) Proprietary facilities may receive an efficiency incentive of up to 8.5% of the Statewide average net operating per diem cost of general nursing facilities excluding hospital-based and special rehabilitation facilities for each level of care for the prior fiscal year.
- (2) Nonprofit facilities may receive an efficiency incentive of up to 6% of the Statewide average net operating per diem cost of general nursing facilities excluding hospital-based and special rehabilitation facilities for each level of care for the prior fiscal year.
- (3) In no event may the total of a facility's audited net operating per diem rate and the efficiency incentive exceed the applicable group ceiling for the facility.

#### Source

The provisions of this § 1181.215 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial page (124145).

#### § 1181.216. Depreciation and interest reimbursement.

Except as provided otherwise in §§ 1181.91—1181.96 (relating to administrative sanctions) and in this subchapter allowable depreciation and interest on capital indebtedness, within the limitations specified in this subchapter, will be recognized as separate cost items and will be excluded from the limitation of the applicable ceiling on net operating costs.

**Source**

The provisions of this § 1181.216 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial page (124145).

**§ 1181.217. Establishing ceilings for allowable net operating costs.**

(a) The Department will establish annual ceilings on allowable net operating costs for each level of care.

(b) For ceiling setting purposes, the following apply:

(1) Certain facilities will be grouped together as follows:

(i) Hospital-based skilled nursing and intermediate care facilities and special rehabilitation facilities separately on a Statewide basis.

(ii) General skilled nursing and intermediate care facilities according to Metropolitan Statistical Areas (MSA) groups. For general skilled nursing and intermediate care facilities the MSA classifications will be grouped, based along geographic and economic lines, into levels as announced by the Federal Office of Management and Budget. For county facilities, Level A will be combined with Level B and Level C will be combined with the non-MSA level. The resulting two levels will be the county nursing facility groups for ceiling setting purposes.

(2) The MSA groupings used by the Department will reflect the latest MSA groupings announced no later than 90 days prior to the implementation date of the new ceilings by the Federal Office of Management and Budget. The MSA groupings will be published by notice in the *Pennsylvania Bulletin*.

(c) The cost data base for each group ceiling is the allowable net operating costs of each facility within each group. The cost information will be taken from each facility's most recent annual cost report. The Department will use only those year-end cost reports that cover a period of at least 180 days, are acceptable and are received no later than 90 days prior to the implementation date of the new ceilings. Cost reports that meet the requirements of § 1181.66(a)(1) (relating to setting ceilings on allowable net operating costs) are acceptable.

(d) The Department will establish ceilings as described in § 1181.66(a)—(c).

**Authority**

The provisions of this § 1181.217 amended under sections 201 and 443.1(2) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(2)).

**Source**

The provisions of this § 1181.217 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended September 6, 1985, effective September 7, 1985, except groups and ceilings shall be effective and apply at audit to costs of services rendered from July 1, 1984 through December 31, 1984, 15 Pa.B. 3181; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial pages (124145) to (124146).

1181-67

(201437) No. 253 Dec. 95

**RATE DETERMINATIONS****§ 1181.221. Determining the interim per diem rate.**

(a) An interim per diem rate will be established based on the facility's most recently filed cost report as adjusted for nonallowable costs by desk review. The cost report shall cover at least a 180 day period in order to qualify as a basis for interim per diem rate setting.

(b) Interim per diem rates will remain in effect for no less than 6 months.

(c) Interim per diem rates will be established under § 1181.68 (relating to upper limits of payment).

**Source**

The provisions of this § 1181.221 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**Notes of Decisions**

The "grandfather clause" providing that "in no case will the per diem payment . . . be less than the interim rates that were in effect prior to July 1, 1978 . . ." 55 Pa. Code section 9424.713. See 8 Pa.B. 2826-38 (1978), applied only to interim payments and not to final audited per diem payments. *Westmoreland Manor v. Department of Public Welfare*, 496 A.2d 1282 (Pa. Cmwlth. 1985).

**Cross References**

This section cited in 55 Pa. Code § 1181.101 (relating to facility's right to a hearing).

**§ 1181.222. Determining a cost-related prospective rate for certain facilities.**

(a) As an alternative to having a current interim per diem rate that is subject to annual adjustment to allowable costs under this subchapter, an in-State facility with a monthly average of ten Medical Assistance patients or less may request that the Department determine a prospective per diem rate for the facility. County and hospital-based nursing facilities, special rehabilitation facilities and intermediate care facilities for the mentally retarded may not elect to have a prospective rate.

(b) The prospective rate shall be determined prior to the beginning of the Department's fiscal year and will be based on the facility's projected MA-11 cost report, historical financial statements, and other third-party payor audit reports. The established per diem rate will be effective July 1 and will remain in effect through June 30 of the current fiscal year.

(c) Payments made under a prospective rate may not be subject to annual cost reporting by the facility or to year-end adjustment by the Medical Assistance Program. However, facilities with a prospective rate which render more than 3,650 Medical Assistance patient days may not meet the conditions specified in subsection (a) and will be required to submit a year-end cost report and will be subject to an audit and year-end adjustment by the Department.

1181-68

(d) The prospective rate, excluding depreciation and interest, may not exceed the applicable group ceiling for the facility. The prospective rate, including depreciation and interest, may not exceed the facility's private payor rate or the facility's Medicare interim rate.

(e) Facilities that request a prospective rate will not be eligible to receive an efficiency incentive.

(f) The costs of facilities with prospective rates will not be included in the costs used to establish ceilings.

**Source**

The provisions of this § 1181.222 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**§ 1181.223. Determining the interim per diem rate for a new facility or a facility with a change of ownership.**

For existing or newly constructed facilities that are entering the Medical Assistance Program and for facilities in the Program that have undergone a change of ownership, the facility's MA-11 projected cost report and all other required information as specified in this part will be used to set the interim rate for Medical Assistance during the initial period of operation, pending the filing of the first year-end cost report.

**§ 1181.224. Final per diem rate.**

The final per diem rate may not exceed the upper limits of payment specified in § 1181.68 (relating to upper limits of payment) and is subject to the sanctions in §§ 1181.91—1181.96 (relating to administrative sanctions).

**Source**

The provisions of this § 1181.224 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial page (125808).

**ALLOWABLE COSTS**

**§ 1181.231. Standards for general and selected costs.**

The Department will determine providers' allowable costs in accordance with all of the following:

- (1) Chapter 1101 (relating to general provisions), Subchapter A (relating to nursing facility care), and this subchapter.
- (2) The Medicare Provider Reimbursement Manual (HIM-15), except that where this part and the HIM-15 differ with respect to the treatment of a cost allowable in both, this part will govern.
- (3) Section 1181.68 (relating to upper limits of payment).

**Source**

The provisions of this § 1181.231 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**§ 1181.232. Changing the basis for allocating cost centers.**

(a) Occasionally a provider may wish to use an allocation basis for a particular cost center which is different than that required by the MA-11 because the provider believes the change will result in more appropriate and more accurate allocation. In these cases the provider shall submit a written request to the Department for approval of the change and provide reasonable justification for the change prior to the beginning of the cost reporting period for which the change is to apply.

(b) The Department's approval or denial of a provider's request will be furnished to the provider in writing. If the Department approves the provider's request, the change shall be applied to the cost reporting period for which the request was made and to all subsequent cost reporting periods unless the Department approves a subsequent request for change by the provider. If the request is denied, the facility shall continue to use the most current of either the allocation basis established by the Department or the facility's most current revised allocation basis that was approved by the Department. The acknowledgement by the Department's auditors that a particular cost-allocation methodology exists may neither be construed as nor used as a substitute for written Departmental approval of the facility's request for a change in the basis for allocating costs.

(c) The effective date of an approved request for a change in the allocation basis will be the beginning of the cost-reporting period for which the request was made.

**Source**

The provisions of this § 1181.232 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**Notes of Decisions***Procedure*

The attorney examiner correctly declined to apply the square footage method of allocating home office costs where the organization failed to submit a timely written request to make the change. *Sycamore Manor Health Ctr. v. Department of Public Welfare*, 663 A.2d 820 (Pa. Cmwlth. 1995).

**§ 1181.232a. Bed changes during a cost reporting period—statement of policy.**

(a) *Interim rate level.* The Department will accept the required or previously approved allocation bases and use the bed complement on the final day of the reported period as the basis for setting the interim rate. Allocation bases accepted at interim rate will be subject to verification at audit.

(b) *Audit level.* The provider is required by regulation to keep adequate documentation of the cost by the level of care.



(1) For cost reporting periods ending before June 30, 1988, the provider may use multiple Schedule C's or actual statistics. The preferred method for documenting this is to submit supplemental Schedule C's which identify costs being allocated by proper statistics for each period of change. These supplemental Schedule C's will then be combined on a summary Schedule C which would become the required Schedule C to be included in the MA-11 Cost Report. The supplemental Schedule C's should be submitted with the MA-11 Cost Report. For periods ending after June 30, 1988, the provider shall use multiple Schedule C's.

(2) For either time period, the absence of required documentation will result in zero cost. The absence of required documentation or the use of other methods which do not properly reflect use of the Department's required allocation bases or approved change in bases will result in zero cost being allowed for that line item.

#### Source

The provisions of this § 1181.232a adopted April 29, 1988, effective July 1, 1983, 18 Pa.B. 2033; amended December 30, 1988, effective July 1, 1983, 18 Pa.B. 5760. Immediately preceding text appears at serial page (125809).

### § 1181.233. Bed occupancy allowance.

(a) A facility shall maintain an average annual rate of occupancy of a minimum of 90% of its available bed capacity on a facility-wide basis.

(b) For a facility with less than 90% occupancy facility-wide, the number of total patient days shall be adjusted so that the 90% factor can be achieved. If occupancy for each level of care is below 90%, the patient days for each shall be adjusted to bring each to the 90% level.

(c) The occupancy level adjustment will be applicable to fixed costs such as depreciation, rent, interest, insurance and taxes. It will not apply to variable costs, such as staffing and food, since these costs should decrease as the occupancy level decreases.

(d) The average per diem rate determined at the end of the facility's fiscal year will be calculated in accordance with this section.

(e) A bed reserved for a recipient who is hospitalized will not be counted as an occupied bed unless the reserved bed is filled with another patient while the Medical Assistance recipient is hospitalized. A bed reserved for a recipient who is on therapeutic leave will be counted as an occupied bed.

(f) A waiver to the minimum bed occupancy allowance will be made for a new facility, at the time of the audit, relating to the facility's first 12 months of operation. If the facility has been in operation for at least 12 months prior to coming into the Medical Assistance Program, this waiver does not apply. This subsection does not apply to new additions to existing facilities or to the replacement of existing facilities.

**Source**

The provisions of this § 1181.233 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005; corrected October 1, 1993, effective January 1, 1989, 23 Pa.B. 4645. Immediately preceding text appears at serial pages (135950) to (135951).

**Notes of Decisions**

The nursing home's new 180 bed facility was not a "new facility" allowing for the application of the minimum bed occupancy allowance rule used in the determination of depreciation expense in that the home has been in existence since 1873. *Lemington Home for the Aged v. Department of Public Welfare*, 641 A.2d 637 (Pa. Cmwlth. 1994).

**§ 1181.234. General administration allowance.**

(a) The allowable cost of general administration will be limited. The allowable cost of general administration for each level of care will be determined so that all other allowable costs, excluding depreciation and interest on capital indebtedness, equal no less than 88% of the allowable net operating costs, except as provided in this section.

(b) General administration expenses may include, but are not limited to: administrative salaries, including fringe benefits and payroll taxes; home office expenses; compensation of owners, officers or persons other than facility employees; personnel; procurement; accounting; auditing; management consultants; office services and supplies; telephone; licenses; travel; association dues; and legal costs, including attorney's fees.

(c) Home office allocations and management fees are subject to the following conditions and limitations:

(1) Home office allocations and management fees between related parties shall be reported without any markup by the provider.

(2) Costs, such as those related to nonworking officers or officers' life insurance, which are not allowable, may not be included in home office allocations or management fees.

(3) Components of the home office and management costs shall be documented through work time records. If documentation of these costs is not provided to the Department's auditors upon request, the total home office and management costs will be disallowed.

(4) Home office allocations, including depreciation and interest, shall be charged to the general administration line on the cost report.

(d) A facility providing more than one level of care shall allocate the total administrative costs to each level of care on the basis of a percentage of the costs of each level of care to the total costs.

**Source**

The provisions of this § 1181.234 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**Notes of Decisions**

Where petitioner failed to establish percentage of Office of Public Information (OPI) expense attributable to newsletters distributed to facility residents and immediate family, hearing officer did not err in concluding OPI costs were not related to patient case and were not reimbursable related to patient case. *Tressler Lutheran Service Associates v. Department of Public Welfare*, 514 A.2d 661 (Pa. Cmwlth. 1986).

**Cross References**

This section cited in 55 Pa. Code § 1181.251 (relating to contracted management services).

**SALARY COSTS AND STAFFING STANDARDS****§ 1181.241. General administration salaries.**

(a) Salaries of the facility's administrator, comptroller, purchasing agent, personnel director, pharmacy consultant and other persons performing general supervision or management duties shall be includable in the general administration allowance.

(b) Compensation of owners, officers or persons other than facility employees means actual payment during the cost reporting period on a current basis of salary or benefits for services rendered to the facility.

(c) If a person performs work customarily performed by different or several types of employees, the cost of the salary and other compensation allowable for the person shall be determined by the prorated customary salary and other compensation paid to employees for performing the same types of work in accordance with the methodology established in subsection (f). This cost will be allowable only if adequate documentation verifying the cost is supplied by the facility. Adequate documentation consists of a job description defining the responsibilities of the person and time records documenting the allocation of the person's time for the performance of each type of work on a daily basis. The cost of salary and other compensation paid to the person for work performed shall be recorded as general administration costs.

(d) The salary or compensation costs of owners, operators or persons other than facility employees may be included only to the extent of their documented time and involvement in the required management of a facility.

(e) The allowable cost for a person performing necessary duties may not exceed the customary compensation and fringe benefits, as determined in accordance with the methodology established in subsection (f) that an employee would normally receive while performing that work.

(f) The cost of customary compensation and fringe benefits for employees performing necessary duties in general facilities, excluding hospital-based and special rehabilitation facilities, will be based on an average of the cost of the compensation and fringe benefits of employees performing the same work in enrolled general facilities, excluding hospital-based and special rehabilitation facilities, which are located in the county in which the facility is located and in counties within this Commonwealth which are contiguous to that county. The cost of customary compensation and fringe benefits for employees performing necessary duties in hospital-based, special rehabilitation and county facilities will be

based upon separate Statewide averages of the cost of enrolled facilities of each type for the compensation and fringe benefits of employees performing the same work.

(g) The cost of general administrative salaries and benefits are included within the 12% overall maximum allowance, prorated between skilled nursing and intermediate care units, for general administration costs.

**Source**

The provisions of this § 1181.241 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**Notes of Decisions**

*Allowable Costs*

Department of Public Welfare's regulations capping the amount of reimbursement to Medical Assistance providers for nursing care excludes salaries of unit managers and director of infection control program; even though the managers and director had nursing degrees, they did not provide direct patient care and therefore their salaries did not constitute "nursing costs." *St. Ignatius v. Department of Public Welfare*, 918 A.2d 838, 845-846 (Pa. Cmwlth. 2007)

Nursing home's purchase of bereavement flowers for nursing facility employees was not an expense that was related to the proper care of nursing reimbursement facility residents; therefore, Department of Public Welfare properly excluded the expense from facility's allowable Medical Assistance costs. *St. Ignatius v. Department of Public Welfare*, 918 A.2d 838, 846-847 (Pa. Cmwlth. 2007)

In order for general administration salaries of a skilled nursing facility to be included in allowable cost reimbursement, language must be included in documenting the responsibilities of the person and time records evidencing the allocation of that person's time to each type of work. *Carbondale Nursing Home, Inc. v. Department of Public Welfare*, 548 A.2d 376 (Pa. Cmwlth. 1988).

*Salary Averages*

Where proprietors of a nursing facility introduced documents to show that the salaries fell within a range of salaries paid to persons performing similar duties in facilities within the same area, the auditor was not required to base his calculations on a range of salaries, but rather on an "average." *Siemon's Lakeview Manor Estate v. Department of Public Welfare*, 703 A.2d 551 (Pa. Cmwlth. 1997).

In order for general administration salaries of a skilled nursing facility to be included in allowable cost reimbursement, language must be included in documenting the responsibilities of the person and time records evidencing the allocation of that person's time to each type of work. *Carbondale Nursing Home, Inc. v. Department of Public Welfare*, 548 A.2d 376 (Pa. Cmwlth. 1988).

**§ 1181.242. Nursing staff allowance.**

(a) Except for special rehabilitation facilities, the allowable costs recognized for Medical Assistance may not exceed 3 nursing hours per patient per day for skilled nursing care and 2.6 nursing hours per patient per day for intermediate care.

(b) For special rehabilitation facilities, the allowable costs recognized for Medical Assistance may not exceed 3.75 nursing hours per patient per day for skilled nursing care and 3.2 nursing hours per patient per day for intermediate care.

(c) Allowable nursing hours are calculated in accordance with the instructions of the Department's preprinted cost report.

**Authority**

The provisions of this § 1181.242 amended under section 443.1(2) and (3) of the Public Welfare Code (62 P. S. § 443.1(2) and (3)).

**Source**

The provisions of this § 1181.242 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended September 5, 1986, effective July 1, 1985, 16 Pa.B. 3294. Immediately preceding text appears at serial page (99421).

**Notes of Decisions***Allowable Costs*

Department of Public Welfare's regulations capping the amount of reimbursement to Medical Assistance providers for nursing care excludes salaries of unit managers and director of infection control program; even though the managers and director had nursing degrees, they did not provide direct patient care and therefore their salaries did not constitute "nursing costs." *St. Ignatius v. Department of Public Welfare*, 918 A.2d 838, 845-846 (Pa. Cmwlth. 2007)

Nursing home's purchase of bereavement flowers for nursing facility employees was not an expense that was related to the proper care of nursing home facility residents; therefore, Department of Public Welfare properly excluded the expense from facility's medical assistance reimbursement. *St. Ignatius v. Department of Public Welfare*, 918 A.2d 838, 846-847 (Pa. Cmwlth. 2007)

**Cross References**

This section cited in 55 Pa. Code § 1181.2 (relating to definitions).

**§ 1181.243. Social service staff.**

Cost, pro rata, of up to one full-time equivalent unit of social service professional staff for each 60 patients will be allowable.

**Notes of Decisions***Allowable Costs*

Department of Public Welfare's regulations capping the amount of reimbursement to Medical Assistance providers for nursing care excludes salaries of unit managers and director of infection control program; even though the managers and director had nursing degrees, they did not provide direct patient care and therefore their salaries did not constitute "nursing costs." *St. Ignatius v. Department of Public Welfare*, 918 A.2d 838, 845-846 (Pa. Cmwlth. 2007)

Nursing home's purchase of bereavement flowers for nursing facility employees was not an expense that was related to the proper care of nursing reimbursement facility residents; therefore, Department of Public Welfare properly excluded the expense from facility's allowable Medical Assistance costs. *St. Ignatius v. Department of Public Welfare*, 918 A.2d 838, 846-847 (Pa. Cmwlth. 2007)

**Source**

The provisions of this § 1181.243 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**OTHER COST ITEMS****§ 1181.251. Contracted management services.**

(a) In lieu of home office allocations and management fees, a facility may contract with a nonrelated management service. The cost of this contract shall be shown as a general administrative cost and may not be allocated among other cost centers.

(b) Management services contracted with a related party will be treated as home office allocations and are subject to § 1181.234(c) (relating to general administration allowance).

**Source**

The provisions of this § 1181.251 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**§ 1181.252. Volunteer and donated services of individuals.**

(a) The actual costs that are necessary for a facility to utilize the services of members of volunteer or religious organizations who donate their services on a regularly scheduled basis to serve in positions customarily held by full-time

employees to provide normal patient care or to assist with the operation of the facility will be allowable costs. The following conditions and limitations apply:

- (1) The costs shall be limited to the fair market value of comparable salaries of full-time personnel who perform similar services.
  - (2) The costs shall be based on regular working hours, excluding overtime.
  - (3) The actual costs for these services shall be supported by documentation substantiating all expenditures.
  - (4) The costs will be reimbursed as part of the net operating costs.
- (b) The recognition as allowable costs for workers who are members of an organization of nonpaid workers is subject to the following conditions:
- (1) Nonpaid workers shall be members of an organization of nonpaid workers that has arrangements with the provider for the performance of services by nonpaid workers.
  - (2) Membership in the organization shall be substantiated by adequate documentation in the files of the organization of nonpaid workers.
  - (3) A legally enforceable agreement between the provider and the organization of nonpaid workers shall exist and shall establish the provider's obligation to remunerate the organization for services rendered. A legally enforceable agreement will not be considered to exist if the provider's legal obligation to pay the organization of nonpaid workers is nullified by an offsetting legal obligation by the organization of nonpaid workers to pay or make a contribution to the provider of all or part of the salary liability. The part of the provider's obligation required to be paid by the organization of nonpaid workers will not be allowed.
  - (4) A payment made by the organization of nonpaid workers to the provider for the nonpaid workers' maintenance, prerequisite or fringe benefits shall be used as an offset to the total of the cost actually incurred by the providers.
- (c) Staff services relating to the use of volunteer workers will be an includable cost.

**Source**

The provisions of this § 1181.252 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**Cross References**

This section cited in 55 Pa. Code § 1181.271 (relating to excluded expenses and revenues).

**§ 1181.253. Pastoral services.**

- (a) Salary costs will be allowed for pastoral services rendered directly to patients by professional staff employed by, or under contract with, the facility.
- (b) Costs for a chaplaincy training program will not be allowable costs.

**Source**

The provisions of this § 1181.253 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**§ 1181.254. Medicare Part B type services.**

- (a) Facilities shall have the option of using one of two methods of dealing with Medicare Part B services provided by nursing facility owners or operators to MA recipients:
  - (1) *Option 1.* The nursing facility may exclude from its cost report any operating and capital costs incurred in, and any income derived from, the pro-

vision of Medicare Part B services. The nursing facility shall attach, to the cost report the facility submits to the Department, a copy of the cost report the facility submits to Medicare for the Part B services and a copy of the Medicare final audit, including audit adjustments. If final audits are not available, the Department will exclude any operating or capital cost associated with providing the Medicare Part B service.

(2) *Option 2.* The nursing facility may elect, through advance written notification to the Department, to include in its cost report the operating and capital costs incurred in, and the income derived from, the provision of Medicare Part B services. If the nursing facility elects this option, the facility's fiscal year must coincide with that of the Department; and the facility may not change its methodology for Medicare Part B services for the duration of the fiscal year. The Department, at the final settlement, will take the following steps in determining its reimbursement to the facility:

(i) The Department will identify the percentage of the total operating costs represented by the Medicare Part B services and reduce the ceiling on net operating costs for the facility by that percentage.

(ii) The Department will identify and deduct from the total capital costs of the facility the percentage of depreciation and interest costs associated with the provision of Medicare Part B services.

(iii) The Department will apply any revenue received by the facility from Medicare for providing the Part B service as an adjustment to the cost of providing these services before the Department adjusts for the ceiling on net operating costs for the facility.

(3) If the facility did not provide advance written notification to the Department of the facility's election of Option 2 and the facility's cost report contains costs associated with the provision of Medicare Part B services, the Department will credit against the total reimbursement due any revenue the facility received from Medicare for the Part B services rendered to the facility's Medical Assistance recipients.

(b) The cost of providing Medicare Part B type services to non-Medicare Part B eligible recipients which are otherwise allowable costs under this part should be reported as provided elsewhere in this subchapter.

#### Source

The provisions of this § 1181.254 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

#### Notes of Decisions

Hearing Officer's finding that Department of Public Welfare did not intend to use the exclusion method for Medicare Part B costs and revenue related to services provided by salaried physicians at the time the net operating costs ceiling was imposed, was supported by substantial evidence, and where only interpretation applied to regulations thus far referred to offset method, petitioner could not claim that current interpretation of exclusion method contradicted prior practice. *Fair Acres Geriatric Center v. Department of Public Welfare*, 528 A.2d 1008 (Pa. Cmwlth. 1987).

This section provides two options for handling Medicare Part B Services which a facility itself provides, the exclusion method and the offset method. *Fair Acres Geriatric Center v. Department of Public Welfare*, 528 A.2d 1008 (Pa. Commw. 1987).

#### Cross References

This section cited in 55 Pa. Code § 1181.254a (relating to Medicare Part B adjustments—statement of policy).



**§ 1181.254a. Medicare Part B adjustments—statement of policy.**(a) *Option 1*

(1) To qualify for Option 1, the facility shall:

(i) Exclude operating and capital costs incurred to provide Medicare Part B services.

(ii) Attach a copy of its Medicare cost report when it submits its MA-11.

(2) The MA-11 should contain the adjustments excluding the incurred Medicare Part B costs and those adjustments should be included in the decreasing adjustments made on Schedule C.

(3) If the Medicare cost report or the Medicare audit report is not submitted with the MA-11, the facility cannot qualify for Option 1, and § 1181.254(a)(3) (relating to Medicare Part B type services) will apply at audit unless the facility has also qualified for Option 2 at § 1181.254(a)(2).

(4) If a facility does submit the Medicare cost report with the MA-11 and its MA-11 contains the adjustments required by Option 1, the facility can qualify for Option 1 as long as the auditors can verify and reconcile the costs on the Medicare cost report to the adjustments made on the MA-11. At audit, if the Medicare audit of the submitted Medicare cost report is available, it shall be provided for the auditors' use.

(5) If there is a discrepancy between the costs on the Medicare cost report—or, if available, the Medicare audit report—and the adjustments made by the facility on the MA-11, the auditors will make reconciling adjustments if there is sufficient detail in the MA-11 and the facility's books and records to support the reconciliation. However, if the auditors are not able to substantiate a basis for reconciliation, the auditors will not apply § 1181.254(a)(1), and will reverse the adjustments to reported costs on the MA-11 for Medicare Part B services made by the facility in the facility's efforts to claim treatment under Option 1 and apply §§ 1181.254(a)(2) or (3), as appropriate.

(b) *Failure to claim Medicare Part B.*

(1) If a service is covered by Medicare Part B but reimbursement is not claimed or received from Medicare Part B because of facility error or policy, a facility may not receive reimbursement from the Medical Assistance Program in excess of that which it could receive had the Medicare Part B payments been received. The facility is obligated to know whether a recipient has Medicare Part B coverage and a duty to seek payment for covered services whether or not the facility is a participating provider in the Medicare program. Those services affected by § 1181.254 and § 1181.274 (relating to direct provider payments not includable in costs) are presumed to be coverable by Medicare Part B unless Medicare Part B has determined that they are not.

(2) At audit, a facility shall be able to document that costs affected by §§ 1181.254 and 1181.274, but claimed for reimbursement, were incurred either for services not covered by Medicare Part B or were incurred with respect to patients not covered by Medicare Part B or other insurance resources. If a facility is not able to document this basis for the inclusion of



these costs, they will be adjusted at audit where § 1181.254(a)(3) applies, by a below the line offset of the costs claimed on the MA-11.

**Source**

The provisions of this § 1181.254a adopted June 17, 1988, effective June 22, 1988, and pertains to all cost reports, unaudited or to be settled, having reporting periods subsequent to July 1, 1983, 18 Pa.B. 2732.

**§ 1181.255. Recreational services.**

The cost of recreational services of a facility will be allowed and will be based on an hourly or salary rate only, and not on a fee-for-service basis.

**Source**

The provisions of this § 1181.255 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**§ 1181.256. Other practitioner services.**

(a) Other practitioner services which are provided on a contract or salary basis by the facility will be allowed. Arrangements for these services, if made on a fee-for-service basis, will not be allowed.

(b) The direct and indirect costs associated with noncompensable cost centers, such as a pharmacy or space rented or used by an independent practitioner, will not be allowed.

**Source**

The provisions of this § 1181.256 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**§ 1181.257. Drug services.**

(a) Allowable costs for drug services will be subject to the following conditions:

(1) A facility will be reimbursed for nonlegend drugs such as laxatives, aspirin, and antacids that are provided directly to an MA patient by a facility from its own supply.

(2) Detailed and itemized support documentation must be maintained for the claimed expense; otherwise, the expense will be disallowed.

(b) Any costs related to legend drugs for which payment would be made under the MA Program to an enrolled pharmacy or cost related to legend drugs that are noncompensable under the MA Program will not be considered as allowable costs for a facility. The Department will directly reimburse licensed pharmacies for compensable prescribed drugs furnished to eligible MA recipients.

(c) The provision of all nonlegend drugs furnished by a facility to its MA recipients shall be based on a physician's written order or prescription, be administered judiciously, and be limited to those that are medically necessary for the patient.

(d) Medically needy MA recipients are not eligible to receive prescription drugs under the MA Program. Therefore, these recipients must use their own funds to purchase drugs. If the facility acts as an agent for its MA recipients in purchasing drugs, the facility shall act as a prudent buyer.

(e) Facilities may not solicit or receive a remuneration, directly or indirectly, in cash or in kind, from a person in connection with the furnishing of drugs or in connection with referring a recipient to a person for the furnishing of drugs.

(f) A cost related to a pharmacy consultant shall be shown under general administration expenses on the cost report and will be included under the general administration allowance.

**Source**

The provisions of this § 1181.257 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**Cross References**

This section cited in 55 Pa. Code § 1181.257a (relating to clarification of the term “written”—statement of policy).

**§ 1181.257a. Clarification of the term “written”—statement of policy.**

(a) The term “written” in § 1181.257(c) (relating to drug services) includes orders and prescriptions that are handwritten or transmitted by electronic means.

(b) Written orders and prescriptions transmitted by electronic means must be electronically encrypted or transmitted by other technological means designed to protect and prevent access, alteration, manipulation or use by any unauthorized person.

**Source**

The provisions of this § 1181.257a adopted July 16, 2010, effective July 17, 2010, 40 Pa.B. 3963.

**§ 1181.258. Utilization, medical review, and program audits.**

The cost of services mandated by Federal and State regulations for utilization review, medical review, and program audits shall be included on the cost report under “Utilization Control” as a separate item under “Other Costs.”

**Source**

The provisions of this § 1181.258 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**§ 1181.259. Depreciation allowance.**

(a) Depreciation on capital assets used to provide compensable services to Medical Assistance recipients, including assets for normal, standby, or emergency use, is an allowable cost.

(b) Except as specified in subsections (c) and (d), a facility will be reimbursed for allowable depreciation costs only if the facility is the recorded holder of legal title.

(c) Facilities which participated in the Medical Assistance Program prior to July 1, 1983 which are not part of a related organization and which are not the recorded holder of legal title to the facility, are considered to meet the recorded holder of legal title requirement, and, therefore, will be reimbursed for allowable depreciation on a particular project, if, at the time services were rendered, the following existed:

(1) The particular project was wholly funded through an Industrial Development Authority bond issue.

(2) The facility provided the Department with all documents relating to ownership and financial obligations relating to the facility.

(3) The facility met the standards of HIM-15, Section 110-B, with respect to virtual purchases.

(d) Facilities which participated in the Medical Assistance Program prior to July 1, 1983, which are part of a related organization and which are not the

recorded holder of legal title to the facility, are considered to meet the recorded holder of legal title requirement, and, therefore, will be reimbursed for allowable depreciation on a particular project, if, at the time services were rendered, the following existed:

(1) The particular project was wholly funded through an Industrial Development Authority bond issue.

(2) The facility was a related organization to a corporation, person, or company which, if it operated the facility, could qualify for reimbursement for allowable depreciation costs under subsection (c).

(3) All of the documentation necessary to substantiate that the facility meets the requirements of subsection (c) and documentation and statement of the fact that the two entities are related organizations were supplied to the Department.

(4) The related organization agreed in writing as required by the Department that it and its successors will be responsible for any overpayment which the Department is unable to collect directly from the facility.

(e) The straight-line method of depreciation shall be used. Accelerated methods of depreciation shall not be acceptable. The amount of annual depreciation shall be determined by first reducing the cost of the asset by any salvage value and then dividing by the number of years of useful life of the asset. The useful life may be shorter than the physical life depending upon the usefulness of the particular asset to the provider. A useful life may not be less than the relevant useful life published by the Internal Revenue Service or the Uniform Chart of Accounts and Definitions for Hospitals published by the American Hospital Association for the particular asset on which the depreciation is claimed. However, the accelerated cost recovery system under section 168(c) of the Internal Revenue Code (26 U.S.C.A. § 168(c)) and any other accelerated life systems shall not be permitted.

(f) Depreciation expense for the year of acquisition and the year of disposal can be computed by using either the half-year or actual time method of accounting. In no instance may the number of months of depreciation expense exceed the number of months that the asset was in service. If the first year of operation is less than 12 months, depreciation is allowed only for the actual number of months in the first year of operation.

(g) The method and procedure, including the assigned useful lives, for computing depreciation shall be applied from year-to-year on a consistent basis from the date of the facility's first filed cost report after July 1, 1975, and may not be changed, even if the facility is purchased as an ongoing operation.

(h) All assets shall be recorded at cost. Donated assets shall be recorded at the current appraisal value or the lower of the following if available: the construction cost, the original purchase price or the donor's original purchase price. Costs incurred during the construction of an asset, such as architectural, consulting and legal fees, interest, and fund raising, shall be capitalized as a part of the cost of

the asset. When an asset is acquired by a trade-in, the cost of the new asset is the sum of the book value of the old asset and any cash or issuance of debt as consideration paid.

(i) Facilities that previously did not maintain fixed asset records and did not record depreciation in prior years shall be entitled to any straight-line depreciation of the remaining useful life of the asset. The depreciation shall be based on the cost of the asset at the time of original purchase or construction. No depreciation may be taken on an asset that would have been fully depreciated if it had been properly recorded at the time of acquisition.

(j) Depreciation on facilities that have no fixed asset records and are sold will be recognized to the extent to which the prior owner would have been entitled to depreciation.

(k) Leasehold improvements shall be depreciated over the useful life of the asset.

(l) Gains on the sale of fixed or movable assets are considered to be equal to the salvage value which must be established prior to the sale of the item. All gains on the sale of fixed and movable assets will offset the facility's total depreciation expense in the year that the asset was either sold or retired from service. Losses incurred on the sale or disposal of fixed or movable assets will not be reimbursed under the Program.

(m) The cost basis for depreciable assets is determined as follows:

(1) Except as provided otherwise in this section, the cost basis of the depreciable assets of a facility that are acquired as used, shall be computed by the following method:

(i) The lower of the purchase price or the fair market value shall be established at the time of sale based on the lowest of two or more bona fide appraisals at the time of sale.

(ii) All depreciation that was taken or could have been taken by all prior owners shall be subtracted.

(iii) Subsections (r) and (s) establish the Department's extent of participation in the payment of allowable depreciation.

(2) The cost basis for depreciable assets of a facility transferred between related parties shall be the net book value of the seller at the date of the transfer as recognized under this subchapter.

(3) The cost basis for depreciable assets of a facility acquired through stock purchase will remain unchanged from the cost basis of the previous owner.

(4) The cost basis for depreciable assets of a facility purchased in types of transactions other than those specified in paragraphs (1), (2), (3) and (5), may not exceed the seller's basis under this subchapter, less depreciation that was taken or could have been taken by all prior owners.

(5) The cost basis for depreciation on an asset the ownership of which changes on or after July 18, 1984, shall be the lesser of the remaining allow-

able cost basis of the asset to the owner of record on or after July 18, 1984, or, in the case of an asset not in existence as of that date, the first owner of record of the asset after that date, or the allowable cost basis to the new owner. The cost basis shall exclude costs, including legal fees, accounting and administrative costs, travel costs, or the cost of feasibility studies, attributable to the negotiation or settlement of the sale or purchase—by acquisition or merger—for which a payment was previously made under Title XVIII of the Social Security Act (42 U.S.C.A. §§ 1395—1395xx), except as specified in § 1181.65(c) (relating to cost-finding).

(n) The reasonable cost of depreciation will be recognized for the construction and renovation of buildings to meet Federal, State or local laws and building codes for skilled nursing and intermediate care facilities serving Medical Assistance recipients. These costs will be recognized as allowable if the facility has either a Certificate of Need or a letter of nonreviewability for the project from the Department of Health in accordance with subsection (r)(1) and (2). In accordance with Federal and State regulations, the facility shall submit to the Department, the Certificate of Need or letter of nonreviewability, as appropriate, or the provider will not receive reimbursement for interest on capital indebtedness, depreciation, and operating expenses.

(o) If the purchases of a facility or improvements to the facility are financed by tax exempt bonds, the acquired property, plant or equipment shall be capitalized and depreciated over the life of the assets. The acquired property, plant or equipment are the only items that may be capitalized. If the principal amount of the bond issue was expended in whole or in part on capital assets which fail to meet the requirements of the subsections (m) and (n) regarding eligibility for depreciation, the includable depreciation will be proportionately reduced.

(p) The fixed asset records shall include:

- (1) The depreciation method used.
- (2) A description of the asset.
- (3) The date the asset was acquired.
- (4) The cost of the asset.
- (5) The salvage value of the asset.
- (6) The depreciable cost.
- (7) The estimated useful life of the asset.
- (8) The depreciation for the year.
- (9) The accumulated depreciation.

(q) Effective July 1, 1983, for SNF and ICF providers, the funding of depreciation is recommended so that funds may be available for the acquisition and future replacement of assets by the facility. To qualify for treatment as a funded depreciation account, the funds shall be clearly designated in the provider's records as funded depreciation accounts and shall be maintained in accordance with the provisions of HIM-15.

(r) The Department will recognize depreciation as an allowable cost subject to the following conditions:

(1) Depreciation on new or additional beds is an allowable cost only if:

(i) The facility was issued either a Section 1122 approval or letter of nonreviewability in accordance with 28 Pa. Code Chapter 301 (relating to limitation on Federal participation for capital expenditures) or a Certificate of Need or letter of nonreviewability in accordance with 28 Pa. Code Chapter 401 (relating to Certificate of Need Program) for the project by the Department of Health no later than August 31, 1982.

(ii) The facility was issued a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 for the construction of a nursing facility and there was no nursing facility, including county, private or hospital-based, located within the county.

(2) The Department will not recognize depreciation as an allowable cost if the facility does not substantially implement the project as defined at 28 Pa. Code § 401.5(m)(3) (relating to Certificate of Need) within the effective period of the original Section 1122 approval or the original Certificate of Need.

(3) Depreciation on replacement beds is an allowable cost only if the facility was issued a Certificate of Need or a letter of nonreviewability for the project by the Department of Health.

(s) After July 1, 1977, allowable depreciation costs for existing, new, renovated or purchased facilities shall be limited to a maximum construction cost per bed of \$22,000. The actual cost per bed will be based on the total project cost which includes the cost of land (no depreciation is recognized on land), site surveys, architectural and engineering fees, supervision, inspection and overhead, site preparation, construction, fixed equipment, contingencies, interest during construction and other related costs such as attorney's fees, recording costs, transfer taxes, mortgage insurance and service charges including finder's and placement fees. If an existing facility constructs additional beds or renovates portions of the facility which include supportive services, such as a dining room, physical therapy room, occupational therapy room, or maintenance area, the cost of construction of these supportive services is prorated among both existing and new beds of the facility. A separate \$22,000 per bed limit applies to each construction or renovation project. The cost of movable equipment is not included in the \$22,000 per bed limit.

#### **Authority**

The provisions of this § 1181.259 issued under sections 201 and 443.1 of the Public Welfare Code (62 P. S. §§ 201 and 443.1).

#### **Source**

The provisions of this § 1181.259 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended February 17, 1984, effective July 1, 1983, 14 Pa.B. 546; amended March 1, 1986, effective March 1, 1986, 16 Pa.B. 600; amended March 10, 1989, effective immediately and applies retroac-

tively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial pages (99425) to (99426), (105517) to (105518) and (128286).

#### Notes of Decisions

The waiver by the Department of Public Welfare allowing a nursing facility to change the “useful life” of its depreciable fixed assets does not also allow the facility to use the common date expiration methodology as opposed to the straight line method of depreciation when it fails to follow the prescribed procedures. *Oakmont Presbyterian Home v. Department of Public Welfare*, 633 A.2d 1315 (Pa. Cmwlth. 1993).

For depreciation purposes, Department of Public Welfare properly required new owner of nursing home to utilize prior owner’s asset life. Petitioner failed to meet its burden of providing proper documentation to establish depreciable cost basis of newly acquired assets. *Homestead Nursing and Convalescent Home v. Department of Public Welfare*, 579 A.2d 440 (Pa. Cmwlth. 1990).

Department may not adopt a method of calculating allowable depreciation costs which is inconsistent with one it failed to refute. *State College Manor, Ltd. v. Department of Public Welfare*, 576 A.2d 407 (Pa. Cmwlth. 1990).

The Department can not use a methodology for determining depreciation expenses that would result in the depreciation costs for nonallowable cost centers to be deducted twice. *Meadows Nursing Center v. Department of Public Welfare*, 561 A.2d 68 (Pa. Cmwlth. 1989).

Where the seller of a building was never a participant in the MA Program, the proper allowable cost basis in the building for purposes of depreciation reimbursement, under the MA Program, is the purchase price of the building not the seller’s basis therein. *Mercy Hospital of Johnstown v. Department of Public Welfare*, 561 A.2d 58 (Pa. Cmwlth. 1989).

The term “year” refers to the “fiscal year”, and the Department’s attempt to apply a different definition through an interpretive policy statement was an improper attempt to substantively change the regulation in violation of the Commonwealth Documents Law. *Hillcrest Home, Inc. v. Department of Public Welfare*, 553 A.2d 1037 (Pa. Cmwlth. 1989).

The fact that the nursing care facility was not the record title holder of the realty (the depreciable capital asset) meant that the asset could not be depreciated under this section. *Fair Winds Manor v. Department of Public Welfare*, 535 A.2d 42 (Pa. 1987); order confirms 514 A.2d 642 (Pa. Cmwlth. 1986).

The Court concluded that the American Hospital Association’s Uniform Chart of Accounts and Definitions for Hospitals remain applicable, even though it does not differentiate between freestanding buildings and existing structures, because the Medical Provider Reimbursement Manual, to be referred to in the case of ambiguity, considers a building as including its shell and any additions thereto. *The Jewish Home of Eastern Pennsylvania v. Department of Public Welfare*, 480 A.2d 1316 (Pa. Cmwlth. 1984).

#### Cross References

This section cited in 55 Pa. Code § 1181.69 (relating to annual adjustment); 55 Pa. Code § 1181.259a (relating to elimination of funded depreciation—statement of policy); 55 Pa. Code § 1181.260 (relating to interest allowance); 55 Pa. Code § 1181.262 (relating to fund raising expenses); and 55 Pa. Code § 1181.264 (relating to rental property and plant).

#### § 1181.259a. Elimination of funded depreciation—statement of policy.

(a) The Department has abolished at 55 Pa. Code §§ 1181.259(q) and 6211.79(q) (relating to depreciation allowance) the requirement that county and general nursing facilities fund the depreciation portion of their MA payment rate.



(b) The Department's decision to repeal the funded depreciation requirement permits many providers, currently required to fund depreciation, to eliminate funding, to liquidate present funded depreciation accounts, if they choose to do so, and to resolve present administrative appeals. It also eliminates the need of providers that choose to liquidate their funded depreciation accounts to complete Schedule M of the MA 11 in cost reporting periods following the period in which the funded depreciation account was liquidated. Providers that choose to liquidate their funded depreciation account should document their decision to do so for MA audit purposes; the funded depreciation account should then be liquidated prior to the start of their next fiscal year. The Department will treat the offset of investment income earned on the funded depreciation account of providers that choose to liquidate the account in accordance with the principles of Medicare's Health Insurance Manual 15 (HIM-15).

(c) Providers are not required to liquidate their funded depreciation accounts. They may choose to continue to maintain the funded depreciation accounts as a prudent fiscal management practice and in order to immunize income earned on the fund from offset against interest expense. To immunize the investment income earned on the funded depreciation account from offset, the account should be maintained in accordance with the principles of HIM-15. Income earned in an account maintained under the Department's guidelines between July 1, 1983, and the start of the provider's next fiscal year, will not be subject to offset as a result of an inconsistency between the Department's guidelines and the guidelines for funded depreciation accounts in HIM-15, as long as the income is retained in the account and the account itself is thereafter maintained according to HIM-15 guidelines. Providers who retain the funded depreciation account but have not maintained it in accordance with the HIM-15 principles, will have until the start of their next fiscal year to reorganize their account in order to maintain it in accordance with HIM-15 guidelines.

(d) The Office of Medical Assistance Programs will cease making disallowances based on the funding requirement.

#### Source

The provisions of this § 1181.259a adopted July 14, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 3052.

#### Cross References

This section cited in 55 Pa. Code § 6211.80 (relating to elimination of funded depreciation requirement—statement of policy).

### § 1181.260. Interest allowance.

(a) Necessary and proper interest on capital and current indebtedness is an allowable cost. The Department will recognize interest as an allowable cost subject to the following conditions:



(1) Interest on new or additional beds is an allowable cost only if one of the following applies:

(i) The facility was issued either a Section 1122 approval or letter of nonreviewability under 28 Pa. Code Chapter 301 (relating to limitation on Federal participation for capital expenditures) or a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 (relating to Certificate of Need program) for the project by the Department of Health no later than August 31, 1982.

(ii) The facility was issued a Certificate of Need or letter of nonreviewability under 28 Pa. Code Chapter 401 for the construction of a nursing facility, and there was no nursing facility, including county, private or hospital-based, located within the county.

(2) The Department will not recognize interest as an allowable cost if the facility does not substantially implement the project as defined at 28 Pa. Code § 401.5(m)(3) (relating to Certificate of Need) within the effective period of the original Section 1122 approval or the original Certificate of Need.

(3) Interest on replacement beds is an allowable cost only if the facility was issued a Certificate of Need or a letter of nonreviewability by the Department of Health.

(b) Except as specified in subsections (c) and (d), a facility will be reimbursed for allowable interest on capital indebtedness with respect to assets only if the facility is the recorded holder of legal title of the assets involved.

(c) A facility which participated in the MA Program prior to July 1, 1983, which is not part of a related organization and which is not the recorded holder of legal title to the facility, is considered to meet the recorded holder of legal title requirement, and therefore, will be reimbursed for allowable interest on a particular project, if, at the time services were rendered the following existed:

(1) The particular project was wholly funded through an Industrial Development Authority bond issue.

(2) The facility provided the Department with documents relating to ownership and financial obligations relating to the facility.

(3) The facility met the standards of HIM-15, Section 110-B, with respect to virtual purchases.

(d) A facility which participated in the MA Program prior to July 1, 1983, which is part of a related organization and which is not the recorded holder of legal title to the facility, is considered to meet the recorded holder of legal title requirement, and, therefore, will be reimbursed for allowable interest on a particular project, if, at the time services were rendered the following existed:

(1) The particular project was wholly funded through an Industrial Development Authority bond issue.

(2) The facility was a related organization to a corporation, person or company which, if it operated the facility, could qualify for reimbursement for allowable interest costs under subsection (c).

- (3) The documentation necessary to substantiate that the facility meets the requirements of subsection (c) and documentation and statement of the fact that the two entities are related organizations was supplied to the Department.
- (4) The related organization agreed in writing as required by the Department that it and its successors will be responsible for an overpayment which the Department is unable to collect directly from the facility.
- (e) Allowable interest on capital indebtedness may not exceed that amount which a prudent borrower would pay. Interest on capital indebtedness may not be considered prudent if the provider cannot demonstrate that the rate does not exceed the rate available from lenders in this Commonwealth to nursing home borrowers at the time that the funds were borrowed. In no event will the upper limit on interest on capital indebtedness exceed the prime interest rate charged by the lending institution at the time funds are borrowed. For the purpose of this section, the time that the funds were borrowed is the date of the loan commitment.
- (f) To be considered allowable, necessary and proper, the interest expense shall be incurred and paid within 90 days of the close of the cost reporting period on a loan made to satisfy a financial need of the facility and for a purpose reasonably related to patient care.
- (g) Necessary interest on capital indebtedness applying to mortgages, bonds, notes or other securities on the property and plant of the facility will be recognized subject to the limitation of the amount recognized for depreciation purposes. The total value of mortgages, bonds, notes or other securities on which interest on capital indebtedness is allowed may not exceed the depreciation basis of the assets at § 1181.259(m), (n) and (o) (relating to depreciation allowance).
- (h) Investment income shall be used to reduce allowable interest expense on capital and current indebtedness unless the investment income is from one of the following:
- (1) Gifts or grants, of which the corpus and interest are restricted by the donor.
  - (2) Funded depreciation, if the interest earned remains in the fund.
  - (3) The facility's qualified pension fund, if the interest earned remains in the fund.
- (i) Investment income including income on operating capital, shall be used to reduce interest expense on capital indebtedness first, then used to reduce interest on noncapital indebtedness.
- (j) Interest expense shall be allowable if paid on loans from the facility's donor-restricted funds, the funded depreciation account or the facility's qualified pension fund. The upper limit on allowable interest may not exceed the limitations specified in subsection (e).
- (k) Interest on capital indebtedness will be recognized on debt services incurred to finance a maximum construction cost per bed of \$22,000 as defined in § 1181.259(m) and (s). If the construction cost exceeds the \$22,000 per bed

limit, the interest on the portion of the construction cost which exceeds the \$22,000 limit is not allowable.

(l) Moneys borrowed for the purchase or redemption of capital stock will be considered as a loan for investment purposes and the interest paid on these borrowed funds is not an allowable cost.

(m) Income earned from funds included in a trust agreement, including those funds deemed to be funded depreciation, shall be offset against allowable interest on capital indebtedness.

(n) Interest expense on funds borrowed for capital purchases may not be allowed until the funds in the facility's funded depreciation account are fully expended.

#### Authority

The provisions of this § 1181.260 issued under sections 201 and 443.1 of the Public Welfare Code (62 P. S. §§ 201 and 443.1).

#### Source

The provisions of this § 1181.260 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402; amended February 17, 1984, effective July 1, 1983, 14 Pa.B. 546; amended February 28, 1986, effective March 1, 1986, 16 Pa.B. 600; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005. Immediately preceding text appears at serial pages (128286) to (128289).

#### Notes of Decisions

##### *Capital Indebtedness*

Where a nursing facility offered evidence explaining how interest costs were reported, but failed to explain how the loan proceeds were used, the facility failed to show that interest costs were allowable "noncapital" interest. *Siemon's Lakeview Manor Estate v. Department of Public Welfare*, 703 A.2d 551 (Pa. Cmwlth. 1997).

This section indicated that necessary interest on capital indebtedness was an allowable cost for Medicaid reimbursement but allowed the Department of Public Welfare to disallow reimbursement for excess interest when the facility's purchase price exceeded the cost basis adjusted for depreciation taken by the prior owner. *Nottingham Village v. Department of Public Welfare*, 616 A.2d 204 (Pa. Cmwlth. 1992).

The income earned by a debt service reserve fund was properly classified as investment income and, therefore, offset against allowable interest expense on capital indebtedness. *Atlas Development Association, Inc. v. Department of Public Welfare*, 587 A.2d 817 (Pa. Cmwlth. 1991).

The Department did not err in its decision to reduce petitioner's interest expense on capital indebtedness by the income generated by an endowment fund because there was no showing that a direct and express donor restriction existed on the interest income earned on the fund. *Messiah Village v. Department of Public Welfare*, 545 A.2d 956 (Pa. Cmwlth. 1988).

##### *Interest Income*

Commonwealth Court was correct when it found reasonable Department of Public Welfare's interpretation of this section, requiring that interest income first be offset against interest expense on capital indebtedness with remaining balance offset against interest expense on current indebtedness. *Fair Winds Manor v. Department of Public Welfare*, 535 A.2d 42 (Pa. 1987); order confirms 514 A.2d 642 (Pa. Cmwlth. 1986).

The Department of Public Welfare, in carrying out the Medical Assistance Program, was empowered to decide what constituted a reimburseable expense when it reviewed necessary "interest expenses." *Harston Hall Nursing and Convalescent Home, Inc. v. Department of Public Welfare*, 513 A.2d 1097 (Pa. Cmwlth. 1986).

The Department of Public Welfare, through its medical assistance program, will reimburse for interest expenses and properly concluded that imputation of interest was necessary in reviewing an interest free loan made by a nursing care facility to its president. *Harston Hall Nursing and Convalescent Home, Inc. v. Department of Public Welfare*, 513 A.2d 1097 (Pa. Cmwlth. 1986).

#### *Refinanced Loans*

The Department of Public Welfare interprets this provision as not permitting reimbursement for interest expense after refinancing beyond that which the facility received before refinancing. Also, if a variable rate after refinancing drops below the original rate, the lower rate will be applied. Therefore, where a loan was refinanced with a variable rate after the first 3 years, the attorney examiner could conclude that it was impossible for the agency to prove that the ultimate effect of the refinancing would be a savings on total interest cost. *Sycamore Manor Health Ctr. v. Department of Public Welfare*, No. 1625 C. D. 1994, No. 2460 C. D. 1994, 1995 Pa. Cmwlth. LEXIS 349 (July 27, 1995).

#### **Cross References**

This section cited in 55 Pa. Code § 1181.69 (relating to annual adjustment).

### **§ 1181.261. Bad debt expense.**

Bad debts and all associated collection expenses related to the bad debts are not allowable costs.

#### **Source**

The provisions of this § 1181.261 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

### **§ 1181.262. Fund raising expenses.**

(a) Costs pertaining to raising funds for operating expenses and cash flow will be allowed up to 10% of the amount raised.

(b) Fund raising expenses for capital and replacement items up to 5% of the amount raised will be allowed to be capitalized as a part of the cost of the asset under § 1181.259(h) (relating to depreciation allowance).

#### **Source**

The provisions of this § 1181.262 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

### **§ 1181.263. Costs of related parties.**

(a) Related parties that provide services to the general public may furnish services and supplies to a facility under the prudent buyer concept, provided the costs of the services and supplies are consistent with costs of these items furnished by independent third party providers in the same geographic area.

(b) The Department will not recognize as allowable the cost of services provided by related parties if related parties do not provide services to the general public in addition to the facility.

#### **Source**

The provisions of this § 1181.263 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**§ 1181.264. Rental of property and plant.**

(a) Rental expense shall be an allowable net operating cost for the leasing of facilities from related or nonrelated parties. The amount of rental expense allowed during a fiscal year may not exceed the equivalent annual depreciation, computed on the historical cost basis, with depreciation being calculated over the facility's useful life. Historical cost will be established on the basis of either the original construction cost or original purchase price as shown on the lessor's books and records. A maximum of 25% of the equivalent annual depreciation will be allowed if the lessor pays the related costs of ownership. This additional allowance is established upon the documented amount of actual incurred related costs.

(b) Allowable costs for lease purchase agreements and installment sales agreements in which title does not transfer to the lessee will be accounted for in accordance with subsection (a) except as provided otherwise in this subchapter.

(c) For those lease purchase agreements and installment sales agreements in which title transfers to the lessee, Medical Assistance reimbursement for the period of time prior to the date of transfer will be based upon subsection (a). Subsequent to the transfer date, providers shall follow § 1181.259 (relating to depreciation allowance).

**Source**

The provisions of this § 1181.264 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**§ 1181.265. Prudent buyer concept.**

The purchase or rental by a facility of a property, plant, equipment, service, supply and the like, may not exceed the cost that a prudent buyer would pay in the open market to obtain these items.

**Source**

The provisions of this § 1181.265 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

**EXPENSES AND REVENUE ITEMS NOT ALLOWABLE IN  
DETERMINING NET OPERATING COSTS****§ 1181.271. Excluded expenses and revenues.**

In determining the net operating costs of a facility, the Department will not allow expenses or revenues relating to:

- (1) Nonworking officers' salaries.
- (2) Fund raising expenses for capital and replacement items exceeding 5% of the amount raised, and, for operating expenses and cash flow, fund raising expenses exceeding 10% of the amount raised.
- (3) Free care or discounted services.
- (4) Parties and social activities not related to patient care.
- (5) Organizational memberships not necessary to patient care.

- (6) Personal telephone service.
- (7) Personal radio and television service.
- (8) The direct and indirect costs related to nonallowable cost centers including gift, barber, beauty, flower and coffee shops, homes for administrators or pastors, convent areas, and nurses' quarters, except as provided in § 1181.252 (relating to volunteer and donated services of individuals).
- (9) Vending machines.
- (10) Charitable contributions.
- (11) Employe and guest meals.
- (12) Pennsylvania Capital Stock and Franchise Tax.
- (13) Income tax.
- (14) Ambulance costs.
- (15) Promotional advertising, including a yellow page listing that is greater than a minimum insert.
- (16) Late payment penalties.
- (17) Taxes based upon receivables, revenues or net income.
- (18) Officers' and directors' life insurance, including life insurance premiums necessary to obtain mortgages and other loans.
- (19) Bad debts or contractual adjustments.
- (20) Collection expenses associated with bad debts.
- (21) Losses on the sale of fixed and movable assets.
- (22) Remuneration of any kind for any purpose including travel expenses for members of the Board of Directors.
- (23) Personal laundry services.
- (24) Depreciation and interest on capital indebtedness for costs in excess of the per bed limitation.
- (25) Expenses or revenues not necessary to patient care.
- (26) Net operating or capital cost, including legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies, attributable to the negotiation or settlement of the sale or purchase of a capital asset—by acquisition or merger—for which payment has previously been made under Title XVIII of the Social Security Act (42 U.S.C.A. §§ 1395—1395xx) if the sale or purchase was made on or after July 18, 1984.

#### Authority

The provisions of this § 1181.271 issued under sections 201 and 443.1 of the Public Welfare Code (62 P. S. §§ 201 and 443.1).

#### Source

The provisions of this § 1181.271 adopted August 5, 1989, effective July 1, 1989, 13 Pa.B. 2402; amended February 28, 1986, effective March 1, 1986, 16 Pa.B. 600. Immediately preceding text appears at serial pages (99433) to (99434).

1181-92

**Notes of Decisions**

The Department can not use a methodology for determining depreciation expenses that would result in the depreciation costs for nonallowable cost centers to be deducted twice. *Meadows Nursing Center v. Department of Public Welfare*, 561 A.2d 68 (Pa. Cmwlth. 1989).

**§ 1181.272. Costs related to revenue producing items.**

In determining the operating costs of a facility, the Department will not allow costs related to:

- (1) The sale of laundry and linen service.
- (2) The sale of drugs to nonpatients.
- (3) The sale of medical and surgical supplies to nonpatients.
- (4) The sale of medical records and abstracts.
- (5) The rental of quarters to employes and others.
- (6) The rental of space.
- (7) Payments received from specialists.
- (8) Trade, quantity, time and other discounts on purchases.
- (9) Rebates and refunds of expenses.

**Source**

The provisions of this § 1181.272 adopted August 5, 1989, effective July 1, 1989, 13 Pa.B. 2402.

**§ 1181.273. Income that will reduce allowable costs.**

(a) Any form of investment income from the use of unrestricted funds will be used to reduce the allowable interest on capital indebtedness first, then other interest. Any form of investment income from the use of restricted funds found to be used for purposes other than their designated purpose, will be used to reduce the allowable interest on capital indebtedness first, then other interest. If restricted and unrestricted funds are commingled, all income to the common fund will reduce capital indebtedness first, then other interest.

(b) Grants, gifts and income designated by the donor for specific operating expenses will be used to reduce the allowable costs relating to the specific operating expense.

(c) Recovery of insured loss will be used to reduce the allowable costs relating to the insured loss.

**Source**

The provisions of this § 1181.273 adopted August 5, 1989, effective July 1, 1989, 13 Pa.B. 2402.

**Notes of Decisions**

The income earned by debt service reserve fund was properly classified as investment income and, therefore, offset against allowable interest expense on capital indebtedness. *Atlas Development Association, Inc. v. Department of Public Welfare*, 587 A.2d 817 (Pa. Cmwlth. 1991).

In case applying prior regulation found at Section IV(D)(10)(e)(5) of Medical Assistance Program Manual for Allowable Cost Reimbursement of Skilled Nursing and Intermediate Care Facilities, 8 Pa.B. 2837, fact that funds invested by central corporate Cash Management Office were not gener-

ated by any of the five corporation-owned facilities, but rather by other corporate operations, did not preclude offset of investment income against interest on the facilities' capital indebtedness; further, there is nothing in the regulations to authorize deduction of expenses incurred in generating the investment income. *Tressler Lutheran Service Associates v. Department of Public Welfare*, 514 A.2d 661 (Pa. Cmwlth. 1986).

Interest paid by a care provider to a related party is not to be deemed investment income to the facility and therefore, is not subject to set-off against reimbursable interest on capital indebtedness under subsection (a). *Chateau Convalescent Center v. Secretary of the Department of Public Welfare*, 495 A.2d 659 (Pa. Cmwlth. 1985).

### § 1181.274. Direct provider payments not includable in costs.

Costs for prescription drugs, physicians', dental, dentures, podiatry, eyeglasses, appliances, X-rays, laboratory and any other materials or services covered by payments made directly to providers other than facilities under Medical Assistance and Medicare including Part B, Champus, Blue Cross, Blue Shield or other insurers or third parties shall not be allowable in determining net operating costs.

#### Source

The provisions of this § 1181.274 adopted August 5, 1983, effective July 1, 1983, 13 Pa.B. 2402.

#### Cross References

This section cited in 55 Pa. Code § 1181.254a (relating to Medicare Part B adjustments—statement of policy).

### Subchapter C. [Reserved]

Sec.  
1181.301—1181.304. [Reserved].

#### Cross References

This subchapter cited in 55 Pa. Code § 1181.43 (relating to additional participation requirements for intermediate care facilities for the mentally retarded); 55 Pa. Code § 1181.65 (relating to cost-finding); 55 Pa. Code § 1181.66 (relating to setting ceilings on allowable net operating costs); 55 Pa. Code § 1181.67 (relating to setting interim per diem rates); 55 Pa. Code § 1181.68 (relating to upper limits of payment); and 55 Pa. Code § 1181.74 (relating to auditing requirements related to cost reports).

### §§ 1181.301—1181.304. [Reserved].

#### Source

The provisions of these §§ 1181.301—1181.304 adopted May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (138456) and (135977) to (135980).



**§§ 1181.331—1181.338. [Reserved].****Source**

The provisions of these §§ 1181.331—1181.338 adopted May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (135981) to (135984).

**§§ 1181.351—1181.355. [Reserved].****Source**

The provisions of these §§ 1181.351—1181.355 adopted May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (135984) to (135986).

**§§ 1181.361—1181.368. [Reserved].****Source**

The provisions of these §§ 1181.361—1181.368 adopted May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (135987) to (135990).

**§§ 1181.391—1181.394. [Reserved].****Source**

The provisions of these §§ 1181.391—1181.394 adopted May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (135990) to (135992).

**§ 1181.401. [Reserved].****Source**

The provisions of this § 1181.401 adopted May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial page (135992).

**§ 1181.403. [Reserved].****Source**

The provisions of this § 1181.403 adopted May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (135992) to (135994).

**§§ 1181.406—1181.411. [Reserved].****Source**

The provisions of these §§ 1181.406—1181.411 adopted May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (135994) to (135996).

**§ 1181.412. [Reserved].****Source**

The provisions of this § 1181.412 adopted May 3, 1985, effective retroactively as of July 1, 1984, except for § 1181.412(m)(5) which will be effective October 1, 1984 related to the Deficit Reduction Act of 1984, 15 Pa.B. 1629; amended March 10, 1989, effective immediately and applies retroactively to January 1, 1989, 19 Pa.B. 1005; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (135996) to (136000) and (138457).

**§ 1181.412a. [Reserved].****Source**

The provisions of this § 1181.412a adopted July 14, 1989, effective immediately and apply retroactively to January 1, 1989, 19 Pa.B. 3052; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial page (138457).

**§§ 1181.413—1181.420. [Reserved].****Source**

The provisions of these §§ 1181.413—1181.420 adopted May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (138457) to (138459) and (136003) to (136008).

**§ 1181.431. [Reserved].****Source**

The provisions of this § 1181.431 adopted May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (136008) to (136009).

**§§ 1181.441—1181.444. [Reserved].****Source**

The provisions of these §§ 1181.441—1181.444 adopted May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (136009) to (136011).

**§§ 1181.451—1181.454. [Reserved].**

**Source**

The provisions of these §§ 1181.451—1181.454 adopted May 3, 1985, effective retroactively to July 1, 1984, 15 Pa.B. 1629; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (136011) to (136012) and (141233).

**Subchapter D. NURSING HOME REFORM—  
STATEMENT OF POLICY**

**GENERAL**

Sec.

- 1181.501. Purpose.
- 1181.502. Scope.
- 1181.503. Definitions.
- 1181.504. Background.
- 1181.505. Discussion.

**CONDITIONS OF PARTICIPATION**

- 1181.511. Provider conditions of participation.

**NURSE AIDE TRAINING AND  
COMPETENCY EVALUATION PROGRAM**

- 1181.521. Nurse aide training and competency evaluation system.

**NURSE AIDE REGISTRY SYSTEM**

- 1181.531. Nurse aide registry system.

**PREADMISSION SCREENING PROGRAM**

- 1181.541. Preadmission screening program.
- 1181.542. Who is required to be screened.
- 1181.543. Agencies that manage the evaluation process.
- 1181.544. Where and how evaluations will be made.
- 1181.545. Charges for screening.
- 1181.546. How providers and applicants will be notified.
- 1181.547. How long it will take to get a determination.

1181-97

- 1181.548. What happens if active treatment is required.  
1181.549. Confidentiality of information.

### APPEALS OF ADVERSE DETERMINATIONS

- 1181.561. Process to appeal adverse determinations in the preadmission screening program.  
1181.562. Adverse determinations.  
1181.563. Who may appeal.  
1181.564. When an appeal is required to be filed.  
1181.565. What an appeal is required to contain.  
1181.566. Where appeals should be filed.  
1181.567. How and where hearings will be conducted.  
1181.568. How long it will take to get a decision.

#### Source

The provisions of this Subchapter D adopted December 3, 1988, effective January 1, 1989, 18 Pa.B. 5711, unless otherwise noted.

### GENERAL

#### § 1181.501. Purpose.

This subchapter provides information on the implementation of OBRA-87 provisions pertaining to nursing home reform due for implementation by January 1, 1989, including notices of Federal requirements for nursing home providers and statements of policy.

#### § 1181.502. Scope.

This subchapter affects skilled nursing facilities and intermediate care facilities—but not intermediate care facilities for the mentally retarded—participating as providers or seeking to enroll as providers in the Medical Assistance Program; persons—and their families—seeking admission to the facilities; persons employed or seeking employment by the facilities as nurse aides; and persons or entities providing or intending to provide training and competency evaluations for nurse aides employed by the facilities. This subchapter addresses the application of requirements established by Federal law to be effective January 1, 1989.

#### § 1181.503. Definitions.

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

*Department*—The Department of Human Services of the Commonwealth.

*LAMP*—The Long Term Care Assessment and Management Program.

*OBRA-87*—Subtitle C of the Omnibus Budget Reconciliation Act of 1987 (42 U.S.C.A. §§ 1395i-3, 1395x, 1396a note, 1396b, 1396b note, 1396o, 1396r, 1396r note, 1396r-3 note, 1396s).

**§ 1181.504. Background.**

(a) In 1987, Congress enacted major nursing home reform legislation affecting providers participating in the Medicare and Medical Assistance Programs as part of OBRA-87. Congress made some technical amendments to OBRA-87 in Title IV, Subtitle B of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360, 102 Stat. 768) (July 1, 1988). The nursing home reform provisions affecting the Medical Assistance Program are codified at 42 U.S.C.A. § 1396r, as part of Title XIX of the Social Security Act.

(b) The nursing home reform provisions enacted by Congress establish a timetable for action by Federal and state agencies, as well as by providers, from 1987 through 1993, including requirements for continuing approval of State plans. In a number of cases, state agencies are required to take action even where Federal guidelines required by the law are not timely promulgated. The reform provisions grew out of concerns that the preexisting system of certification and review of participating providers did not adequately deal with the quality of patient care and did not sufficiently inform patients and providers of rights and limitations. While most of the new requirements established by OBRA-87 do not become effective until October 1, 1990, some are required to be implemented prior to that date.

(c) Since the enactment of OBRA-87, the Department in cooperation with the Departments of Aging, Education, Health and State and the Governor's Budget Office and Office of Policy, as well as with the responsible Federal agencies and representatives of providers and recipients, has been conducting planning and development activities necessary for the implementation of OBRA-87. These activities are part of a program of change to improve the quality of care provided in nursing facilities, to provide quality services in the most appropriate setting and to increase public awareness of rights and limitations under the Medical Assistance Program. The Department is the single State agency for the administration of the Medical Assistance Program in this Commonwealth and is therefore responsible for issuing information and regulations with respect to the application of OBRA-87 to the Medical Assistance Program.

(d) OBRA-87 requires the Department to implement certain provisions of the law on January 1, 1989. These provisions are:

(1) Specification of nurse aide training and competency evaluation programs and those competency evaluation programs that the Department approves for use by providers and that meet requirements established by the law. See 42 U.S.C.A. § 1396r(e)(1)(A).

(2) Establishment of a registry of individuals who satisfactorily complete a nurse aide training and competency evaluation program or a nurse aide competency evaluation program approved by the Department. See 42 U.S.C.A. § 1396r(e)(2).

(3) Implementation of a preadmission screening program, applicable to persons seeking admission to a provider nursing facility, whether or not that person is applying for or receiving Medical Assistance, to determine, based on criteria established by the Federal government under OBRA-87, whether persons who are mentally ill or are mentally retarded or have related disabilities require nursing facility services and, if they do, whether they also require active treatment for their condition. See 42 U.S.C.A. § 1396r(e)(7)(A).

(4) Implementation of an appeals process for individuals who are adversely affected by the preadmission screening program and wish to seek relief. See 42 U.S.C.A. § 1396r(e)(7)(F).

(5) Enforcement of conditions of participation established by OBRA-87 and effective for current nursing facility providers.

(e) The Department currently has regulations with respect to provider facilities in this chapter. The regulations require participating providers to abide by applicable Federal and State laws and regulations, including Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396s) and to conform with requirements of Title XIX and of the regulations promulgated thereunder which are necessary for the Department to qualify for Federal Financial Participation (FFP) with respect to their participation. See § 1181.41(3) (relating to provider participation requirements). The regulations require provider facilities to comply with the requirements for provider facilities added by OBRA-87 to Title XIX. The Department also has regulations with respect to appeals procedures for persons applying for or receiving Medical Assistance benefits in Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings), as well as for others. See 1 Pa. Code Part II (relating to general rules of administrative practice and procedure).

#### **§ 1181.505. Discussion.**

(a) This subchapter is the first of a series involving the implementation of OBRA-87. Since the implementation of OBRA-87 is to be phased over several years, the Department will be issuing statements of policy and other documents in advance of the implementation of State and Federal requirements to provide information on Department policy with respect to the requirement, to announce Department regulations and to describe procedures and resources for compliance. Since the implementation of OBRA-87 involves coordination with policies established by the United States Department of Health and Human Services (HHS) under the law, publications may also be required to update or revise standards in light of announcement of HHS criteria and regulations.

(b) This subchapter deals with five areas:

(1) Conditions of participation affecting providers of nursing home services that are being added by OBRA-87.

(2) The Nurse Aide Registry System being established by the Department of Health in cooperation with the Department.

(3) The Nurse Aide Training and Competency Evaluation Program being established by the Department of Education in cooperation with the Department.

(4) The Preadmission Screening Program for persons seeking admission to nursing facilities.

(5) The appeals process for persons adversely affected by the Preadmission Screening Program.

(c) Each of the areas in subsection (b) involves implementation of a phase of OBRA-87. Under section 501 of The Administrative Code of 1929 (71 P. S. § 181), the Department has been working with other departments and agencies of the Commonwealth to utilize their expertise in the development and implementation of OBRA-87 provisions. Cooperation among different departments will continue to have a role in this implementation process. The Departments of Aging, Education and Health will be responsible for the implementation and management of several aspects of the reforms required by OBRA-87. The Department remains the single State agency for the overall administration of the Medical Assistance Program and is the agency responsible for the resolution and adjudication of disputes concerning the Program.

(d) The January 1, 1989 nursing home reform requirements of OBRA-87 do not involve changes to existing Department regulations. They do involve new activities about which the Department wishes to inform the general public and those directly involved. The Department has established procedures for providing information to the public. See Chapter 9 (relating to regulatory document information system). The Department issues statements of policy to provide guidelines in response to Federal statutes such as OBRA-87 under § 9.12(b)(2) (relating to statements of policy). The Department also issues notices under § 9.13 (relating to notices). The Department is publishing a series of statements of policy and notices to inform the general public and those affected by OBRA-87 of the guidelines used by the Department under the law to implement those activities required by January 1, 1989. This subchapter does not preclude the Department from changing its policies and procedures with respect to OBRA-87, including changes required by modifications of Federal requirements or changes implemented by regulation.

(e) This subchapter includes a timetable of key MA related implementation dates under OBRA-87, as amended. See Appendix G. This timetable indicates activities with which the Department, as well as providers and the United States Department of Health and Human Services, will be involved over the next few years. The Department will be issuing additional statements of policy, notices and

regulations with respect to later phases in the implementation of the nursing home reform provisions of OBRA-87.

(f) This subchapter also includes forms related to the preadmission screening process. These forms are subject to change.

### CONDITIONS OF PARTICIPATION

#### § 1181.511. Provider conditions of participation.

(a) OBRA-87, as amended, establishes a number of conditions of participation (42 U.S.C.A. §§ 1396r(a), (b), (c) and (d)). Most of these conditions of participation are not effective until October 1, 1990; however, some are effective prior to that date (OBRA-87, section 4214(a), as amended by sections 411(i)(3)(c) of the Medicare Catastrophic Coverage Act (42 U.S.C.A. § 1396r note)).

(b) OBRA-87, as amended, requires providers to meet the conditions of participation established in sections 1861(j) and 1905(c) of the Social Security Act (42 U.S.C.A. §§ 1395x(j) and 1396d(c)), as applicable, in addition to those sections of OBRA-87 itself expressly made effective prior to October 1, 1990 until all of the OBRA-87 conditions of participation become effective (OBRA-87, section 4214(a) and (c)) (42 U.S.C.A. § 1396r note). Providers are required to comply with OBRA-87 requirements as they become effective. See § 1181.41(3) (relating to provider participation requirements).

(c) The changes in conditions of participation which OBRA-87, as amended, makes effective prior to October 1, 1990, are:

(1) Effective July 1, 1988, a provider shall permit immediate access to a resident—whether or not the resident is applying for or receiving MA or Medicare benefits—by the resident's individual physician, by a representative of the Secretary of the United States Department of Health and Human Services, by a representative of the Commonwealth, by an ombudsman authorized by the Department of Aging—including those employed by a local Area Agency on Aging—and, with respect to residents with developmental disabilities or who are mentally ill, by a representative of Pennsylvania Protection and Advocacy, 116 Pine Street, Harrisburg, Pennsylvania 17101, the agency designated under subchapter III of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C.A. §§ 6041—6043) and the Protection and Advisory for Mentally Ill Individuals Act of 1986 (42 U.S.C.A. §§ 10801—10851). See 42 U.S.C.A. § 1396r(c)(3)(A).

(2) Effective January 1, 1989, a provider facility may not admit a new resident—whether or not the person seeking admission is applying for or receiving, or otherwise eligible for MA or Medicare benefits—who is mentally ill or is mentally retarded or has another related condition, as defined in OBRA-87, unless the Department has determined and notified the provider that the individual requires nursing facility services and, if the individual does,



whether the individual requires active treatment for mental illness, mental retardation or other related conditions, as defined by regulations and guidelines issued by the United States Department of Health and Human Services. See 42 U.S.C.A. § 1396r(b)(3)(F).

(d) Information on the procedures to secure the necessary State agency determinations required to comply with the preadmission screening conditions of participation is presented in § 1181.541 (relating to preadmission screening program). This requirement applies to a person seeking admission and is not restricted to a person applying for or already eligible for MA or Medicare.

(e) While other statutory conditions of participation established by OBRA-87 may not apply until October 1, 1990, existing conditions of participation, under Federal and State law and regulations, continue to apply. Providers and their employes should also note that under 42 U.S.C.A. § 1396r(b)(5), a provider is required to provide for approved nurse aide competency evaluation programs for staff members employed as of July 1, 1989 to prepare them for successful completion of an approved competency evaluation program by January 1, 1990, and is limited in its use of unregistered staff members as of January 1, 1990.

(f) The Department will be publishing additional notices and statements of policy to inform providers and others about the subsequent phases in the implementation of OBRA-87. The Department will also be promulgating regulations, as necessary.

#### **NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM**

#### **§ 1181.521. Nurse aide training and competency evaluation system.**

(a) Section 1396r(e)(1)(A) of 42 U.S.C.A. provides: “The State must by not later than January 1, 1989, specify those training and competency evaluation programs and those competency evaluation programs, that the State approves for purposes of (42 U.S.C.A. § 1396r(b)(5)) and that meet the requirements established under (42 U.S.C.A. §§ 1396r(f)(2)(A)(i) or (ii)).”

(b) For purposes of 42 U.S.C.A. § 1396r(e)(1)(A):

(1) “The Secretary (of HHS) shall establish, by not later than September 1, 1988, requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, basic restorative services, and residents’ rights), content of the curriculum; minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training); qualifications of instructors; and procedures for determination of competency.”

(2) “Requirements for the approval of nurse aide competency evaluation programs, including requirements relating to the areas to be covered in such a

program, including at least basic nursing skills, personal care skills, cognitive, behavioral and social care, basic restorative services, and residents' rights, and procedures for determination of competency."

(c) The Secretary of HHS has not yet established requirements for these programs. The Department of Education in cooperation with the Department has not approved existing programs as meeting the statutory requirements.

(d) The Department of Education in cooperation with the Department is developing criteria for the approval of nurse aide training and competency evaluation programs. The Department of Education will manage the review and approval of nurse aide training and competency evaluation programs and of nurse aide competency evaluation programs required by OBRA-87. The Department of Education will be the source for information about those programs and the agency responsible for determining nurse aide competency.

(e) Beginning January 1, 1989, the Department of Education will issue applications for approval of nurse aide training programs. The application will include information on the criteria that will be used to approve programs, which at a minimum, will conform with the Federal requirements noted in this section. Existing nurse aide training and competency evaluation programs, including those previously approved under the Department of Education's voluntary approval program, will have to obtain reapproval for purposes of training nurse aides under the OBRA-87 requirements. The Department of Education will be mailing copies of the application to existing nurse aide training programs which the Department of Education is aware are currently operating in this Commonwealth. Applications and information on nurse aide training and competency evaluation programs may be obtained from:

Vocational Licensure and Developmental Services  
Section  
Bureau of Vocational and Adult Education  
Pennsylvania Department of Education  
333 Market Street  
Harrisburg, Pennsylvania 17126-0333  
(717) 787-8867

(f) The Department, in cooperation with the Department of Education, will publish Pennsylvania-specific approval criteria for both nurse aide training and competency evaluation programs and nurse aide competency evaluation programs in the *Pennsylvania Bulletin*.

(g) The Department and the Department of Education are currently planning to contract for the administration of nurse aide competency evaluation tests. The Department of Education will arrange for the administration of the tests. These tests will be scheduled Statewide. Notice of the availability of the test and the schedule and locations for its administration will be published in the *Pennsylvania Bulletin* and mailed to participating nursing facility providers.

**Cross References**

This section cited in 55 Pa. Code § 1181.531 (relating to nurse aide registry system).

**NURSE AIDE REGISTRY SYSTEM****§ 1181.531. Nurse aide registry system.**

(a) Section 1396r(e)(2)(A) of 42 U.S.C.A. provides: “By no later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aid competency evaluation program, approved . . . by the State.”

(b) The registry required by OBRA-87 is established and will be maintained by the Department of Health in cooperation with the Department and the Department of Education. Within the Department of Health, the administration of the registry is the responsibility of:

Nurse Aide Registry Section  
Division of Long Term Care  
Department of Health  
Room 526, Health and Welfare Building  
Harrisburg, Pennsylvania 17108  
(717) 787-1816

(c) The registry is not required by OBRA-87 to include information relating to findings of nurse aide misconduct until October 1, 1990. See 42 U.S.C.A. §§ 1396r(e)(2)(B) and 1396r(g)(1)(C). The Department of Health is currently considering the promulgation of regulations to make the OBRA-87 nurse aide training and competency evaluation and registry requirements—including investigation and findings with respect to reported staff misconduct—applicable to licensed nursing facilities within this Commonwealth. If the Department of Health does not issue these regulations before July 1, 1989, the Department will be issuing regulations for provider facilities with respect to the inclusion of findings of misconduct on the registry.

(d) Currently the registry contains no names of individuals who have satisfactorily completed approved training or competency evaluation programs, or both. The Secretary of Health and Human Services (HHS) has not yet established requirements for nurse aide training and competency evaluation programs. The Department, in cooperation with the Department of Education, has not approved existing programs under the statutory requirements of 42 U.S.C.A. § 1396r(f)(2)(A). If HHS does not establish its requirements before January 1, 1989, the Department of Education will review programs for approval as of that date using the statutory criteria.

(e) Once approved programs have been identified, names of certified nurse aides will be entered onto the registry upon notification from the Department of Education that the individual has satisfactorily completed an approved nurse aide

training and competency evaluation program or a nurse aide competency evaluation program. Section 1181.521 (relating to nurse aide training and competency evaluation system) provides additional information on the process for obtaining approval of the programs.

(f) A nursing facility will be required to make inquiry with the registry about individuals they plan to use as nurse aides. See 42 U.S.C.A. § 1396r(b)(5)(C). This requirement does not become effective until January 1, 1990. Beginning on July 1, 1989, a nursing facility will be required to provide individuals used as nurse aides by the facility with approved competency evaluation programs and preparation as those individuals require to complete the programs by January 1, 1990. Providers will be limited in their use of unregistered staff as of January 1, 1990. See 42 U.S.C.A. § 1396r(b)(5)(A).

(g) An individual who is currently on a nurse aide registry in another state and who seeks listing on Pennsylvania's registry should contact the registry.

#### **PREADMISSION SCREENING PROGRAM**

##### **§ 1181.541. Preadmission screening program.**

(a) Section 1396r(e)(7)(A) of 42 U.S.C.A. provides: "Effective January 1, 1989, the State must have in effect a preadmission screening program, for making determinations using criteria developed under 42 U.S.C.A. § 1396r(f)(8) and described in 42 U.S.C.A. § 1396r(b)(3)(F) for mentally ill and mentally retarded individuals (as defined in subparagraph G) who are admitted to nursing facilities on or after January 1, 1989. The failure of the Secretary (of HHS) to develop minimum criteria . . . shall not relieve any State of its responsibility to have a preadmission screening program under this subparagraph."

(b) Section 1396r(b)(3)(F) of 42 U.S.C.A. provides: "A nursing facility must not admit, on or after January 1, 1989, any new resident who—"

(1) "is mentally ill (as defined in (42 U.S.C.A. § 1396r(e)(7)(G)(i))) unless the State mental health authority has determined (based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires active treatment for mental illness, or"

(2) "is mentally retarded (as defined in (42 U.S.C.A. § 1396r(e)(7)(G)(ii))) unless the State mental retardation or developmental disabilities authority has determined that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires active treatment for mental retardation."

(c) Health and Human Services (HHS) has issued draft criteria for states to use in making preadmission screening determinations. The preadmission screening program is being implemented by the Department based on its analysis of the HHS draft criteria and the requirements which Congress has established in OBRA-87 itself. The Department is the state authority with respect to the administration of mental health, mental retardation and developmental disability programs, as well as for the MA Program.

#### Cross References

This section cited in 55 Pa. Code § 1181.511 (relating to provider conditions of participation).

### § 1181.542. Who is required to be screened.

(a) OBRA-87 requires only that individuals who are mentally ill or mentally retarded, including persons with other related conditions, as defined by the law, be screened prior to admission. This requirement applies to all those individuals, whether or not the individual is eligible or applying for MA or Medicare benefits. However, this requirement does not displace the existing preadmission assessment requirements for persons eligible or applying for MA—for example, LAMP. This subchapter deals with the OBRA-87 requirement, which is in addition to existing preadmission screening requirements.

(b) OBRA-87 applies only to persons seeking admission to nursing facilities, but it does not apply to persons seeking admission to intermediate care facilities for the mentally retarded (ICF/MR). It also does not apply to persons seeking admission to inpatient psychiatric facilities, institutions for mental diseases, community placement or nursing facilities which are not providers participating in the MA Program or the Medicare Program.

(1) *Who is mentally ill as defined by OBRA-87.*

(i) OBRA-87 defines an individual who is mentally ill and therefore subject to screening as an individual who has a primary or secondary diagnosis of mental illness—as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition—but does not have a primary diagnosis of dementia, including Alzheimer's disease or a related disorder. Thus, an individual who does have a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, is exempt from the OBRA-87 preadmission screening requirements.

(ii) The Health and Human Services (HHS) draft criteria seek to limit the OBRA-87 definition to only those individuals with the following types of major mental disorders: schizophrenic; paranoid; major affective; schizoaffective; and atypical psychotic. The Department will apply this limiting definition of mental illness. Thus, an individual has a primary or secondary diagnosis of mental illness for OBRA-87 screening purposes only if the condition falls within the definitions of schizophrenic, paranoid, major affective, schizoaffective or atypical psychotic disorders.

(iii) Since OBRA-87 focuses on the actual condition of the individual seeking admission, the HHS draft criteria indicate that certain information in addition to the diagnoses be reviewed and that the information can be the basis for screening even if the individual does not have a primary or secondary diagnosis of mental illness. The Department will apply these additional criteria. Thus, except as provided in paragraph (3), an individual shall be screened, for OBRA-87 purposes, even if they do not have a primary or secondary diagnosis of mental illness, if one of the following applies:

(A) The individual has a history of mental illness—as limited by definitions in this subparagraph—within the last 2 years.

(B) The individual has been prescribed a major tranquilizer on a regular basis in the absence of a justifiable neurological disorder.

(C) There is presenting evidence of mental illness—as limited by definitions in this subparagraph—including possible disturbances in orientation, affect or mood.

(iv) If the individual has a primary diagnosis of dementia—as defined in this subparagraph—even if the individual meets one or more of the additional criteria, the individual is exempt from the preadmission screening process.

(2) *Who is mentally retarded under OBRA-87.*

(i) OBRA-87 uses the term “mentally retarded” to involve both individuals who are mentally retarded and those who may not be mentally retarded, but have other related conditions under 42 U.S.C.A. § 1396d(d).

(A) *Individuals who are mentally retarded.* Mental retardation is defined as having a level of retardation—mild, moderate, severe or profound—as described in the American Association on Mental Deficiency’s *Manual on Classification in Mental Retardation* (1983).

(B) *Individuals with other related conditions.* Other related conditions are defined by 42 CFR 435.1009 (relating to definitions relating to institutional status), and include cerebral palsy and epilepsy, as well as other conditions—such as autism—other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for the mentally retarded. Related conditions are conditions which are:

(I) Manifested before age 22.

(II) Likely to continue indefinitely.

(III) Resulting in substantial functional limitations in three or more of the following areas of major life activity:

(-a-) Self-care.

(-b-) Understanding and use of language.

(-c-) Learning.

- (-d-) Mobility.
  - (-e-) Self-direction.
  - (-f-) Capacity for independent living.
- (ii) Thus, for OBRA-87 purposes, a person is subject to preadmission screening if that individual:
- (A) Has a diagnosis that fits the definitions of “Mental retardation” or “other related conditions” in clauses (A) and (B).
  - (B) Has a history of a condition that fits the definitions.
  - (C) Presents evidence—cognitive or behavior functions—that may indicate those conditions.
  - (D) Is referred by an agency that serves persons with those conditions and has been found eligible for services by the agency.
- (3) *Exceptions to the rule.*
- (i) Exceptions to the rule are as follows:
    - (A) *Convalescent care.* An individual who may otherwise be mentally ill or mentally retarded or who has another related condition under OBRA-87, but is not a danger to himself or others, may be admitted to a nursing facility without going through the OBRA-87 preadmission screening process for up to 120 days as part of a medically prescribed period of recovery after release from an acute care hospital. If a person admitted under this exception requires more than 120 days of recovery, a determination permitting the continued stay shall be sought promptly.
    - (B) *Terminal illness.* An individual who may otherwise be mentally ill or mentally retarded or who has another related condition under OBRA-87, but is not a danger to himself or others, may be admitted to a nursing facility without going through the OBRA-87 preadmission screening process, if certified by a physician to be terminally ill—as defined in 42 U.S.C.A. § 1395x(dd)(3)(A)—and requiring continuous nursing care or medical supervision and treatment, or both, due to the individual’s physical condition. “Terminally ill” is defined in 42 U.S.C.A. § 1395x(dd)(3)(A) as an individual who has a medical prognosis of a life expectancy of 6 months or less.
    - (C) *Severity of illness.* An individual who may otherwise be mentally ill or mentally retarded or who has another related condition under OBRA-87 may be admitted to a nursing facility without going through the OBRA-87 preadmission screening process if certified by a physician to be comatose, ventilator dependent, functioning at the brain stem level or having a diagnosis of either Chronic Obstructive Pulmonary Disease, Severe Parkinson’s Disease, Huntington’s Disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure or another diagnosis later determined by the Health Care Financing Administration (HCFA) to be sufficient.
    - (D) *Not mentally ill or mentally retarded.* An individual who is not mentally ill, mentally retarded, who doesn’t have another related condition,



as defined by OBRA-87, and who is not otherwise subject to preadmission screening as described in this subparagraph may be admitted to a nursing facility without going through the OBRA-87 preadmission screening process.

(ii) Thus, a person who qualifies for an exception in this paragraph may be admitted to a nursing facility without further determinations by the Department within the OBRA-87 preadmission screening process.

(4) *Necessary documentation.* A nursing facility provider—except an ICF/MR—is required to comply with the preadmission screening process as a condition of continuing participation in the Medical Assistance Program. The process involves certain documentation requirements with respect to individuals who are subject to preadmission screening and individuals who are not.

(i) *Form PA-PASARR-ID.*

(A) The Department will require the use of Form PA-PASARR-ID by a nursing facility subject to the OBRA-87 requirement. Form PA-PASARR-ID is designed to evaluate whether an applicant for admission to the nursing facility is subject to the determination requirements of OBRA-87 and, if not, to document the bases for excepting that individual from the process.

(B) The record of each resident admitted to a nursing facility on or after January 1, 1989 shall include the completed Form PA-PASARR-ID for that resident. Failure to maintain documentation of the completion of the form in a resident's record shall be a basis for the disallowance of payment under the Medical Assistance Program with respect to that resident under §§ 1101.51(e), 1101.61, 1101.71(a) and 1101.83(a), and may be a basis for the termination of the provider agreement or for the imposition of another sanction permitted by law.

(C) Where Form PA-PASARR-ID indicates that an applicant for admission is subject to further preadmission screening by the Department, the provider shall refer the applicant to the appropriate agency, for evaluation, and shall provide the agency and the applicant with a copy of the completed Form PA-PASARR-ID. The applicant—including a legal or personal representative acting on behalf of the applicant—shall have the right to appeal a referral. The appeals process is described in § 1181.561 (relating to process to appeal adverse determinations in the preadmission screening program). An attachment to form PA-PASARR-ID provides the applicant with notice of the appeals process.

(D) Completion of Form PA-PASARR-ID does not replace Department requirements with respect to Form MA-51. When Form MA-51 is required by current Department procedures, that form shall be filed as well as Form PA-PASARR-ID.

(ii) *Form PA-PASARR-YN.*



(A) The determinations of whether individuals requiring preadmission screening require nursing facility services and, if they do, whether they require active treatment shall be issued to the involved applicants for admission to the facility on Form PA-PASARR-YN. No individual who has been referred by a provider for evaluation may be admitted to the nursing facility without presenting Form PA-PASARR-YN authorizing admission for copying and verification by the provider.

(B) Providers are required to maintain their copy of Form PA-PASARR-YN as part of the record of a person admitted to the facility on or after January 1, 1989. Certification to the provider on Form PA-PASARR-YN, verified by the agency designated by the Department of Aging to manage the evaluation process, is the only acceptable evidence as to whether a person who has been referred by the provider for further determination under the preadmission screening process has been determined to be eligible for admission. The Department will not make payment for services provided to a resident referred for preadmission screening process determinations unless the Department has certified on Form PA-PASARR-YN that the resident requires the level of services provided in a nursing facility.

(C) A copy of the completed Form PA-PASARR-YN is provided to each applicant who has been referred for further determination. The applicant—including a legal or personal representative acting on behalf of the applicant—shall have the right to appeal from a determination. The form provides the applicant with notice of the appeals process.

**§ 1181.543. Agencies that manage the evaluation process.**

(a) *Preadmission screening process.* For an individual subject to the preadmission screening process, relevant determinations shall be made by the State mental health, mental retardation and developmental disability authority. In this Commonwealth, the Department is that authority. The authority is required to make a determination of whether the referred individual requires nursing facility services and, if the individual does, whether the individual requires active treatment. The Department will notify the designated evaluation agency and each individual involved of its determination using Form PA-PASARR-YN.

(b) *Determination by Department.* The Department is required to base its determination on an independent physical and mental evaluation performed by a person or entity other than the Department. The Department will therefore not perform the evaluations itself, but will utilize evaluations performed by the Department of Aging through its LAMP sites and other authorized agents. The Department of Aging will utilize Form PA-PASARR-EV as the protocol for the evaluations.

(c) *LAMP site counties.*

(1) *General.* The Department, in cooperation with the Department of Aging, is already conducting preadmission screening with respect to persons eligible for MA in counties which have LAMP sites. LAMP assesses the need for nursing facility services in light of the condition of the individual involved in the assessment and of the alternatives available for the care of that individual outside of a nursing facility in the individual's community. LAMP will continue to be available for the assessment of individuals eligible for MA. In designated counties, LAMP will be the agency to which providers will refer applicants for admission to the nursing facility who have been determined to require further determination after the administration of Form PA-PASARR-ID.

(2) *Definition.* The term "LAMP site" refers to a site doing both LAMP and OBRA assessments and providing alternative community services.

(3) *Counties.* The counties where OBRA evaluations will be done by LAMP sites and the addresses and telephone numbers of the sites are:

<i>County</i>	<i>AAA Information</i>
Allegheny	Allegheny County Department of Aging 416 County Office Building Pittsburgh, Pennsylvania 15219 (412) 355-4305
Erie	Greater Erie Community Action Committee Erie County Area Agency on Aging 18 West Ninth Street Erie, Pennsylvania 16501 (814) 459-4581
Luzerne and Wyoming	Luzerne/Wyoming Counties Bureau for Aging 111 North Pennsylvania Boulevard Wilkes-Barre, Pennsylvania 18701 (717) 822-1158
Philadelphia	Philadelphia Corporation for Aging 111 North Broad Street Philadelphia, Pennsylvania 19107 (215) 496-0520
Schuylkill	Schuylkill County Area Agency on Aging 13-15 North Centre Street Pottsville, Pennsylvania 17901 (717) 622-3103

<i>County</i>	<i>AAA Information</i>
Westmoreland	Westmoreland County Office on Aging 2482 South Grande Boulevard Greensburg, Pennsylvania 15601 (412) 836-1111
York	York County Area Agency on Aging 141 West Market Street York, Pennsylvania 17401 (717) 771-9610

(d) *Preadmission site.*

(1) *Definition.* The term “preadmission site” refers to an AAA which is doing preadmission assessments for MA applicants and persons identified through the OBRA screening process, which are “LAMP Lite,” “Diet LAMP” or “modified LAMP” sites.

(2) *Counties.* The counties where the assessment portion of the LAMP program, as well as OBRA evaluations, will be done by preadmission sites and the addresses and telephone numbers of the sites are:

<i>County</i>	<i>AAA Information</i>
Berks	Berks County Area Agency on Aging 15 South Eighth Street Reading, Pennsylvania 19602-1105 (215) 378-8808
Blair	Blair Senior Services, Inc. 1404 Eleventh Avenue Altoona, Pennsylvania 16601 (814) 946-1235
Bradford, Sullivan, Susquehanna and Tioga	Area Agency on Aging for Tioga/ Bradford/Susquehanna/Sullivan Counties 701 Main Street Towanda, Pennsylvania 18848 (717) 265-6121 or 1 (800) 982-4346
Cambria	Cambria County AAA Post Office Box 88 Ebensburg, Pennsylvania 15931 (814) 472-5580

<i>County</i>	<i>AAA Information</i>
Clearfield	Clearfield County Area Agency on Aging 211 Ogden Avenue Post Office Box 550 Clearfield, Pennsylvania 16830 (814) 765-2696
Clinton and Lycoming	Lycoming/Clinton Bi-County Office of Aging Post Office Box 770 352 Water Street Lock Haven, Pennsylvania 17745 (717) 748-8665
Cumberland	Cumberland County Office on Aging Room 111-R, East Wing Cumberland County Courthouse Carlisle, Pennsylvania 17013 (717) 240-6110
Fayette, Greene and Washington	Southwestern PA AAA, Inc. Eastgate 8 Monessen, Pennsylvania 15062 (412) 684-9000
Indiana	Aging Services, Inc. of Indiana County 201 Airport Professional Center Indiana, Pennsylvania 15701 (412) 349-4500
Jefferson	Jefferson County Area Agency on Aging Jefferson County Services Center R. D. 5 Brookville, Pennsylvania 15825 (814) 849-3096
Juniata and Mifflin	Mifflin/Juniata AAA, Inc. Post Office Box 750 Lewistown, Pennsylvania 17044 (717) 242-0315

<i>County</i>	<i>AAA Information</i>
Lackawanna	Lackawanna County Area Agency on Aging Lackawanna County Office Building 200 Adams Avenue Scranton, Pennsylvania 18503 (717) 963-6707
Lawrence	Lawrence County AAA— Catholic Charities of the Diocese of Pittsburgh, Inc. 20 South Mercer Street New Castle, Pennsylvania 16101 (412) 658-5661 or (412) 658-0322
Mercer	Mercer County Area Agency on Aging, Inc. Human Services Complex 120 South Diamond Street Mercer, Pennsylvania 16137 (412) 662-3800 (Extension 538)
Monroe	Monroe County Area Agency on Aging 62 Analomink Street Post Office Box 384 East Stroudsburg, Pennsylvania 18301 (717) 424-5290
Montgomery	Montgomery County Office on Aging and Adult Services Montgomery County Court House Norristown, Pennsylvania 19404 (215) 278-3601
Northampton	Northampton County Area Agency on Aging Gracedale—Southwest Ground Gracedale Avenue Nazareth, Pennsylvania 18064 (215) 746-1990
Northumberland	Northumberland County AAA R. D. 1, Box 943 Shamokin Pennsylvania 17872 (717) 644-4545

<i>County</i>	<i>AAA Information</i>
Somerset	AAA of Somerset County 132 East Catherine Street Post Office Box 960 Somerset, Pennsylvania 15501 (814) 443-2681

(e) *OBRA only site.*

(1) *Definition.* The term “OBRA only site” refers to an AAA doing only the OBRA preadmission assessments.

(2) *Counties.* The counties currently providing evaluations at OBRA only sites, and the addresses and telephone numbers of the sites are:

<i>County</i>	<i>AAA Information</i>
Adams	Adams County Office for Aging, Inc. 100 North Stratton Street Gettysburg, Pennsylvania 17325 (717) 334-9296
Armstrong	Armstrong County AAA 125 Queen Street Kittanning, Pennsylvania 16201 (412) 548-3290
Beaver	Beaver County Office on Aging 599 Market Street, W. B. Beaver, Pennsylvania 15009 (412) 728-5700 (Extension 406)
Bedford, Fulton and Huntingdon	Huntingdon/Bedford/Fulton AAA 240 Wood Street Post Office Box 46 Bedford, Pennsylvania 15522 (814) 623-8149
Bucks	Bucks County Area Agency on Aging 30 East Oakland Avenue Doylestown, Pennsylvania 18901 (215) 348-0510
Butler	Butler County AAA 715 Morton Avenue Building 3A Butler, Pennsylvania 16001 (412) 282-3008

<i>County</i>	<i>AAA Information</i>
Cameron, Clarion, Elk and McKean	Jefferson County Area Agency on Aging Jefferson County Services Center R. D. 5 Brookville, Pennsylvania 15825 (814) 849-3096
Carbon	Carbon County Area Agency on Aging Post Office Box 251 Jim Thorpe, Pennsylvania 18229 (717) 325-2726
Centre	Clearfield County Area Agency on Aging 211 Ogden Avenue Post Office Box 550 Clearfield, Pennsylvania 16830 (814) 765-2696
Chester	Chester County Office of Aging 10 North Church Street West Chester, Pennsylvania 19380 (215) 431-6350
Columbia and Montour	Luzerne/Wyoming Counties Bureau of Aging 111 North Pennsylvania Boulevard Wilkes-Barre, Pennsylvania 18701 (717) 822-1158
Crawford	Active Aging, Inc. 1034 Park Avenue Meadville, Pennsylvania 16335 (814) 336-1792
Dauphin	Dauphin County AAA 25 South Front Street Harrisburg, Pennsylvania 17107-2025 (717) 255-2790
Delaware	County of Delaware Services of the Aging Government Center Media, Pennsylvania 19063 (215) 891-4455

<i>County</i>	<i>AAA Information</i>
Forest and Warren	Greater Erie Community Action Committee Erie County Area Agency on Aging 18 West Ninth Street Erie, Pennsylvania 16501 (814) 459-4581
Franklin	Franklin County Office for the Aging Franklin County Farm Lane Chambersburg, Pennsylvania 17201 (717) 263-2153
Lancaster	Lancaster County Office on Aging 50 North Duke Street Lancaster, Pennsylvania 17603-1881 (717) 299-7979
Lebanon	Lebanon County AAA 710 Maple Street Room 209—Senior Centers Lebanon, Pennsylvania 17042 (717) 273-9262 or (717) 274-1439
Lehigh	Lehigh County Area Agency on Aging Court House Annex 523 Hamilton Street Allentown, Pennsylvania 18101 (215) 820-3248
Perry	Cumberland County Office on Aging Room 111-R, East Wing Cumberland County Courthouse Carlisle, Pennsylvania 17013 (717) 240-6110
Pike and Wayne	Wayne/Pike Area Agency on Aging Pike County Program Office 106 Broad Street Milford, Pennsylvania 18337 (717) 296-7813
Potter	Area Agency on Aging for Tioga/ Bradford/ Susquehanna/Sullivan Counties 701 Main Street Towanda, Pennsylvania 18848 (717) 265-6121 or 1 (800) 982-4346



<i>County</i>	<i>AAA Information</i>
Snyder and Union	Mifflin/Juniata AAA, Inc. Post Office Box 750 Lewistown, Pennsylvania 17044 (717) 242-0315
Venango	Venango County Area Agency on Aging Post Office Box 1130 Franklin, Pennsylvania 16323 (814) 437-6871

#### Source

The provisions of this § 1181.543 adopted December 3, 1988, effective January 1, 1989, 18 Pa.B. 5711; amended August 4, 1989, effective upon publication and applies retroactively to January 1, 1989, 19 Pa.B. 3314. Immediately preceding text appears at serial pages (136029) to (136034).

#### § 1181.544. Where and how evaluations will be made.

The designated agency managing the evaluations in the county in which the applicant is located—either as the result of residence or temporary accommodation in a residential or medical facility—shall conduct the evaluation. The agency shall conduct the evaluations using Form PA-PASARR-EV and following the protocol noted in Appendix M. Appendix M details kinds of information and medical records necessary for the preadmission screening process. Evaluations will be conducted at specified locations in the county, but, if necessary because of the condition of the applicant, at the applicant's place of residence or place of care. The agencies will coordinate the place and time of each evaluation with the applicant.

#### § 1181.545. Charges for screening.

A person eligible for Medical Assistance will not be charged fees or copayments as part of the preadmission screening process, either by the nursing facility or by another agency or department. A person who is not eligible for Program benefits may be charged, but at no more than cost.

#### § 1181.546. How providers and applicants will be notified.

When the evaluation process has been completed, Form PA-PASARR-EV, along with documentation and data required by Appendix M, will be forwarded by the evaluation agency to the Department. The Department will determine whether the applicant requires the level of services provided in a nursing facility. The Department will notify the applicant and the evaluation agency using Form PA-PASARR-YN. The applicant is responsible for providing the nursing facility with Form PA-PASARR-YN as part of the admissions process. The nursing facil-

ity shall verify the Form PA-PASARR-YN with the Department. A provider may obtain verification of Form PA-PASARR-EV from the evaluation agency indicated on the Form, but shall include the control number indicated on the PA-PASARR-EV in a request. Verification is provided using Form PA-PASARR-OK.

**§ 1181.547. How long it will take to get a determination.**

The Department will issue a determination within 5 working days of its receipt of Form PA-PASARR-EV from the evaluation agency. Subject to the cooperation of the applicant, the evaluation agency will complete the evaluation and file Form PA-PASARR-EV with the Department as soon as possible after its receipt of Form PA-PASARR-ID from the nursing facility. The nursing facility should be able to complete and file Form PA-PASARR-ID in 3 working days.

**§ 1181.548. What happens if active treatment is required.**

OBRA-87 permits the Secretary of Health and Human Services to define the meaning of “active treatment,” but provides that its meaning may not include those services which a nursing facility is required to provide or arrange for its residents under OBRA-87 (42 U.S.C.A. § 1396r(e)(7)(G)(iii)). Health and Human Services has issued draft definitions which significantly limit determinations that an individual requires active treatment but has not yet established official criteria for the preadmission screening programs. The Department has adopted the Health and Human Services draft definitions under its authority under OBRA-87. See 42 U.S.C.A. § 1396r(e)(7)(A).

(1) *Active treatment.* The Health and Human Services draft defines active treatment as follows:

(i) *For individuals with mental illness.* The implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals, that prescribes the specific therapies and activities for the treatment of persons experiencing an acute episode of severe mental illness, which necessitates supervision by trained mental health personnel.

(ii) *For individuals with mental retardation or other related conditions.* A continuous program which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program. See 42 CFR 435.1009 (relating to definitions relating to institutional status).

(2) *Who determines if it is required.* The Department is required under OBRA-87 to determine, with respect to individuals who are mentally ill or mentally retarded—including those with other related conditions—and require nursing facility services, whether those individuals require active treatment for their condition. The Department is required to base this determination on the data collected as part of the evaluation process conducted by the Department of Aging. Department staff who will be responsible for issuing the determination on the need for active treatment are listed in Appendix H.

(3) *Persons needing active treatment admitted to a nursing facility.* An individual determined by the preadmission screening process to require active treatment may be admitted to a provider nursing facility if the individual is determined to require the level of services provided by a nursing facility. The Department may, nevertheless, determine that an individual does not require the level of services provided by a nursing facility, because, for example, they require a different level of services provided by another facility, such as an ICF/MR, institution for mental diseases (IMD) or acute care hospital. The Department may recommend alternative placements for those individuals. However, for an individual of advanced age—65 years of age or older on the date of admission, who is competent to make an independent decision and is not a danger to himself or others—for example, not assaultive or self-destructive, or both—and who requires the services which a nursing facility is required to provide under OBRA-87, the Department may determine that the individual requires the level of services provided by a nursing facility where the individual chooses to receive that care in a nursing facility.

(4) *Information and services available to those needing active treatment but denied admission to provider nursing facilities.* An individual may require active treatment but be determined to be ineligible for admission to a provider nursing facility under OBRA-87. That individual may obtain information from the county MH/MR agency and other local resources to assist in the determination of an appropriate plan of care and an appropriate placement to meet the individual's needs. The county MH/MR agency will provide an individual who is mentally ill or mentally retarded with information on available programs, including information on costs and financial support, as well as on services covered by the MA Program and other programs administered by the Commonwealth. For an individual who has another related condition, the Department will provide information on local agencies which help individuals obtain care, as well as on services covered by the MA Program and other programs administered by the Commonwealth.

(5) *Persons requiring active treatment and admitted to nursing facilities; receiving active treatment while in the nursing facility.* If an individual determined to need nursing facility services and active treatment is admitted to a

provider nursing facility, the provider is not required to provide or arrange for active treatment for that individual. A facility may provide or arrange for active treatment.

**§ 1181.549. Confidentiality of information.**

Information collected as part of the preadmission screening process is considered confidential and may only be released for purposes directly connected to the administration of the MA Program. PA-PASARR-ID Forms are subject to review by the Department, HHS, the Department of Health and their authorized agents.

**APPEALS OF ADVERSE DETERMINATIONS**

**§ 1181.561. Process to appeal adverse determinations in the preadmission screening program.**

(a) Section 1396r(e)(7)(F) of the Social Security Act (42 U.S.C.A. § 1396r(e)(7)(F)) provides: “Each State, as a condition of approval (of its State Plan), effective January 1, 1989, must have in effect an appeals process for individuals adversely affected by determinations under (42 U.S.C.A. §§ 1396r(e)(7)(A) and 1396r(e)(7)(B) (relating to the pre-admission screening program and to the annual resident review program)).”

(b) An applicant—including a legal or personal representative acting on behalf of the applicant—for admission to a nursing facility participating as a provider in the MA Program has the right to appeal from an adverse determination made as part of the preadmission screening program established under OBRA-87. The Department currently has regulations in effect which provide for appeals in Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings).

(c) Under Chapter 275, an applicant for admission to a nursing facility who is seeking or is already eligible for MA benefits has the right to appeal to the Department’s Office of Hearings and Appeals with respect to a decision affecting the applicant’s rights to receive Program benefits. Chapter 275 will be applied to appeals of adverse determinations in the OBRA-87 preadmission screening process where the appeals are filed by or on behalf of individuals who are seeking or receiving MA.

(d) The OBRA-87 preadmission screening process can also adversely affect an applicant for admission who is not seeking or receiving MA. Appeals by or on behalf of those individuals shall still be filed with the Office of Hearings and Appeals. These appeals will be heard under the authority established in 1 Pa. Code Part II (relating to general rules of administrative practice and procedure).

**Source**

The provisions of this § 1181.561 amended October 3, 2008, effective November 3, 2008, 38 Pa.B. 5435. Immediately preceding text appears at serial pages (201492) to (201493).

**Cross References**

This section cited in 55 Pa. Code § 1181.542 (relating to who is required to be screened).

**§ 1181.562. Adverse determinations.**

(a) OBRA-87 requires an appeal process for an individual adversely affected by determinations made in the preadmission screening process effective January 1, 1989. An adverse determination is one which denies or conditions the individual admission to the nursing facility. The preadmission screening process involves the following kinds of adverse determinations:

(1) Classification as an individual who is subject to the preadmission screening process administered by the Department of Aging under OBRA-87—not including the existing LAMP site review process—including the issue of whether the individual is mentally ill, mentally retarded or has a related condition (Form PA-PASARR-ID Appeals).

(2) Classification as an individual who may not be admitted to a nursing facility (Form PA-PASARR-YN Appeals).

(b) The determination that an individual requires nursing facility services is not an adverse determination which is appealable under OBRA-87 or Department regulations.

**§ 1181.563. Who may appeal.**

Only the applicant—including a legal or personal representative acting on behalf of the applicant—has the right to appeal. A provider does not have the right to appeal unless it has the applicant's power of attorney to act as the applicant's personal representative.

**§ 1181.564. When an appeal is required to be filed.**

(a) An appeal from an adverse determination in the preadmission screening process shall be filed within 30 days of the date of written notice of the determination involved. Additional time will be permitted only as provided at § 275.3(b) (relating to requirements).

(b) For purposes of OBRA-87 adverse determination appeals, the notice required by § 275.3(b) will be issued by the following:

(1) Notice of classification as an individual who requires a determination by the Department of Aging will be issued by the service provider—the nursing home—using Form PA-PASARR-ID.

(2) Notice that an individual referred to the Department of Aging may not be admitted to a nursing facility will be issued by the Department, using Form PA-PASARR-YN.

(c) An appeal is deemed filed on the date it is actually received by the Office of Hearings and Appeals. If there is an official United States Post Office postmark on an envelope transmitting an appeal, it will be deemed filed on the postmark date.

**§ 1181.565. What an appeal is required to contain.**

An appeal from an adverse determination may be made by letter. No formal pleadings are required. The letter shall identify the name of the individual on whose behalf the appeal is being filed, the name of the nursing facility involved, the date of the written notice of the adverse determination, the agency or provider that issued the adverse determination and the address of the person to whom information from the Office of Hearings and Appeals should be sent. In addition, the appeal shall include a copy of the written notice of adverse determination in question. There are no filing fees or other charges.

**§ 1181.566. Where appeals should be filed.**

(a) An appeal shall be filed with the Department's Office of Hearings and Appeals at the following address:

Office of Hearings and Appeals  
Department of Human Services  
Post Office Box 2675  
Harrisburg, Pennsylvania 17105-2675

(b) The Office of Hearings and Appeals is currently located in Room 305, Capitol Associates Building, Seventh and Forster Streets, in Harrisburg.

(c) Information concerning the filing of appeals can be obtained by calling the Office of Hearings and Appeals at the following telephone numbers: Harrisburg, (717) 783-3950; Reading, (215) 378-4188; Philadelphia, (215) 560-2385; Pittsburgh, (412) 565-5213; and Scranton, (717) 963-3016.

**§ 1181.567. How and where hearings will be conducted.**

Hearings on matters involving adverse determinations in the preadmission screening process will be conducted on an informal basis. Hearings will be held at the regional offices of the Office of Hearings and Appeals—Harrisburg, Reading, Philadelphia, Pittsburgh and Scranton—as well as, in extraordinary cases, at local County Assistance Offices. The parties may agree to submit documentation in advance and conduct the hearing by telephone. The individual on whose behalf the appeal was filed may handle the case or may be represented by an attorney or personal representative.

**§ 1181.568. How long it will take to get a decision.**

Under Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings), a decision on appeals will be issued within 90 days of the date on which the appeal is received by the Office of Hearings and Appeals.

Chapter 275 provides that the decisions are subject to reconsideration by the Department and, if the decision is adverse to the individual who filed the appeal, subject to appellate review before the Commonwealth Court of Pennsylvania.

**APPENDIX A**  
**[Reserved]**

**APPENDIX B**  
**[Reserved]**

**APPENDIX C**  
**[Reserved]**

**Source**

The provisions of this Appendix C codified July 24, 1981, effective retroactively to October 1, 1980, 11 Pa.B. 2610; amended March 5, 1982, effective retroactively to July 1, 1981, 12 Pa.B. 869; amended March 25, 1983, effective retroactively to July 1, 1982, 13 Pa.B. 1140; amended April 1, 1983, effective April 1, 1983, 13 Pa.B. 1185; amended February 17, 1984, effective July 1, 1983, 14 Pa.B. 546; corrected March 2, 1984, effective July 1, 1983, 14 Pa.B. 731; reserved September 6, 1985, effective September 7, 1985, 15 Pa.B. 3181. Immediately preceding text appears at serial pages (99469) to (99472).

**APPENDIX D**  
**[Reserved]**

**APPENDIX E**  
**SKILLED NURSING CARE**

*I. Introduction.*

(a) The Department has developed criteria to be used in determining whether an applicant or recipient is medically eligible for skilled level of care. To be determined medically eligible for skilled level of care, a recipient must receive at least one skilled care service which meets all of the requirements specified in section II(a). If any one of the requirements specified in section II(a) are not met, the service does not qualify as a skilled care service and recipient cannot be determined to be medically eligible for skilled level of care.

(b) If an applicant is applying for nursing facility care from a nonnursing facility setting and, therefore, does not meet certain conditions, such as receiving a skilled care service on an inpatient basis, the determination should be made based on what services the physician would order and the applicant would receive if the applicant were admitted to a skilled nursing facility.

*II. Skilled Care Services.*

(a) For an individual service provided to the recipient to be considered a skilled care service, the service shall:

- (i) Be required and provided to the recipient on a daily basis.

- (ii) Be ordered and provided under the direction of a physician.
  - (iii) Require the skills of, and be provided either directly by or under the supervision of, medical professionals; for example, registered nurse, licensed practical nurse, physical therapist, occupational therapist, speech pathologist or audiologist.
  - (iv) Be one that, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis.
  - (v) Be documented in the recipient's medical record consistent with standard medical practice.
- (b) Skilled care services, as specified in the *Skilled Nursing Care Assessment Form Handbook*, fall into three categories: skilled nursing services, skilled rehabilitative services and skilled nursing/rehabilitative services.
- (i) Skilled nursing services, as specified in the *Skilled Nursing Care Assessment Form Handbook* include:
    - (A) Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feedings.
    - (B) Levin tube and gastrostomy feedings.
    - (C) Nasopharyngeal and tracheostomy aspiration.
    - (D) Insertion and sterile irrigation and replacement of catheters.
    - (E) Application of dressings involving prescription medications and aseptic techniques.
    - (F) Treatment of extensive decubitus ulcers or other widespread skin disorders.
    - (G) Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the recipient's progress.
    - (H) Initial phases of a regimen involving administration of medical gases.
    - (I) Rehabilitative nursing procedures, including related teaching and adaptive aspects of nursing, that are part of active treatment.
    - (J) Another skilled nursing procedure that the recipient needs and meets the requirements of section II(a).
  - (ii) Skilled rehabilitative services, as specified in the *Skilled Nursing Care Assessment Form Handbook* include:
    - (A) Therapeutic exercises or activities.
    - (B) Gait evaluation and training.
    - (C) Range of motion exercises.
    - (D) Maintenance therapy: design and establishment of a maintenance program by a qualified therapist based on an initial evaluation and periodic reassessment of the recipient's needs and consistent with the recipient's capacity and tolerance.
    - (E) Ultrasound, shortwave, and microwave therapy.



(F) Hot pack, hydrocollator, infrared treatments, paraffin baths and whirlpool.

(G) Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(H) Other skilled rehabilitative services that the recipient needs and meets the requirements of section II(a).

(iii) Skilled nursing/rehabilitative services as specified in the *Skilled Nursing Care Assessment Form Handbook* include:

(A) *Overall management and evaluation of care plan*—The development, management and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the recipient's physical or mental condition, those activities require the involvement of technical or professional personnel to meet the recipient's needs, promote recovery and ensure medical safety. This includes the management of a plan involving a variety of personal care services—nonskilled services—when, in light of the recipient's condition, the aggregate of those services requires the involvement of technical or professional personnel. A condition that does not ordinarily require skilled services may require them because of special medical complications. Under these circumstances, a service that is usually non-skilled may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitative personnel. In situations of this type, the complications, and the skilled services they require, shall be documented by physicians' orders and nursing or therapy notes. Skilled planning and management activities are not always specifically identified in the recipient's clinical record. Therefore, if the recipient's overall condition supports a finding that recovery and safety can be assured only if the total care is planned, managed and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are being provided.

(B) *Observation and assessment of the patient's changing condition*—Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the recipient's need for modification of treatment for additional medical procedures until the recipient's condition is stabilized. The need for services of this type shall be documented by physicians' orders and/or nursing or therapy notes.

(C) *Patient education services*—Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a recipient self-maintenance.

#### Source

The provisions of this Appendix E adopted January 7, 1983, effective January 8, 1983, 13 Pa.B. 148; amended March 10, 1989, effective immediately and applies retroactively to February 23, 1988, 19 Pa.B. 999.

**Notes of Decisions**

Appendix E II (c) does permit the DPW to consider, in accordance with interpretations of the Social Security Act, a patient's overall condition in the course of determining level of care. *Fifty Residents of Park Pleasant v. Commonwealth*, 503 A.2d 1057 (Pa. Cmwlth. 1986).

The Department's regulations at 55 Pa. Code Chapter 1181 Appendix E, do comply with the corresponding Federal regulations, *cf.* 42 CFR 409.32-409.36. *Fifty Residents of Park Pleasant v. Commonwealth*, 503 A.2d 1057 (Pa. Cmwlth. 1986).

Appendix E II (c) is consistent with 42 CFR 409.33(a), the "catch-all" Federal regulation; and petitioners receiving personal care services, but whose conditions did not warrant the services of medical professionals, did not qualify under either regulation. *Barnett v. Department of Public Welfare*, 491 A.2d 320 (Pa. Cmwlth. 1985).

**Cross References**

This appendix cited in 55 Pa. Code § 1181.2 (relating to definitions); 55 Pa. Code § 1181.53 (relating to payment conditions related to the recipient's initial need for care) and 55 Pa. Code § 1181.54 (relating to payment conditions related to the recipient's continued need for care).

**APPENDIX F****HEAVY CARE/INTERMEDIATE SERVICES****I. Introduction.**

The Department has developed criteria to be used in determining whether an applicant or recipient is medically eligible for the heavy care/intermediate level of care. To be determined medically eligible for the heavy care/intermediate level of care, a recipient shall meet the requirements in Section II. If any one of the requirements specified in Section II are not met, the recipient cannot be determined to be medically eligible for the heavy care/intermediate level of care.

**II. Heavy care/intermediate services.**

(a) Heavy care/intermediate services shall be provided in a dually certified skilled bed and are subject to the same limits on nursing hours as skilled care services.

(b) Heavy care/intermediate services are services provided to patients who are functionally impaired to the following extent with respect to the following activities of daily living:

(1) *Eating*—requires total care. Requires total care means that the individual must be hand fed by another person, is tube fed, or is in a feeding retraining program. Functional impairment shall be at level 3 or 4.

(2) *Dressing*—requires total care. Requires total care means that the individual must be dressed by another person. Functional impairment shall be at level 3.

(3) *Continence of urine*—is incontinent or has an indwelling bladder catheter. Incontinent means incontinent more than 50% of the time. Functional impairment shall be at level 3 or 4.

(4) *Mental status*—confused or speech-aphasic with behavioral problems. Confused means confused most of the time, semi-comatose or comatose. Func-

tional impairment shall be at level 3, 4 or 5. Speech-aphasic with behavioral problems means unable to communicate for whatever reason. Functional impairment shall be at level 3 and there shall be behavioral problems.

(5) *Mobility*—wheelchair/mobile. Mobility includes those categories of mobility status which are wheelchair/mobile, cane/walker, chairbound or bed-fast. Functional impairment shall be at level 2, 3, 4 or 5.

ITEM	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
<input type="checkbox"/> Eating	Self	With Assistance	Total Care	Tube Fed	
<input type="checkbox"/> Bathing	Self	With Assistance	Total Care		
<input type="checkbox"/> Dressing	Self	With Assistance	Total Care		
<input type="checkbox"/> Continence of Urine	Continent	Occas. Incontinent	Incontinent	Catheter	
<input type="checkbox"/> Continence of Bowel	Continent	Occas. Incontinent	Incontinent	Colostomy	
<input type="checkbox"/> Mental Status	Clear	Occas. Confused	Confused	Semi Comatose	Comatose
<input type="checkbox"/> Noisy	Never	Occasionally	Most of the Time		
<input type="checkbox"/> Combative	Never	Occasionally	Most of the Time		
<input type="checkbox"/> Withdrawn	Never	Occasionally	Most of the Time		
<input type="checkbox"/> Wanders	Never	Occasionally	Most of the Time		
<input type="checkbox"/> Suicidal	Never	Occasionally	Most of the Time		
<input type="checkbox"/> Mobility	Ambulatory	Wheelchair/Mobile	Most of the Time	Chairbound	Bedfast
<input type="checkbox"/> Sight	Not Impaired	Impaired	Cane/Walker/Asst.		
<input type="checkbox"/> Hearing	Not Impaired	Impaired	Blind		
<input type="checkbox"/> Speech	Not Impaired	Impaired	Deaf		
			Aphasic		

(c) Documentation justifying the need for heavy care/intermediate services on an inpatient basis shall be recorded in the patient's medical record at least monthly.

**Source**

The provisions of this Appendix F adopted December 24, 1988, effective January 1, 1989, 18 Pa.B. 5711; amended March 10, 1989, effective immediately and applies retroactively to February 23, 1988, 19 Pa.B. 999.

**Cross References**

This section cited in 55 Pa. Code § 1181.2 (relating to definitions); and 55 Pa. Code § 1181.54 (relating to payment conditions related to the recipient's continued need for care).

**APPENDIX G**

**TIMETABLE OF KEY MEDICAL ASSISTANCE RELATED  
IMPLEMENTATION DATES UNDER OBRA-87, as amended, FOR HHS,  
PROVIDER FACILITIES AND STATE AGENCIES**

*1988*

7/1/88	Facilities:	Must provide LTC ombudsmen, physicians and State/Federal officials immediate access to residents.
7/1/88	HHS:	Issue regulation to define which costs can be charged to Medicaid eligible nursing facility residents' personal fund, and which costs are included in the Medicaid payment amount.
9/1/88	HHS:	Establish requirements for approval of nurse aide training and competency evaluation programs.
10/1/88	HHS:	Establish guidelines for minimum standards for state appeals process for transferred and discharged residents.
10/1/88	HHS:	Develop minimum criteria for preadmission screening and annual resident review (PASARR) for mentally retarded and mentally ill residents of nursing facilities.
10/1/88	HHS:	Develop criteria for appeals process for residents adversely affected by PASARR process.
10/1/88	HHS:	Develop criteria to monitor state performance in granting nursing facilities waiver of 24-hour licensed professional nurse provision.
10/1/88	HHS:	Publish regulation regarding alternative remedies (sanctions) for nursing facilities out of compliance.

1989

- 1/1/89      States:      Must have in effect a preadmission screening program for mentally retarded and mentally ill patient placement determinations.
- 1/1/89      States:      Establish a nurse aide registry.
- 1/1/89      States:      Must establish appeals process for residents adversely affected by screening and review process for mentally retarded and mentally ill individuals.
- 1/1/89      States:      Specify approved nurse aide training and competency evaluation programs.
- 1/1/89      Facilities:    Must not admit any mentally retarded or mentally ill individuals unless screened by appropriate state authority and found to need level of care provided by facility.
- 1/1/89      HHS:        Specify minimum data set of core elements and common definitions for use by nursing facilities in conducting resident assessments. Establish guidelines for utilization of data set.
- 4/1/89      States/HHS:    Enter into agreement regarding alternative disposition plan for review/placement of mentally retarded or mentally ill residents needing active treatment but not level of care provided by facility in which they reside (NOTE: Since HCFA usually requires a 90-day period to review and approve such plans, states are advised to submit their alternative disposition plans to HCFA by January 1, 1989.
- 7/1/89      States:      Implementation and enforcement of standards for nursing facility administrators.
- 7/1/89      Facilities:    Must provide for nurse aid competency evaluation programs for nurse aides employed in facility as of July 1, 1989; and for any preparation needed to complete program by January 1, 1990.
- 10/1/89     States:      Must have appeals process in place for residents involuntarily transferred or discharged from nursing facilities on or after October 1, 1989.
- 10/1/89     States:      Establish alternative remedies (sanctions) for nursing facilities out of compliance.
- 10/1/89     Facilities:    Must notify residents of right to appeal all transfers and discharges.

*1990*

1/1/90	States:	Provide for review and reapproval of all nurse aide training and competency evaluation programs.
1/1/90	Facilities:	All nurses aides must have completed training and competency evaluation program if they are employed more than 4 months by facility.
1/1/90	HHS:	Develop, test and validate protocol for standard and extended survey of nursing facilities.
4/1/90	States:	Complete review of all mentally retarded and mentally ill residents currently residing in nursing facilities and determine and implement appropriate placement.
4/1/90	States:	Submit to HHS a state plan amendment which provides for appropriate payment adjustment to nursing facilities (which takes into account the cost of complying with nursing home reform provisions).
4/1/90	HHS:	Must designate one or more resident assessments which a state may specify for use by nursing facilities.
7/1/90	States:	Must specify resident assessment instrument to be used by nursing facilities.
7/1/90	States:	Must specify resident assessment instrument to be used by nursing facilities.
9/30/90	HHS:	Must review and approve/disapprove state plan amendments for payment adjustments to nursing facilities.
10/1/90	States:	Survey and Certification requirements become effective.
10/1/90	Facilities:	Must conduct resident assessment within 4 days for residents admitted on or after October 1, 1990 and must begin conducting annual resident assessments.
10/1/90	Facilities:	Must provide 24-hour/day licensed professional nursing services and full-time registered nurse services 7 days/week (unless waived). Distinction between SNF and ICF level of care eliminated.

*1991*

10/1/91	Facilities:	Resident assessment for all residents admitted to facility prior to October 1, 1990 must be completed.
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1993

\*1/1/93 HHS: Evaluation of resident assessment process—report to Congress.

**Source**

The provisions of this Appendix G adopted December 23, 1988, effective January 1, 1989, 18 Pa.B. 5711.

**Cross References**

This section cited in 55 Pa. Code § 1181.505 (relating to discussion).

**APPENDIX H**

**State Offices and Contact Persons for Determination of Eligibility  
or Active Treatment**

*For persons with mental illness:*

Estelle Richman, Area Director, Southeastern Area Office, Philadelphia State Office Building, 1400 Spring Garden Street, Philadelphia, Pennsylvania 19130.

Ford Thompson, Jr., Acting Area Director, Central Area Office, 2330 Ararat Boulevard, Harrisburg, Pennsylvania 17110.

Kathleen D. Reese, Acting Area Director, Northeastern Area Office, Scranton State Office Building, 100 Lackawanna Avenue, Scranton, Pennsylvania 18503.

Shirley Dumpman, Acting Area Director, Western Area Office, Pittsburgh State Office Building, Pittsburgh, Pennsylvania 15222.

*For persons with mental retardation:*

Vicki Stillman-Toomey, MR Program Manager, Southeastern Area Office, 306 State Office Building, 1400 Spring Garden Street, Philadelphia, Pennsylvania 19130, (215) 560-2242.

Marvin Meyers, MR Program Manager, Northeastern Area Office, 100 Lackawanna Avenue, Post Office Box 1127, Scranton, Pennsylvania 18503, (717) 963-4393.

Ed Manning, MR Program Manager, Central Area Office, 2330 Ararat Boulevard, Harrisburg, Pennsylvania 17105, (717) 657-4471.

Mary Puskarich, MR Program Manager, Western Area Office, 1403 State Office Building, 300 Liberty Avenue, Pittsburgh, Pennsylvania 15222, (412) 565-5144.

*For persons with other related developmental disabilities:**Final Determinations Contact Person*

Tammy McElfresh-Tyburski, Department of Human Services, Office of Social Programs, Room 529, Health and Welfare Building, Harrisburg, Pennsylvania 17120, (717) 787-5753.

**Source**

The provisions of this Appendix H adopted December 23, 1988, effective January 1, 1989, 18 Pa.B. 5711.

1181-134



**Cross References**

This appendix cited in 55 Pa. Code § 1181.548 (relating to what happens if active treatment is required).

**APPENDIX I. [Reserved]****Source**

The provisions of this Appendix I adopted December 23, 1988, effective January 1, 1989, 18 Pa.B. 5711; reserved July 24, 1992, effective July 1, 1992, 22 Pa.B. 3918. Immediately preceding text appears at serial pages (150214) and (136051) to (136053).

**APPENDIX J. [Reserved]****Source**

The provisions of this Appendix J adopted December 23, 1988, effective January 1, 1989, 18 Pa.B. 5711; reserved July 24, 1992, effective July 1, 1992, 22 Pa.B. 3918. Immediately preceding text appears at serial page (136054).

**APPENDIX K. [Reserved]****Source**

The provisions of this Appendix K adopted December 23, 1988, effective January 1, 1989, 18 Pa.B. 5711; reserved July 24, 1992, effective July 1, 1992, 22 Pa.B. 3918. Immediately preceding text appears at serial pages (136055) and (136063).

**APPENDIX L. [Reserved]****Source**

The provisions of this Appendix L adopted December 23, 1988, effective January 1, 1989, 18 Pa.B. 5711; reserved July 24, 1992, effective July 1, 1992, 22 Pa.B. 3918. Immediately preceding text appears at serial page (136064).

**APPENDIX M****DEPARTMENTAL DETERMINATIONS**

The Department is required to determine the need for nursing care and active treatment for all applicants to nursing homes who are mentally ill, mentally retarded or who have a related condition unless otherwise exempt.

For Departmental Determination of the applicant's need for nursing care and active treatment, the following information must be sent with the LAMP Summary and the PASARR-EV to the appropriate office listed in Appendix G. If a new evaluation or set of evaluations are required, those preparing their reports should address themselves to the following items.

I. *Determination of All Persons.* Data sent to the Department for determination of need for nursing care for all persons must include:

A. The finding that the applicant's medical needs cannot be adequately met in noninstitutional settings include at least:

1. An evaluation of medical status including at least the applicant's:
    - a. Diagnoses.
    - b. Date of onset.
    - c. Medical history.
    - d. Prognosis.
  2. A history of previous rehabilitation within the past year.
- B. A recommendation based upon medical determination that nursing care is needed.
- II. *Determination of Persons with Mental Illness.* Data sent to the Department for determinations to be made for persons with mental illness must also include a recommendation and sufficient supporting information in order to determine whether or not the person needs the implementation of "active treatment" in order to be able to function. Information must include:
- A. A comprehensive history and physical examination of the person. At a minimum, the examination must address the following areas—if not previously addressed:
1. Complete medical history.
  2. Review of all body systems.
  3. Specific evaluation of the person's neurological system in the areas of:
    - a. Motor functioning.
    - b. Sensory functioning.
    - c. Gait.
    - d. Deep tendon reflexes.
    - e. Cranial nerves.
    - f. Abnormal reflexes.
  4. In case of abnormal findings which are the basis for a nursing facility placement, additional evaluations must be conducted by appropriate specialists.
  5. If the history and physical examination used for the PASARR Determination is not performed by a physician, then a physician's countersignature is required.
- B. A comprehensive drug history of all current or immediate past utilization of medications used by the person that could mask symptoms, as well as the use of medications that could mimic mental illness.
- C. A psychosocial evaluation of the person. At a minimum, this includes an evaluation of the following:
1. Current living arrangements.
  2. Medical and support systems.
  3. If the psychosocial evaluation is not conducted by a social worker, then a social worker's countersignature is required.
- D. A comprehensive mental health evaluation. At a minimum, the evaluation must address the following areas:
1. Complete mental health history.

2. Evaluation of intellectual functioning, memory functioning, and orientation.
3. Description of current attitudes and overt behaviors.
4. Affect.
5. Suicidal/homicidal ideation.
6. Degree of reality testing—presence and content of delusions—and hallucinations.
7. If the mental health evaluation is not performed by a physician who is knowledgeable about mental illness or a clinical psychologist. Then the countersignature of one or the other is required.

E. The information must include all medical and psychiatric diagnoses which require treatment. Copies of previous discharge summaries—during the past 2 years.

III. *Determination of Persons with Mental Retardation or Related Conditions.* Data sent to the Department for determination to be made for persons with mental retardation or other related conditions must also include a recommendation and sufficient supporting information to determine whether or not the person needs the implementation of a continuous “active treatment” program as defined at 42 CFR 435.1009 “Active Treatment in Intermediate Care Facilities for the Mentally Retarded” in order to be able to function. Information must include:

A. The individual’s comprehensive history and physical examination results so that the following, minimum information can be identified:

1. A list of the individual’s medical problems.
2. The level of impact these problems have on the individual’s independent functioning.
3. A list of all current medications used by the individual.
4. Current response of the individual to any prescribed medications in the following drug groups:
  - a. Hypnotics.
  - b. Antipsychotics (neuroleptics).
  - c. Mood stabilizers and antidepressants.
  - d. Antianxiety-sedative agents.
  - e. Anti-parkinsonian agents.

B. An assessment of the individual’s:

1. Self-monitoring of health status.
2. Self-administering and/or scheduling of medical treatments.
3. Self-monitoring of nutrition status.
4. Self-help development—such as: toileting, dressing, grooming and eating.
5. Sensorimotor development—such as: ambulation, positioning, transfer skills, gross motor dexterity, visual motor/perception, fine motor dexterity, eye-

hand coordination and extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual's functioning capacity.

6. Speech and language (communication) development—such as: expressive language (verbal and nonverbal), receptive language (verbal and nonverbal), extent to which nonoral communication systems can improve the individual's functional capacity, auditory functioning and extent to which amplification devices (hearing aid) or a program amplification can improve the individual's functional capacity.

7. Social development, such as: interpersonal skills, recreation-leisure skills and relationships with others.

8. Academic/educational development, including functional learning skills.

9. Independent living development—such as: meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to the neighborhood, town, city), laundry, housekeeping, shopping, bedmaking, care of clothing, and orientation skills—for individuals with visual impairments.

10. Vocational development, including present vocational skills.

11. Affective development—such as: interests and skills involved with expressing emotions, making judgements and making independent decisions.

12. Presence of identifiable maladaptive or inappropriate behaviors of the individual based on systematic observation—including, but not limited to, the frequency and intensity of identified maladaptive or inappropriate behaviors.

C. The information conveyed to the Department must identify to what extent the person's status compares with each of the following characteristics, commonly associated with need for active treatment:

1. Inability to take care of most personal care needs.
2. Inability to understand simple commands.
3. Inability to communicate basic needs and wants.
4. Inability to be employed at a productive wage level without systematic long term supervision or support.
5. Inability to learn new skills without aggressive and consistent training.
6. Inability to apply skills learned in a training situation to other environments or settings without aggressive and consistent training.
7. Without direct supervision, inability to demonstrate behavior appropriate to the time, situation or place.
8. Demonstration of severe maladaptive behaviors which place the person or others in jeopardy to health and safety.
9. Inability or extreme difficulty in making decisions requiring informed consent.
10. Presence of other skill deficits or specialized training needs which necessitates the availability of trained Mental Retardation personnel, 24 hours per day, to teach the person to learn functional skills.

D. The information must indicate that a psychologist, who meets the qualifications of a Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)(1)(2):

1. Identifies the individual's intellectual functioning measurement.
2. Validates the individual has mental retardation or a related condition.
3. Recommends whether the individual needs active treatment to function.

**Source**

The provisions of this Appendix M adopted December 23, 1988, effective January 1, 1989, 18 Pa.B. 5711.

**Cross References**

This appendix cited in 55 Pa. Code § 1181.544 (relating to where and how evaluations will be made); and 55 Pa. Code § 1181.546 (relating to how providers and applicants will be notified).

**APPENDIX N  
RIGHT TO APPEAL AND FAIR HEARING**

**I. GUIDELINES FOR PROVIDERS**

In order to assist providers in meeting the requirements established by OBRA-87 with respect to residents' transfer and discharge rights, the Department is establishing guidelines for the definition of terms contained in OBRA-87 and for the implementation of the procedures required by the law.

**A. Definitions:**

1. **TRANSFER**—A change of the facility from which the resident is to receive necessary health care on a 24-hour basis, including changes to a higher or lower level of care, whether or not that facility is a provider in the MA Program.
2. **DISCHARGE**—An action by which a resident is removed from a facility providing necessary health care on a 24-hour basis to any other situation in which the resident will not be receiving necessary health care in a facility on a 24-hour basis, except where such removal is part of the resident's plan of care administered by the facility (e.g., movement to a hospital or a program of therapeutic leave is a transfer, whereas movement to a personal care home or a program of home health care in the resident's own home is a discharge).
3. **STATE LONG-TERM CARE OMBUDSMAN**—The officer designated by the Department of Aging under 42 U.S.C.A. § 3027(a)(12). As of October 1, 1989, the name, mailing address and telephone of this officer are: State Long-term Care Ombudsman, Department of Aging, Market Street State Office Building, 400 Market St., 6th Floor, Harrisburg, Pennsylvania 17101-2301, (717) 783-7247.
4. **AGENCY RESPONSIBLE FOR THE PROTECTION AND ADVOCACY SYSTEM FOR MENTALLY ILL OR DEVELOPMENTALLY DISABLED INDIVIDUALS UNDER 42 U.S.C.A. § 6041 et seq. AND 10801 et seq.**—

Pennsylvania Protection and Advocacy, 116 Pine Street, Harrisburg, Pennsylvania 17101-1208 (Telephone: (717) 236-8110).

5. *RESIDENT*—Any living person admitted for care into a nursing facility participating in the MA Program, whether or not that care is paid for in whole or in part by the MA Program.

B. *Procedures*

1. While no Department-approved form for the required notice has been established, the form of notice used by providers must be written in clear language designed to effectively communicate with residents and shall be available in English as well as in any other language required for effective communication with the person(s) to be notified (including Braille for blind residents).

2. Lack of proper notice is a basis for a resident to seek an order precluding an intended transfer or discharge.

3. The first availability of a bed in a semiprivate room in the facility, for purposes of permitting a resident who has been transferred for hospitalization or therapeutic leave to return, under 42 U.S.C.A. § 1396r(c)(2)(D)(iii)(III), shall be determined by the facility so that the affected resident is presumed to apply for readmission on the first day on which readmission to a nursing facility is indicated in that person's plan of care; and, provider facilities shall be responsible for obtaining information on the planned readmission date for any resident transferred for hospitalization or therapeutic leave. The provider facility should coordinate a plan for the return of the resident.

II. *STATE APPEALS PROCESS FOR TRANSFERS AND DISCHARGES*

All residents (including any legal or personal representative acting on behalf of the resident) of nursing facilities (other than intermediate care facilities for the mentally retarded) which are enrolled as providers in the MA Program shall have the right to appeal from any decision to transfer or discharge that resident. The Department currently has regulations which provide for such appeals.

Under Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings), residents who are eligible for MA benefits have the right to appeal to the Department's Office of Hearings and Appeals with respect to any decision affecting their rights to receive Program benefits. These regulations will be applied to appeals of decisions with respect to transfers and discharges.

The OBRA-87 requirements, however, also affect persons who are not eligible for MA benefits. The Department currently has regulations which provide for appeals by such persons at 1 Pa. Code Part II (relating to general rules of administrative practice and procedure). Such appeals must still be filed with the Department's Office of Hearings and Appeals.

A. *WHAT MAY BE APPEALED?*

A resident may appeal any determination to transfer or discharge the resident.

B. *WHO MAY APPEAL?*

Only the resident (including any legal or personal representative acting on behalf of the resident, which includes Pennsylvania Protection and Advocacy) shall have the right to appeal. A provider does not have the right to appeal.

C. *WHEN MUST APPEALS BE FILED?*

Appeals must be filed within thirty (30) days of the date of the provider's proper notice to the resident of the intended transfer or discharge. Where a provider fails to provide proper notice, the time to appeal does not begin to run out until proper notice has been given. Appeals should be filed as soon as possible.

Notice to a resident must include all of the information required by law, including information on bed-hold policy and readmission required when a transfer is for hospitalization or therapeutic leave. Failure to provide required information invalidates a notice and extends the period in which the resident may appeal.

An appeal is filed on the date it is actually received by the Office of Hearings & Appeals; however, where there is an official U. S. Post Office postmark or common carrier (e.g., express mail delivery services) receipt in the materials transmitting the appeal, the appeal will be deemed filed when postmarked or received by the common carrier.

D. *WHAT MUST AN APPEAL CONTAIN?*

An appeal from a discharge or transfer decision can be made by letter. No formal pleadings are required. The letter must identify the name of the resident on whose behalf the appeal is being filed, the name and address of the nursing facility involved, and the name of the person filing the appeal. The appeal must also include a copy of the provider's notice of the intended discharge or transfer and a short presentation of the reasons why the resident believes the decision is wrong. There are no filing fees or other charges.

A copy of the appeal letter must be sent to the provider facility. If the appeal involves a dispute with the recommendations of the resident's physician, a copy of the appeal letter must be sent to that physician as well.

An appeal may include a request for an order to halt the transfer or discharge pending the Department's decision on the appeal. Appeals including such a request should be identified with the words "INTERVENTION REQUESTED" in large letters on the envelope transmitting the appeal and in the appeal letter itself.

The more information that is sent with the appeal letter, the faster the appeal can be processed and heard.

E. *WHERE SHOULD APPEALS BE FILED?*

All appeals must be filed with the Department's Office of Hearings and Appeals at the following address:

1181-141

Office of Hearings and Appeals, Department of Human Services, Post Office Box 2675, Harrisburg, Pennsylvania 17105-2675.

The Office of Hearings and Appeals is currently located on the sixth floor of the Bertolino Building, 1401 N. Seventh St. in Harrisburg.

Information concerning the filing of appeals can be obtained by calling the Office of Hearings and Appeals at any of the following telephone numbers:

Erie (814) 871-4433  
Harrisburg (717) 783-3590  
Philadelphia (215) 560-2207  
Pittsburgh (412) 565-5215  
Reading (215) 378-4189  
Wilkes-Barre (717) 826-2106

*F. HOW WILL HEARINGS BE CONDUCTED AND WHERE?*

Hearings will be conducted on an informal basis. Hearings will be held at the regional offices of the Office of Hearings and Appeals (Harrisburg, Philadelphia, Pittsburgh, Reading and Scranton), as well as, where necessary, at the provider facility involved. The parties may agree to submit documentation in advance and conduct the hearing by telephone. The individual on whose behalf the appeal was filed may handle the case or may be represented by an attorney or a personal representative. The provider facility will be given notice of the hearing and may be represented by an attorney or by any authorized officer of the facility or by its medical director.

*G. HOW LONG WILL IT TAKE TO GET A DECISION?*

Decisions will be issued within 90 days of the date on which the appeal is received by the Office of Hearings and Appeals. Any decision is subject to reconsideration by the Department, pursuant to the provisions of Chapter 275, and is also subject to appellate review by the Commonwealth Court of Pennsylvania.

*H. SCOPE OF REVIEW*

When a resident appeals from the decision of a provider facility to transfer or discharge the resident, the Department will exercise a limited scope of review of some questions, but a broad review of others. As to questions concerning: (1) whether a resident was given proper notice or (2) whether the resident is a threat to the safety or health of other individuals in the facility or (3) whether the resident has failed to pay for a stay at the facility or (4) whether the facility has ceased to operate, the Department may determine any question of law or fact raised by the appeal. As to a discharge or transfer to meet the resident's needs or because improvements in the resident's health no longer support the need for nursing facility care, the Department will affirm the decision where there is sufficient documentation in the resident's clinical record, entered by the resident's physician, to support the decision (unless the resident's physician shall have later



documented a change in the disposition of the case) and there is evidence that the resident's need can be met by the situation to which the resident is to be discharged or transferred.

The resident shall be required to present evidence to show that the provider facility's determination is in error. If the resident fails to produce evidence to show that the provider facility's decision is in error, the Department shall affirm the decision. The burden of proof is on the resident.

**I. WHAT KINDS OF RELIEF ARE AVAILABLE?**

Where an appeal has been timely filed and properly served, the Department may enter an order precluding the transfer or discharge of the resident until otherwise ordered by the Department. Where the Department determines that a resident has been improperly transferred or discharged, it may enter an order requiring the readmission of the resident unless the resident no longer requires nursing facility services at the time readmission is ordered. If readmission is ordered and the facility has no available bed for the successful appellant, the Department may enter an order requiring the facility to readmit to the first available bed in a semi-private room, if, at the time of readmission, the resident requires the services provided by the facility. The Department may also order the facility to reimburse the Department or the former resident for any costs of necessary alternative care incurred by the Department or the former resident which could have been avoided had the improper transfer or discharge not occurred.

**Source**

The provisions of this Appendix N adopted December 23, 1988, effective January 1, 1989, 18 Pa.B. 5711; amended October 6, 1989, effective October 1, 1989, 19 Pa.B. 4278; reserved July 24, 1992, effective July 1, 1992, 22 Pa.B. 3918; corrected February 11, 1994, effective July 25, 1992, 24 Pa.B. 874; amended October 3, 2008, effective November 3, 2008, 38 Pa.B. 5435. Immediately preceding text appears at serial pages (201509) to (201513).

**Cross References**

This appendix cited in 55 Pa. Code § 1181.542 (relating to who is required to be screened).

**APPENDIX O  
OBRA SANCTIONS**

**I. Federal Requirements.** OBRA-87 requires the Department to implement six (6) specified remedies with respect to providers that are not in compliance with the provider participation requirements established by the Act:

1. Denial of payment under the State Plan with respect to new admissions.
2. Civil Monetary Penalties, assessed and collected with interest, for each day a provider facility is or was out of compliance with specified requirements under the Act.

(The Act provides for other civil monetary penalties against individuals which are to be administered by Federal agencies. (42 U.S.C.A. §§ 1320a-7a, 1396r(b)(3)(B)(ii)))

3. Appointment of Temporary Management to oversee operations in the event of an orderly closure of the facility or while improvements are made in order to bring the facility into compliance with the Act's requirements.

4. Authority, in the case of an emergency, to close the facility and/or to transfer the residents to another facility. (42 U.S.C.A. § 1396r(h)(2)(A))

5. Denial of payment for new admissions of any provider facility which has not come into compliance with specified requirements of the Act within 3 months after the date on which that facility is found to be out of compliance. (42 U.S.C.A. § 1396r(h)(2)(C))

6. Denial of payment for new admissions and continuous monitoring until the Department is satisfied that the facility will remain in compliance as to a facility which, on 3 consecutive standard surveys, has been found to have provided sub-standard quality of care. (42 U.S.C.A. § 1396r(h)(2)(D))

In addition, the Act permits the States to implement additional remedies, such as directed plans of correction. (42 U.S.C.A. §§ 1396r(h)(1), 1396r(h)(2)(A))

II. *Current State Law. Closure of Facilities and Removal of Jeopardy to Resident Health and Safety.* Under current State law, the Department of Health is authorized to close nursing facilities (other than ICFs/MR) in the event of emergencies and, where necessary, to require the transfer of residents to other nursing facilities and take any other steps required to remove jeopardy to resident health and safety (35 P. S. §§ 448.814—448.819). The Department of Human Services provides limited payment in such situations (55 Pa. Code § 1181.58). Both Departments are required by law to coordinate their activities in such a situation (71 P. S. § 181), and such coordination can include delegation by the Department of Health to Department of Human Services staff to perform duties ordinarily assigned to staff of the Department of Health. The Department of Human Services has determined that these existing provisions of State law are sufficient to comply with the requirement that the State have the authority, in the case of an emergency, to close a provider facility and/or to transfer residents to other facilities, as required by 42 U.S.C.A. § 1396r(h)(2)(A)(iv). Therefore, no new statutes or regulations are required to meet this provision of the Act.

*Denial of Payments for New Admissions.* Under current Department regulations, the Department may terminate or suspend a provider facility's participation in the MA Program (55 Pa. Code § 1101.73 and 1101.77). This includes termination or suspension of payments pending appeals (55 Pa. Code §§ 1101.73 and 1101.77(c)). Such action may be taken if the Department determines that the provider facility has failed to comply with any requirements of 55 Pa. Code Chapters 1101 and 1181, including the requirements that such facilities conform with the requirements established by OBRA-87 (55 Pa. Code §§ 1101.77(a)(1) and 1181.41(3)). The Department may also preclude admissions of certain applicants whom the Department determines cannot be adequately served by the facility because of the facility's noncompliance with certain Program standards (55 Pa. Code §§ 1181.82 and 1181.548(3)). In addition, the Public Welfare Code autho-

rizes the Department to make MA payments to nursing facilities subject to their meeting the requirements established by Title XIX of the Social Security Act for participation in the MA Program (62 P. S. § 443.1). Under this existing authority, the Department has precluded payments for new admissions pending correction of compliance deficiencies as an intermediate sanction. In addition, the Department of Health is authorized to preclude a facility from admitting additional patients as part of a plan of correction of licensing violations. The Department has determined that this existing authority is sufficient to comply with the requirement that the State have the authority to deny payments for new admissions at provider facilities determined to be out of compliance with OBRA-87 standards, as required by 42 U.S.C.A. § 1396r(h)(2)(A)(i), (C) and (D). Therefore, no new statutes or regulations are required to meet such provisions of the Act.

*Monitoring Provider Operations to Assure Compliance.* Under existing Department regulations, the Department has the authority to monitor provider facility operations to review compliance with Program requirements and to preclude the participation of provider facilities which are not in compliance (55 Pa. Code §§ 1101.71, 1101.77 and 1181.83). The Department may also preclude the re-enrollment of a terminated provider until such time as it is satisfied that there will be no repetition of the violations which led to the provider's termination (55 Pa. Code § 1101.82). In addition, the Department of Health is authorized to monitor facility compliance with the requirements of applicable State and federal regulations (35 P. S. § 448.813). The Department has determined that these existing provisions of State law are sufficient to comply with the requirement that the State have the authority to monitor a provider facility in order to determine that the facility will remain in compliance with OBRA-87, as required by 42 U.S.C. § 1396r(h)(2)(D)(ii). Therefore, no new statutes or regulations are required to meet this provision of the Act.

*Civil Monetary Penalties.* Under existing Department regulations, the Department has the authority to terminate or suspend provider facilities' participation in the MA Program, including the suspension of payments pending appeals. Under this existing authority, the Department has imposed administrative monetary penalties on providers as an alternative to termination. The Department has also utilized statistical samples, under 55 Pa. Code § 1101.83(a), to determine restitution for services rendered contrary to Program requirements. The Department of Health is also authorized to impose civil monetary penalties in cases where provider facilities fail to promptly correct serious deficiencies which are also licensure requirements (35 P. S. § 448.817(b)). The Department has determined that these existing provisions of State law are sufficient to comply with the requirement that the State have the authority to impose civil monetary penalties on provider facilities found to be out of compliance with Program requirements, as required by 42 U.S.C.A. § 1396r(h)(2)(A)(ii). Therefore, no new statutes or regulations are required to meet this provision of the Act.

*Appointment of Temporary Management and Directed Plans of Correction.* Under existing State law, the Department of Health may petition the courts for the appointment of a temporary manager or master to oversee facility operations for a specified period of time or until violations of licensing standards or patterns of noncompliance are corrected and may also direct specific plans of correction for the facility (35 P. S. § 448.814). The Department of Human Services has the authority to terminate or suspend provider facilities' participation in the MA Program, including the suspension of payments pending appeals. Under this existing authority, the Department can, as a condition for the continuation of a provider agreement, require providers to permit the imposition of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents and can direct specific plans of correction. The Department can also petition the courts for the appointment of a receiver in appropriate cases, *Tate v. P.T.C.*, 410 Pa. 490, 190 A.2d 316 (1963) (Receivers may be appointed to manage solvent as well as insolvent entities in appropriate cases); or, for injunctive relief to require the facility to conform with OBRA-87 requirements, *Rupel v. Bluestein*, 280 Pa. Super. 65, 421 A.2d 406 (1980) (Courts of equity may prevent or restrain the commission of acts contrary to law and prejudicial to the rights of individuals). The Department has determined that these existing provisions of State law are sufficient to comply with the requirement that the State have the authority to appoint temporary management to oversee facility operations and to assure the health and safety of residents in appropriate cases where such temporary management is needed during the closure of a facility or in order to assure necessary improvements to bring the facility into compliance with OBRA-87 standards, as required by 42 U.S.C.A. § 1396r(h)(2)(A)(iii). Therefore, no new statutes or regulations are required to meet this provision of the Act.

*Other Remedies.* Any person or entity knowingly violating any of the Department's rules and regulations with respect to the MA Program can be prosecuted under 62 P. S. § 483; and, if convicted, they shall be guilty of a misdemeanor and shall be sentenced to pay a fine not exceeding \$100, or to undergo imprisonment not exceeding 6 months, or both. If a provider or the owner, agent, or employe of a provider is convicted of such a crime, the Department can preclude the participation of the provider and any other convicted person(s) in the MA Program for a period of 5 years (55 Pa. Code § 1101.77(b)(3)).

III. *Criteria for the Application of Remedies.* The Act requires the Department to provide for the enforcement of the OBRA-87 facility participation standards through the use of the remedies specified by the Act at 42 U.S.C. § 1396r(h)(2) and the use of the Department's authority to terminate the facility's participation in the MA Program and to administer the Program (42 U.S.C. § 1396r(h)(1)). The Act vests the Department with broad discretion in the use of these remedies and other methods in order to provide the Department with the greatest flexibility to assure the health and safety of facility residents, to minimize the time between the identification of violations and the imposition of remedies, and to effectively

deter and correct deficiencies.

The Act, however, directs the Department with respect to the application of certain remedies; and, where such direction exists, the Department shall apply the remedies as required by the Act. The Act requires the Department to impose incrementally more severe fines for repeated or uncorrected deficiencies; requires the Department to deny payment for new admissions in cases where providers fail to promptly correct deficiencies or have been found on 3 consecutive standard surveys to provide substandard quality of care; and requires the Department to monitor facilities which have been found on 3 consecutive standard surveys to provide substandard quality of care (42 U.S.C.A. §§ 1396r(h)(2)(A), (C) and (D)).

*Effective Date and Basis for the Imposition of Remedies.* While the Act focuses on the determination of provider facility compliance through the use of the survey and certification process, it permits the Department to impose most of the remedies required by the Act even where the Department finds noncompliance through some other method. Under current State law and regulations, the Department and the Department of Health can take action whenever they determine that a facility is not in compliance with applicable law.

Since the survey and certification process required by OBRA-87 is not yet in place due to delays in the required federal training program, the Department cannot presently make a determination that a provider facility has been found to have provided substandard quality of care on 3 consecutive standard surveys, pursuant to 42 U.S.C.A. § 1396r(h)(2)(D), since no such surveys are presently being conducted. The imposition of this mandatory remedy must therefore be delayed until the survey process is in place. This limitation does not preclude or prevent the Department from monitoring provider facilities as already permitted under State laws and regulations or from utilizing other available remedies to assure continued provider facility compliance with OBRA-87 standards.

*The Department will begin to apply and impose the sanctions required by OBRA-87 immediately,* along with any other remedies otherwise available under State law and regulations. Application of these remedies will not be restricted to the survey and certification process. The Department may cite a facility for violations of applicable OBRA-87 standards and may require the provider facility to show cause why any of these remedies should not be imposed at any time. The Department shall continue to coordinate its efforts with those of other agencies involved in protecting the health, safety and welfare of provider facility residents.

*Termination of Facility Participation in the Program.* A provider facility shall be terminated from participation in the MA Program in those cases where termination is required by Program regulations or otherwise by law (e.g., when such termination is directed by federal authorities pursuant to 42 U.S.C.A. 1320a-7 or when the provider is convicted of a Program-related crime or when the provider's license is suspended or revoked). A provider facility shall be terminated from participation in the MA Program as otherwise permitted by Program regulations

whenever the provider facility has not shown cause for and agreed to the application of another remedy provided for in this appendix or otherwise in State law and regulations, including the application of the mandatory remedies required by 42 U.S.C.A. § 1396r(h)(2)(C)—(D). A provider facility shall be terminated from participation in the MA Program in any case in which the Department determines that compliance with Program standards and conditions of participation can most effectively be achieved by terminating the facility's participation, including those cases in which the facility has a history of repeated noncompliance with Program standards or conditions of participation for reasons within the control of the facility or its owners or where the facility or its owners have knowingly violated Program standards or conditions of participation or any Program regulation.

*Closure of Facilities and Transfer of Residents and Intervention to Cure Immediate Threats to Resident Health and Safety.* In the event of an emergency, a provider facility shall be closed and its residents transferred to other facilities, as provided by Department regulations and as determined by the Department of Health in cooperation with the facility. All facilities are required by law to notify the Department of Health in the event of any intended closure and that Department is authorized to require closures in order to protect residents' health and safety (28 Pa. Code § 201.23). Provider facilities must also notify the Department of Human Services of any impending strike or emergency requiring resident transfers (55 Pa. Code § 1181.58). The Department of Human Services shall coordinate with the Department of Health in cases where there is a finding that there are deficiencies which immediately jeopardize the health and safety of residents to take immediate action to remove the jeopardy either by correcting the deficiencies, by transferring the residents, or by closing the facility temporarily or permanently. A provider facility's participation in the MA Program is not automatically terminated because of closures or transfers of residents in the case of an emergency.

*Temporary Management.* The appointment of temporary management will be required to oversee the operation of a provider facility and to assure the health and safety of the facility's residents in the following six (6) cases:

- (1) Where the facility, after notice by the Department or by the Department of Health of a violation of a Program standard and the acceptance of a plan of correction submitted by the facility, has failed to bring the facility into compliance in the time specified in the plan of correction (even in a case where the facility has determined in the interim to close);
- (2) Where the facility has demonstrated a pattern of episodes of noncompliance such as would convince a reasonable person that any correction of violations would be unlikely to be maintained (even in a case where the facility has determined to close);
- (3) Where the facility has failed to submit a plan of correction within thirty (30) days of notice of violations from the Department or the Department of Health (even in a case where the facility has determined to close);



(4) Where persons responsible for the facility's management are disqualified from participation in the Program;

(5) Where persons responsible for the facility's management are otherwise unable to perform and the facility has certified to the Department that it requires a temporary manager pending the hiring of new personnel; or,

(6) Where the facility has been denied renewal of its license and that determination has been timely appealed to the licensing agency (the grant of a provisional license shall not be construed as a denial of renewal of a license).

*Civil Monetary Penalties.* Where the Department determines that a facility is out of compliance with any requirements of 42 U.S.C. § 1396r(b)—(d) and such noncompliance could have been prevented by the provider, the Department may require the facility to make payment at a rate of \$100 per violation per day of noncompliance, plus interest at the legal rate, until paid; however, if the provider unreasonably fails to correct any such deficiency within ten (10) days of notice thereof (including notice from its own records or staff), then the rate shall be increased to \$500 per violation per day of delayed compliance, plus interest at the legal rate, until paid.

Where the Department determines that a provider facility, within sixty (60) days, is again out of compliance with the same requirement of 42 U.S.C.A. § 1396r(b)—(d) as to which the Department has previously sought a civil monetary penalty and such repeated noncompliance could have been prevented by the provider, the Department may require the facility to make payment at a rate of \$200 per violation per day of noncompliance, plus interest at the legal rate, until paid; however, if the provider unreasonably fails to correct any such deficiency within ten (10) days of notice thereof (including notice from its own records or staff), then the rate shall be increased to \$500 per violation per day of delayed compliance, plus interest at the legal rate, until paid.

With respect to deficiencies involving screening, services or notices required for residents, the Department shall deem each resident that failed to receive the required notice or service or screening to be a separate violation.

The provider shall be held liable for violations caused by the acts and omissions of its officers, agents and employees; however, the provider shall not automatically be held liable for violations caused by the criminal acts of such persons, but may be liable in cases where the provider is also liable for such acts. Where the Department determines that a provider facility is knowingly out of compliance with any Program regulation or requirement, it shall refer the matter to the Office of Attorney General for review as to possible prosecution under the Public Welfare Code or other applicable laws, as well as, where appropriate, to relevant licensing agencies.

*Denial of Program Payment for New Admissions.* The Department will require a provider facility to waive Program payments with respect to new admissions (either in general or limited to those requiring certain kinds or levels of care):

(1) Where the provider facility has been out of compliance with any requirement of 42 U.S.C.A. § 1396r(b)—(d) for a period of 3 months after the date the facility is found to be out of compliance with any such requirement and continues to be out of compliance;

(2) Where the provider facility has been found on 3 consecutive standard surveys conducted under 42 U.S.C.A. § 1396r(g)(2) to have provided substandard quality of care and the Department has not made a subsequent determination that the facility is or will remain in compliance with the requirements of 42 U.S.C.A. § 1396r(b)—(d);

(3) Where the Department has determined that the facility is not currently in compliance with requirements of 42 U.S.C.A. § 1396r(b)—(d) and is not able to provide services in compliance with the requirements of 42 U.S.C.A. § 1396r(b)—(d) for such additional residents;

(4) Where the Department determines that the facility is not able to provide services in compliance with the requirements of 42 U.S.C.A. § 1396r(b)—(d) for such additional residents; or,

(5) Where the Department has not approved the admission of such additional residents through the pre-admission screening processes established by law.

*Monitoring Facilities With Repeated Substandard Care.* Where a provider facility has been determined on 3 consecutive standard surveys conducted under 42 U.S.C.A. § 1396r(g)(2) to have provided substandard quality of care, the Department shall require the facility to permit the Department to monitor the facility, consistent with the requirements of 42 U.S.C.A. §§ 1396r(g)(4)(B) and (h)(2)(D)(ii), until the facility has demonstrated to the satisfaction of the Department that it is in compliance with the requirements of 42 U.S.C.A. § 1396r(b)—(d) and that it will remain in compliance with such requirements. Nothing in this paragraph shall be construed to limit the Department's rights to monitor provider facility operations as required by 42 U.S.C.A. § 1396r(g)(4)(B) or as otherwise permitted by law or otherwise.

*IV. Relationship of Remedies and Rights During Appeals.* When the Department determines that a provider facility is subject to the remedies discussed in this appendix, it will issue a notice to the provider facility, as required by 42 CFR 431.154, of the Department's intent to take action and requesting the provider for a response to inform the Department as to any errors in the Department's findings, as well as with respect to the appropriate remedy. If the provider facility fails to respond to such advance notice, the Department will terminate the provider facility's participation in the MA Program by a subsequent notice, effective as of the date specified in the advance notice. If the provider does timely respond to the advance notice, the Department will consider the information submitted and will advise the provider facility of the Department's decision with respect to the matter in a subsequent notice to be issued prior to the effective date of any termination.



The Department’s advance notice will include alternative remedies to termination which the Department will consider, which alternatives shall be based on the criteria in this appendix. If the provider facility agrees to the suggested alternative remedy, the Department shall enter an order permitting the provider facility’s continued participation in the Program subject to the alternative remedy. Such an order shall require compliance with the alternative remedy even though the provider may still be contesting the basis for the Department’s findings and determination; however, such an order shall not require the provider to make payment of any civil monetary penalty until and unless the Department’s determination is sustained by a final order.

If the provider facility’s appeal of the Department’s determination is sustained by a final order, the provider facility may obtain payment for residents admitted to the facility after the effective date of any limitation on new admissions, as permitted by such final order, under 55 Pa. Code § 1101.77(c)(3)(i). The costs of providing temporary management pursuant to 42 U.S.C.A. § 1396r(h)(2)(iii) are borne by the Department.

**Source**

The provisions of this Appendix O adopted October 6, 1989, effective October 1, 1989, 19 Pa.B. 4278.

**APPENDIX P**

**INITIAL RESIDENT REVIEWS REQUIRED BY  
OBRA-87 LEGISLATION**

(a) Several counties were involved as LAMP sites, and OBRA screenings began on January 1, 1989. Therefore, nursing facilities shall complete the PA-PASARR-ID forms and, if necessary, the Facility Report Form for individuals who were admitted prior to January 1, 1989.

(1) The January 1, 1989 date applies to the following counties:

Allegheny	Schuylkill
Erie	Westmoreland
Luzerne	Wyoming
Philadelphia	York

(2) Nursing facilities in the remaining 59 counties of this Commonwealth shall complete the PA-PASARR-ID form and the Facility Report Form (if necessary) for individuals who were admitted prior to March 1, 1989.

(b) When completing the PA-PASARR-ID form, the exemption for severe medical conditions, (question 1E), may be used for an individual in the target group, only if the person’s medical condition is so severe that the person is too sick to benefit from a plan of active treatment for mental illness, mental retardation or other related condition in the foreseeable future.

(c) A person whose PA-PASARR-ID form indicates that further assessment is needed, shall be identified by name, MA ID number (if applicable), and conditions to be assessed on the Facility Report Form. Instructions are available on the reverse side of the form.

(1) When completing the Facility Report Form, if more space is needed for additional names, copies should be made by the nursing facility. If a nursing facility has no individuals identified as needing further evaluation, this form still shall be completed and marked in the appropriate box as having no identified individuals. The completed form shall be returned January 8, 1990 to the following address:

Department of Human Services  
Office of Medical Assistance Programs  
Division of Long Term Care  
Client Services  
Post Office Box 2675  
Harrisburg, Pennsylvania 17105  
or  
FAX: (717) 731-7060

(2) This review does not include individuals who have been discharged from the nursing facility or who are deceased.

(3) Reviews of individuals identified as needing further evaluation to determine the need for active treatment will be done by the Inspection of Care teams. If possible, these reviews will be performed concurrent with the nursing facility's annual Inspection of Care review. If the Inspection of Care review has already occurred, and the next review is not due until after April 1, 1990, a member of the Inspection of Care team will come to the nursing home to review recipients identified as needing further evaluation.

(d) Failure to submit the required information in a timely manner may result in loss of MA funding for MA patients in the facility.

#### Source

The provisions of this Appendix P adopted December 22, 1989, effective December 23, 1989, 19 Pa.B. 5433.

### APPENDIX Q. [Reserved]

#### Source

The provisions of this Appendix Q adopted June 29, 1990, effective June 30, 1990, 20 Pa.B. 3596; reserved October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523. Immediately preceding text appears at serial pages (171927) to (171929).

**Cross References**

This appendix cited in 55 Pa. Code § 1181.53 (relating to payment conditions related to the recipient's initial need for care); and 55 Pa. Code § 1181.54 (relating to payment conditions related to the recipient's continued need for care).

[Next page is 1187-1.]

1181-154

(201524) No. 253 Dec. 95

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