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Part II

This part contains the
Department of Public Welfare
Intermediate Care Facilities for the
Mentally Retarded Program

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RULES AND REGULATIONS

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CHS. 1181, 6210 AND 6211]

Intermediate Care Facilities for the Mentally Retarded

Statutory Authority

The Department of Public Welfare (Department), by this order, adopts the amendments published at 22 Pa.B. 6171 (December 26, 1992) with the changes specified in Annex A, under the authority of section 443.1(2) and (3) of the Public Welfare Code (62 P. S. § 443.1(2) and (3)).

Notice of proposed rulemaking was published at 22 Pa.B. 6171 (December 26, 1992).

Purpose of the Amendments

The Department is amending portions of Chapter 1181 (relating to nursing facility care) and creating a new chapter of regulations applying exclusively to Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). The new chapter entitled "Participation Requirements for the Intermediate Care Facilities for the Mentally Retarded Program" is located at Chapter 6210. The purpose of these regulations is to specify the requirements for State operated and nonState operated ICFs/MR to receive payment for services through the Medical Assistance (MA) Program.

The Department is also making changes and renumbering Chapter 1181, Subchapter C (relating to allowable cost reimbursement for nonState intermediate care facilities for the mentally retarded) as new Chapter 6211. Content changes include clarification and codification of existing Departmental policy. The Department is relocating this subchapter to the mental retardation section of Title 55, since these regulations apply exclusively to ICFs/MR. The purpose of these regulations is to specify the requirements for MA reimbursement and allowable costs for nonState operated ICFs/MR.

Need for the Amendments

The relocation of participation requirements for ICFs/MR is needed to clearly specify and separate the requirements for ICFs/MR from the requirements applying to nursing facilities. Due to changes that will be made in the future to Chapter 1181, Subchapter A as a result of the Omnibus Budget Reconciliation Act of 1987 (42 U.S.C.A. § 1396r), Chapter 1181, Subchapter A is no longer an appropriate location for participation requirements for ICFs/MR. These amendments are also needed in order to clarify the requirements applicable to the ICF/MR program for ICF/MR providers. There are also a few differences from the format, language and content specified in the current Chapter 1181, Subchapter A regulations. The major changes from the current regulations were specified in the Summary of Major Changes portion of the preamble for proposed rulemaking published at 22 Pa.B. 6171. These regulations are necessary to retain Federal ICF/MR funding in both State operated and nonState operated ICFs/MR.

The content amendments to Chapter 1181, Subchapter C are technical revisions to clarify existing regulations, eliminate unnecessary regulations and codify existing Departmental policy. The relocation of the requirements for allowable cost reimbursement for nonState ICFs/MR from Chapter 1181, Subchapter C to Chapter 6211 is needed to consolidate the fiscal requirements for ICFs/MR into the mental retardation section of Title 55.

Drafts of the revised Chapter 6210 and the Department's proposal to revise and renumber Chapter 1181, Subchapter C were distributed for review and comment to all ICF/MR providers and State associations prior to publication as proposed rulemaking. The draft amendments were also reviewed and discussed in detail on several occasions at the Statewide ICF/MR Provider Task Force meetings. The Statewide task force meetings included representatives from almost each individual ICF/MR agency in this Commonwealth, as well as the major provider associations in this Commonwealth. Comments received from providers and associations have been carefully reviewed, and incorporated where appropriate, into the regulations.

The regulations were proposed in the *Pennsylvania Bulletin* on December 26, 1992, with a 30-day comment period. A summary of the public comments and the Department's response to those comments are contained in this preamble in the section titled "Public Comment and Summary of Changes."

Affected Individuals and Organizations

These regulations affect individuals who receive services in ICFs/MR, nonState operated ICFs/MR and State operated ICFs/MR.

Benefits

These amendments benefit ICF/MR providers in that the renumbering of Chapters 6210 and 6211 will make it easier for providers to understand and access all the participation requirements that apply to them as ICFs/MR. The amendments clarify the difference in the participation requirements between ICFs/MR and nursing facilities.

The new § 6210.71(b) which relates to hospital leave allows ICFs/MR to bill for hospital reserve bed days in accordance with the limit imposed and therefore maintain timely cash flow. This amendment also eliminates excess reimbursement and avoids future audit disallowances.

Sections 6211.131—6211.135 (relating to conditions for movement of funds) benefit ICF/MR providers and the Department by reducing the paperwork required to submit and review waiver requests. This change allows providers greater flexibility to manage their internal budgets without Department oversight.

The changes to the tentative cost settlement procedures in § 6211.134 (relating to cost reporting) will offer cash flow relief to ICF/MR providers. The tentative cost settlements will now reflect the amounts due to providers by the Department, as well as amounts owed by providers to the Department. These changes will be initially effective during Fiscal Year 1995-96.

Public Comment and Summary of Major Changes

Written comments, suggestions and objections were requested within a 30-day period after the publication date of the proposed amendments. The Department received a letter of support for the amendments as proposed from one Statewide provider association. The

association commented that the amendments allow greater flexibility for ICF/MR providers and reflect the operational differences between ICFs/MR and other long-term care and nursing facilities. Two individual ICF/MR providers also submitted comments on the proposed rulemaking. Following is a summary of the comments received and the Department's response to those comments.

General

The Independent Regulatory Review Commission (IRRC) recommended that the Department streamline the ICF/MR system regarding the duties of the Inspection of Care Team, State licensure, utilization review, the attending physician's review and the interdisciplinary team process.

Response: No comments from ICF/MR providers or State provider associations were received on this issue. The Department agrees that the ICF/MR system is extremely complex in the areas of program as well as fiscal requirements. However, most of the requirements and duties addressed by IRRC are mandated by Federal Medicaid law and Federal Health Care Financing Administration regulations (42 CFR 456.350). These Federal requirements must be met in order for the Commonwealth to maintain eligibility for over $280 million in Federal financial support it receives each year for the ICF/MR program. Noncompliance with Federal law or regulations would result in the loss of a substantial amount of Federal financial support ($280 million per year) that could not be readily replaced by State funding. Loss of Federal funding would most likely result in loss or reduction of services to many people with mental retardation who now live in ICFs/MR.

While the Department agrees that some of the Federal requirements are overlapping, some duties specified by IRRC as being duplicative are very separate and distinct processes. For example, the purpose of the attending physician's review is to assess the individual's medical need for this type of Medicaid program. The purpose of the interdisciplinary team review is to work with the individual to discuss the individual's wants and needs and help develop the most effective and meaningful program possible for the individual. While these two processes both relate to the assessment of an individual, the purposes and intent are very different. Again, these requirements are mandated by the Federal regulations in order for the Commonwealth to be eligible for Federal funding.

Of those responsibilities listed by IRRC as overlapping with other duties or functions, licensing is the one responsibility that is mandated by State statute and not by Federal law. Article X of the Public Welfare Code (62 P. S. §§ 1001—1009) requires the Department to annually inspect "mental health establishments." See 62 P. S. § 1001. The broad definition of mental health establishment includes ICFs/MR. Licensing is therefore the only function of the ICF/MR system that is completely within the Department's statutory and regulatory control. In a deliberate and thoughtful manner, the Department has decided that rather than apply a separate and possibly duplicative system of licensing requirements, it will adopt the Federal program certification requirements as our State's licensing regulations. To further eliminate duplication, the Department contracts annually with the Department of Health to purchase licensing inspection services from the State agency responsible for inspecting ICFs/MR for certification purposes. By doing this, the Department has eliminated not only dual systems of regulation for licensing and funding, but also eliminated having two State agency inspection teams inspecting the same facility to measure regulatory compliance.

§ 6210.2. Applicability.

To clarify that this chapter applies to Intermediate Care Facilities for Persons with Other Related Conditions (ICFs/ORC), the Department has added a new subsection (b).

ICF/ORC is currently included in the Federal definition of ICF/MR at 42 CFR 483.400. ICFs/ORC were included in the proposed definition of ICFs/MR.

New subsections (c) and (d) have also been added to clarify that certain sections of Chapter 6210 apply differently or do not apply at all for ICFs/ORC.

§ 6210.3. Definitions.

To clarify that the participation requirements for ICFs/MR also apply to ICFs/ORC, the Department has added a separate definition of ICF/ORC which corresponds with the Federal definition at 42 CFR 435.1009. Under Federal law, reference to ICFs/MR include ICF/ORC.

The Department has recently initiated a new funding program for ICFs/ORC and has adopted this chapter of ICF/MR participation requirements. This revision clarifies existing policy for ICFs/ORC.

§ 6210.35. Ongoing provider responsibilities.

IRRC suggested that § 6210.35(b) be amended to delete the word "the" between "for" and "managing."

Response: This change has been made.

One commentator suggested that §§ 6210.35(b)(1) and (2) were misleading and could result in improper disposition of personal funds upon an individual's death. The commentator suggested that the entity from which funds originated, such as Social Security Administration or the Railroad Retirement Board, may have some authority over funds remaining in a decedent's bank account.

Response: These two paragraphs are identical to the current Chapter 1181, Subchapter A regulations and to date there has been no confusion as to the meaning of these paragraphs. The regulations require that $1,000 from a decedent's personal bank account can be used by the facility for burial purposes if no relative takes responsibility for burial of the decedent. As for the remaining monies in the decedent's account, the entity from which the funds originated has no authority over these funds.

IRRC suggested that § 6210.35(b)(1) be amended to clarify the phrase "qualified funeral director." IRRC also suggested revision of § 6210.35(b)(1) and (2) to clarify when a provider should contact a funeral director.

Response: The Department made these suggested changes.

§ 6210.44. Evaluations.

One commentator raised questions about the requirement in subsection (a) to require an evaluation of the need for ICF/MR care prior to admission, as it relates to individuals transferring from one facility to another. The commentator also suggested changing the time frame in subsection (a) from 3 months to 12 months. Two commentators suggested that the requirement in subsection (c), to submit evaluations to the Department for review, be eliminated.

Response: This section is the same as the current requirements in Chapter 1181, Subchapter A. If an individual moves from one ICF/MR to another ICF/MR, this is not considered a new admission and therefore new evaluations are not required. The evaluations may be transferred with the individual from one facility to another. This clarification was added to the regulations in subsection (b).

The 3-month time frame for completion of psychological evaluations is a Federal regulation, published at 42 CFR 456.370(b), and as such, it is not within the Department's jurisdiction to revise.

The Department concurs with the recommendation to eliminate the requirements in subsection (c) to submit evaluations to the Department. The proposed subsection (c) has been deleted.

§ 6210.46. Plan of care.

One commentator suggested that this section contradicts § 6210.47 (relating to continued review of plan of care) and that § 6210.46 requires a unidisciplinary rather than interdisciplinary model of care.

Response: The Department did not propose a change in this requirement from the current Chapter 1181, Subchapter A. These requirements are mandated by Federal regulations as participation requirements for the Federal Medicaid program. Section 6210.46 requires that an initial plan of care be developed prior to admission to an ICF/MR, as mandated at 42 CFR 456.380 (relating to individual written plan of care). Section 6210.47 requires that the plan of care be reviewed every 90 days, as mandated at 42 CFR 456.380(c) (relating to individual written plan of care). These are two separate and distinct requirements. Section 6210.47 requires that the plan of care be developed by an interdisciplinary team. No change was made to these proposed sections.

§ 6210.52. Payment pending appeal.

IRRC recommended that the language in § 6210.50 (relating to recipient notice of adverse decisions) regarding the 10 calendar day period be added to this section.

Response: The Department made this change.

§ 6210.61. Eligibility for an ICF/MR level of care.

One commentator suggested that the ICF/MR program establish varied levels of care rather than a single level of care.

Response: Differing levels of care are not necessary in the ICF/MR program since the Department establishes individualized rates for each ICF/MR based upon the needs of each individual. By setting individualized rates, the Department is more reflective of the needs of individuals than if different levels of care were used with associated cost reimbursement. It would be regressive for ICF/MR providers to revert to different levels of care as the sole factor for determining rate setting. The majority of ICF/MR providers have been continually opposed to using separate levels of care to establish reimbursement rates.

The Department did not make any revisions to this section.

§ 6210.62. Level of care criteria.

In accordance with the changes made in § 6210.2 and 6210.3 (relating to applicability; and definitions) to clarify that these participation requirements for ICFs/MR also apply for ICFs/ORC, subsection (c) was added to clarify the diagnosis for applicants or recipients of ICF/ORC care.

§ 6210.71. Limitations on payment for reserved bed days.

IRRC suggested that the definitions of "hospital leave" and "therapeutic leave" be relocated to § 6210.3 (relating to definitions).

Response: The Department did not make this change. No comments from providers of service were received on this section. Regulation drafting literature and policy from the Legislative Reference Bureau supports including the definition of a word or phrase that is used only once, in the body of the regulations, immediately preceding the use of the word or phrase.

IRRC and one commentator suggested adding reference to each hospitalization in subsection (b).

Response: This clarification was added.

§ 6210.72. Limitations on payment for prescription drugs.

A provider inquired about the specific drugs that are noncompensable under the Medical Assistance program and whether noncompensable drug costs could be included in the per diem rate.

Response: Chapter 1121 entitled "Pharmaceutical Services" specifies which drugs are and are not compensable under the Pennsylvania Medical Assistance Program. If a specific drug is not reimbursable directly under Chapter 1121, the ICF/MR provider may include the cost of the drug under the ICF/MR per diem rate.

§ 6210.73. Limitations on payment during strike or disaster situations requiring recipient evacuation.

A suggestion was received to allow an exception to the need for certification when no other certified facility is available to receive recipients.

Response: This regulation has not been changed from Chapter 1181, Subchapter A. In accordance with Federal regulation (42 CFR 442.12), even in the event of an emergency during which time people need a temporary relocation, ICF/MR monies may only be used in certified facilities. The Federal Medicaid regulations do not permit Pennsylvania to use ICF/MR monies for any days during which a person is living in a noncertified facility. The intent of this requirement is to assure the health and safety of individuals at all times Federal monies are utilized.

§ 6210.74. Services included in the interim per diem rate.

IRRC suggested that the Department clarify the terms "medical supplies" in paragraph (1) and "health care supplies" in paragraph (3). IRRC further questioned the definitions and meaning of items listed in paragraphs (2), (4) and (7).

Response: The Department did not receive any public comments on this section. This section was not changed from the current Chapter 1181, Subchapter A regulations.

This chapter of regulations is one of many chapters of Medical Assistance regulations that providers must be well versed in to participate in the ICF/MR program as well as other Medicaid programs. Providers receive relevant regulations as part of their provider handbook upon enrollment in the Pennsylvania Medical Assistance Program. Providers routinely receive clarifications and revisions of these regulations. For example, "medical supplies" are defined and regulated at Chapter 1123 entitled "Medical Supplies."

§ 6210.75. Noncompensable services.

IRRC questioned how paragraph (4) will affect a facility's reimbursement for items listed in § 6210.74. IRRC questioned who would be responsible to absorb the cost, if the cost of an item was disallowed by Medicare.

Response: No public comments were received on this section. This section was not revised from the current Chapter 1181, Subchapter A.

This section applies to covered, allowable services, which Medicare has already reimbursed up to a limit or which Medicare has disallowed for various reasons. The Department believes that ICF/MR funds should not be used for services or items that Medicare would have covered but has disallowed because the individual did not need the service or the service was paid for through another source. A cost that is not directly allowed under the Pennsylvania Medical Assistance Program may be included in the ICF/MR per diem rate. An item or service that an individual needs or that is required for Federal ICF/MR certification is reimbursable by ICF/MR funds.

§ 6211.2. Applicability.

The Department clarified applicability of this chapter to ICFs/ORC. The Department has recently initiated a new funding program for ICFs/ORC and has adopted that chapter of ICF/MR reimbursement requirements. This revision clarifies existing policy for ICFs/ORC.

§ 6211.4. Definitions.

The Department clarified applicability of this chapter to ICFs/ORC.

§ 6211.33. Denied waiver.

At the request of providers of service and the Department's legal counsel, the Department added § 6211.33(b) regarding the provider's right to appeal waiver denials. Providers are currently unclear about whether waiver decisions can be appealed. This new subsection will clarify that providers may appeal a waiver denial.

It appears that providers sometimes appeal a standard rate because they believe that if they accept a standard rate, later during the year when they submit a waiver due to a cost change, a waiver denial is not appealable. The addition of this subsection will clarify the provider's right to appeal waiver denials and subsequently decrease appeals of standard rates. The authority for the provider's right to appeal waiver denials is found at § 1101.84(c) (relating to provider right to appeal), which is consistent with this amendment.

§ 6211.79. Depreciation allowance.

The Department is revising § 6211.79(s)(1) (relating to the source for establishing depreciation cost limits). The current regulations reference the "Dodge Cost Information Systems Cost for Building Construction" published by McGraw-Hill. This publication has been discontinued and therefore cannot be used to establish depreciation cost limits. The Department is therefore substituting the "Repair and Remodel Quarterly" by Marshall and Swift. The "Repair and Remodel Quarterly" is virtually the same as the Dodge Report.

As a result of a Commonwealth Court decision, *Lebanon County Life Support Facility v. DPW*, 2632 C. D. 1991 (Pa. December 3, 1992), the Department added subsection (t) to clarify the requirements relating to reimbursement for depreciation in ICFs/MR. The Court found that the Department's regulations relating to reimbursement for depreciation were unclear and the Department was ordered to reimburse the provider for the depreciation of assets that were previously purchased under another funding stream.

This amendment clarifies that depreciation cost is not allowable for assets expensed under another State or Federal funding stream. This amendment is consistent with the Department's intent of participating in the cost of property acquisition only once, and only if no other funding source has participated in the property's acquisition costs.

§ 6211.131. Conditions for movement of funds.

One provider suggested that uses of the terms "program" and "facility" are unclear.

Response: The terms selected for this section were discussed and reviewed at length with the Statewide ICF/MR Task Force, which represents ICF/MR providers and the three major State provider associations. The specific language in this section was developed and approved by this Task Force. No other objections or questions about this language were received. No revisions were made to this section.

§ 6211.134. Cost reporting.

In response to concerns from providers, the Department has revised the requirements relating to cost reporting. This section has been revised to include a change in the tentative cost settlement procedures. Since 1981-82, nonState operated ICFs/MR and the major provider associations have consistently argued that the Department should both pay-out and collect at the time of tentative cost settlements. Several Statewide provider associations have identified a concern that by allowing the movement of funds in accordance with § 6211.131 (relating to conditions for movement of funds) and then subsequently issuing tentative cost settlements on a site-by-site basis, there may be increased overpayments due by providers to the Department. While ICF/MR providers fully support the ability to move funds across programs the facility operates, they are concerned about the possible overpayments that may result.

The Department, in consultation with providers, has reviewed various alternatives and developed a procedure to both collect and reimburse providers at the time of tentative cost settlements. As a result of this change in the timing of payment, nonState operated ICF/MR providers will receive payment approximately 1 year earlier than the current 2-year period between the close of the fiscal year and final cost settlement.

§ 6211.352. Departmental decision.

IRRC suggested that this section from Chapter 1181, Subchapter C (relating to a time frame for the Department to make a decision on waiver requests) be maintained in the new Chapter 6211 regulations.

Response: No public comments were received on this issue. This section was intentionally proposed for revision as part of the proposed rulemaking published at 22 Pa.B. 6171. The current regulation in § 1181.352 requires the Department to notify providers of the Department's

decision on waiver requests within 60 days after the waiver request is received.

The Department is deleting former § 1181.352 pertaining to waivers because the 60-day time limit imposed in this section created confusion in the ICF/MR provider community. Specifically, providers believed that a new rate which resulted from a waiver approval would be established within 60 days after the Department's receipt of a waiver request. The Department's intention, however, was to determine whether the prerequisites for a waiver found in former § 1181.351 **(renumbered to 6211.31) were met and that a preliminary determination of the waiver request would be accomplished within 60 days. In order to alleviate this confusion, the Department decided to delete former § 1181.352. Furthermore,** the deletion of former § 1181.352 removes self-regulation of the Department with respect to the 60-day time limitation. Given the Department's existing resources and the complexity of data submitted by providers in requesting a waiver, issues cannot be resolved within a 60-day time frame.

In addition, the Department's regulatory provisions for waiver requests go beyond Federal requirements regarding ICF/MR reimbursement. Federal law neither suggests nor requires a waiver process. As a matter of policy, the Department has instituted waiver procedures to give ICF/MR providers an opportunity to seek reimbursement for unanticipated costs.

Federal law only requires payment on a yearly basis to Medical Assistance providers. However, the Department's reimbursement system provides for interim payments to providers for cash flow purposes. While waiver decisions are pending, providers are still receiving interim payments from the Department for services provided. Providers are therefore not being deprived of any rights with respect to reimbursement during the pendency of waiver requests.

Fiscal Impact

These amendments will allow nonState operated ICFs/MR to be reimbursed the full per diem rate for hospital leave days up to a maximum of 15 consecutive days per hospitalization. Since the reimbursement is limited to the actual, allowable, reasonable costs at final settlement, this change does not increase costs but is expected to result in a temporary cash flow impact.

The prior **regulations allow nonState operated ICFs/MR to bill for 1/3 of their per diem rate for** hospital days up to a maximum of 15 consecutive days per hospitalization. Several new sections have been added to permit agencies that operate multiple programs to move up to 10% of the approved funding level of any program across other programs the facility operates. These new sections codify existing Departmental policy. This change is expected to reduce the number of waivers and the paperwork and workload associated with the current waiver process used to request increases while not increasing costs.

The new procedure developed in response to provider concerns about § 6211.134 (relating to cost reporting), to reimburse providers as well as to collect at the time of tentative cost settlement, has budget implications. Due to budget implications, the Department will implement the revised § 6211.134 on July 1, 1995. Beginning in FY 1995-96, pay-outs to providers, in cases of under payment would be 80% of the difference between the amount paid to the provider through the Medical Assistance Management Information System (MAMIS) report and the provider's unaudited reported costs, as shown on the cost report, up to the provider's approved funding level. This change will be implemented with FY 1994-95 tentative cost settlements, which would be issued in Spring 1996. Implementation of this change for FY 1995-96 would require an estimated $2.2 million in total funds ($1 million State funds). The maximum pay-out will be 80%, with 20% of the amounts held back for future adjustments, eventually payable to providers at the time of final cost settlement following audit.

While this change represents a cash flow item between budget years, it does **not result in an overall increase in** costs to the program. Rather than waiting approximately 2 years to pay-out to providers at the time of final cost settlements, these changes will allow the Department to pay-out to providers at an 80% level at the time of tentative cost settlement, thus offering some relief in cash flow to providers.

Paperwork Requirements

No additional paperwork or recordkeeping will be required as a result of these amendments.

Effective Date

These amendments are effective retroactive to July 1, 1994, with the exception of § 6211.134 (relating to cost reporting) which will be effective on July 1, 1995.

Sunset Date

The effectiveness of the amendments will be evaluated as part of the Department's annual preparation of the rebudget for the upcoming fiscal year.

The Department holds quarterly ICF/MR task force meetings that are open to providers and State associations. During those meetings, the impact of these amendments will be continually reviewed and discussed.

Contact Person

Questions on these regulations should be directed to Karen E. Kroh, Chief, Section of Regulatory Administration, Office of Mental Retardation, Department of Public Welfare, Room 512, Health and Welfare Building, Harrisburg, PA 17120, (717) 783-3636.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), the agency submitted a copy of the notice of proposed rulemaking, published at 22 Pa.B. 6171 (December 26, 1992), to IRRC and to the Chairpersons of the House Committee on Health and Welfare and the Senate Committee on Public Health and Welfare for review and comment. In compliance with section 5(b.1) of the Regulatory Review Act, the agency also provided IRRC and the Committees with copies of all comments received during the public comment period, as well as other documentation requested.

In preparing these final-form regulations, the agency has considered all comments received from IRRC, the Committees and the public.

These final-form regulations were approved by the House and Senate Committees on September 15, 1994, and were approved by IRRC on September 14, 1994, in accordance with section 5(c) of the Regulatory Review Act.

Findings

The Department of Public Welfare finds that:

(1) Public notice of intention to amend the **administrative regulations amended by this order has** been given **under sections 201 and 202 of the act of** July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and the regulations thereunder at 1 Pa. Code §§ 7.1 and 7.2.

(2) The adoption of these amendments in the manner provided in this order is necessary and appropriate for the administration and enforcement of the Public Welfare Code.

Order

The Department of Public Welfare, acting under the Public Welfare Code, orders that:

(a) The regulations of the Department of Public Welfare, 55 Pa. Code, are amended by

(1) Deleting §§ 1181.301—1181.304, 1181.331—1181.338, 1181.351—1181.355, 1181.361—1181.368, 1181.**391—1181.394, 1181.401—1181.412, 1181.412a,** 1181.413—1181.420, 1181.431, 1181.441—1181.444, 1181.451—1181.454 and Appendix Q; and by

(2) Adding §§ 6210.1—6210.3, 6210.11—6210.14, 6210.21, 6210.22, 6210.31—6210.35, 6210.41—6210.52, 6210.61—6210.65, **6210.71—6210.82,** 6210.91—6210.94, 6210.101—6210.109, 6210.111—6210.116, 6210.121—6210.125, 6211.1—6211.4, **6211.11—6211.18,** 6211.31—6211.34, 6211.41—6211.48, 6211.61—6211.64, 6211.71—6211.87, 6211.101, 6211.111—6211.114, 6211.121—6211.124 and 6211.131—6211.135 to read as set forth in Annex A.

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

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

(d) This order shall take effect immediately and apply retroactively to July 1, 1994, with the exception of § 6211.134 (relating to cost reporting), which shall take effect July 1, 1995. As of July 1, 1994, 55 Pa. Code Chapter 1181, Subchapter A does not apply to ICFs/MR and ICFs/ORC.

(e) Chapter 1181, Subchapter C is renumbered as Chapter 6211, and amended as specified in Annex A.

KAREN F. SNIDER,
Secretary

Fiscal Note: 14-396. (1) General Fund; (2) Implementing year 1993-94 is $0; (3) 1st succeeding year 1994-95 is $439,000; 2nd succeeding year 1995-96 is $1,013,000; 3rd succeeding year 1996-97 is $1,033,000; 4th succeeding year 1997-98 is $0; 5th succeeding year 1998-99 is $0; (4) FY 1992-93 $93,925,000; FY 1991-92 $86,565,000; FY 1991-90 $79,640,000; (7) Department of Public Welfare—Intermediate Care Facilities for the Mentally Retarded; (8) recommends adoption.

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 24 Pa.B. 4945 (October 1, 1994).)

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1181. NURSING FACILITY CARE

Subchapter C. (Reserved)

Appendix Q. (Reserved)

PART VIII. MENTAL RETARDATION MANUAL

Subpart C. ADMINISTRATION AND FISCAL MANAGEMENT

CHAPTER 6210. PARTICIPATION REQUIREMENTS FOR THE INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED PROGRAM

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GENERAL PROVISIONS

§ 6210.1. Purpose.

The purpose of this chapter is to specify the requirements for State operated and nonState operated ICFs/MR to receive payment for services through the MA Program.

§ 6210.2. Applicability.

(a) This chapter applies to State operated and nonState operated ICFs/MR.

(b) This chapter applies to nonState operated ICFs/ORC.

(c) Section 6210.63(1) (relating to diagnosis of mental retardation) does not apply to ICFs/ORC.

(d) If a provision specified in Chapter 1101 (relating to general provisions) is inconsistent with this chapter, this chapter prevails.

(e) If a provision specified in this chapter is inconsistent with Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded), Chapter 6211 prevails.

§ 6210.3. Definitions.

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

CAO—County Assistance Office.

Department—The Department of Public Welfare of the Commonwealth.

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

ICF/MR—Intermediate care facility for the mentally retarded (facility)—A State operated or nonState operated facility, licensed by the Department in accordance with Chapter 6600 (relating to intermediate care facilities for the mentally retarded), to provide a level of care 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.

ICF/ORC—Intermediate care facility for persons with other related conditions (facility)—A nonState operated facility, licensed by the Department in accordance with Chapter 6600, to provide a level of care specially designed to meet the needs of persons with other related conditions who require specialized health and rehabilitative services; that is, active treatment. Persons with other related conditions are persons with severe physical disabilities, such as cerebral palsy, spina bifida, epilepsy or other similar conditions which are diagnosed prior to age 22 and result in at least three substantial limitations to activities of daily living.

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.

MA—Medical Assistance.

Reserve bed day—A day counted in the facility census, subject to limits, during which a recipient is temporarily absent from the facility for more than a continuous 24-hour period either for hospitalization or therapeutic leave.

GENERAL REQUIREMENTS

§ 6210.11. Payment.

(a) The MA Program provides payment for intermediate care for the mentally retarded provided to eligible recipients by providers enrolled in the MA Program.

(b) Payment for services is made in accordance with this chapter, Chapter 1101 (relating to general provisions), HIM-15, the Medicaid State Plan, Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded) and the Department's "Cost Apportionment Manual for State Mental Hospitals and Mental Retardation Centers" for State operated ICFs/MR.

§ 6210.12. Applicable statutes and regulations.

The facility shall comply with applicable Federal, State and local statutes and regulations, including Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396u) and the regulations promulgated thereunder, and sections 443.1—443.6 of the Public Welfare Code (62 P. S. §§ 443.1—443.6).

§ 6210.13. Licensure.

ICFs/MR shall be licensed by the Department in accordance with Chapter 6600 (relating to intermediate care facilities for the mentally retarded).

§ 6210.14. Time extensions.

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

(b) Extensions of time in addition to the time otherwise specified for providers in 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 or because of an intervening natural disaster making timely compliance impossible or unsafe.

(c) This section supersedes 1 Pa. Code § 31.15 (relating to extensions of time).

SCOPE OF BENEFITS

§ 6210.21. Categorically needy and medically needy recipients.

Categorically needy and medically needy recipients are eligible for ICF/MR subject to the conditions specified in this chapter, Chapters 1101 and 6211 (relating to general provisions; and allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded).

§ 6210.22. State Blind Pension recipients.

State Blind Pension recipients are not eligible for ICF/MR under the MA Program. Blind and visually impaired individuals are eligible for ICF/MR services if they qualify as categorically or medically needy recipients.

PROVIDER PARTICIPATION

§ 6210.31. Provider agreement.

The facility shall enter into a written provider agreement with the Department's Office of Medical Assistance Programs.

§ 6210.32. Budgets and cost reports for State operated facilities.

(a) State operated ICFs/MR shall submit budgets to the Department's Office of Mental Retardation.

(b) State operated ICFs/MR shall submit cost reports to the Department's Bureau of Financial Operations.

§ 6210.33. Budgets and cost reports for nonState operated facilities.

(a) NonState operated ICFs/MR shall submit cost reports or a budget, if a waiver is granted in accordance with Chapter 6211, to the Department's Office of Mental Retardation.

(b) Cost reports and budgets shall be submitted on forms and by deadlines specified by the Department.

§ 6210.34. Approved funding level.

The Department's Office of Mental Retardation is responsible for establishing an approved funding level for nonState operated ICFs/MR.

§ 6210.35. Ongoing provider responsibilities.

(a) A utilization review plan shall be submitted to the Department's Office of Medical Assistance Programs.

(b) A system for managing recipients' funds that is in compliance with 42 CFR 483.420 (relating to conditions of participation: client protections) shall be in operation. If a recipient dies and there is no will, and if no relative or friend takes responsibility for burial, the following requirements apply:

(1) The facility may make payment of funds for burial expenses, if funds remain in the decedent's personal care account.

(2) Payment may be made only to a person licensed as a funeral director by the Department of State for a debt due and owing and may not exceed $1,000.

(3) The payment may be made whether or not a personal representative has been appointed.

(4) Under 20 Pa.C.S. § 3101 (relating to payments to family and funeral directors), a facility making the payment is released from responsibility to the same extent as if payment had been made to an appointed personal representative of the decedent. The facility is not required to oversee the manner in which the funeral director applies the payment.

(c) A cost report shall be filed with the Department's Office of Mental Retardation for nonState operated **ICFs/MR and with the Department's Bureau of Financial** Operations for State operated ICFs/MR within the time limit specified in § 6210.77 (relating to cost finding) if the facility is continuing its participation in the MA Program or within the time limit specified in § 6210.92 (relating to final reporting) if the facility is sold, transferred by merger or consolidation, terminated or withdraws from participation in the MA Program.

(d) Cost reports shall meet the requirements specified in § 6210.79 (relating to setting interim per diem rates).

(e) An onsite inspection shall be conducted at least annually by the Department's Office of Medical Assistance Programs Inspection of Care Team to determine compliance with the regulations at 42 CFR 456.600 (relating to purpose).

(f) Within 30 days of receipt of the inspection of care team report, the facility shall submit a written response, if required by the Department.

(g) The facility shall submit changes in ownership of persons having a direct or indirect interest of 5% or more in the facility to the Department's Office of Medical Assistance Programs.

(h) If the facility is a corporation, the facility shall submit changes in the name or address of corporate officers to the Department's Office of Medical Assistance Programs.

(i) The facility shall have a written transfer agreement with one or more general hospitals to provide needed diagnostic and other medical services to recipients, and under which acutely ill recipients may be transferred to ensure timely admission. Facilities that are based in hospitals are exempt from this subsection.

(j) 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 Department's Office of Medical Assistance Programs. The agreement in effect at the time of the ownership change shall be assigned to the new owner subject to applicable statutes and regulations and to the terms and conditions under which it was originally issued.

PAYMENT CONDITIONS

§ 6210.41. Payment available from other sources.

Payment will not be made by the Department if full payment, at the MA interim per diem rate, is available from another public agency, another insurance or health program, or the recipient's resources.

§ 6210.42. Certification of initial need for care.

(a) A physician shall certify in writing in the medical record that the applicant or recipient needs intermediate care for the mentally retarded.

(b) A nurse practitioner or clinical nurse specialist, who is not an employe of the facility, but who is working in collaboration with a physician, may complete the certification specified in subsection (a).

(c) The certification specified in subsections (a) and (b) shall be signed and dated not more than 30 days prior to either 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 intermediate care for the mentally retarded.

§ 6210.43. Recertification of continued need for care.

(a) A physician, a physician's assistant under the supervision of a physician or a nurse practitioner, or clinical nurse specialist shall enter into the recipient's medical record a signed and dated statement that the recipient continued to need intermediate care for the mentally retarded.

(b) In a nonState operated ICF/MR, the person who certifies the need for continued care specified in subsec-

tion (a), may not be an employe of the facility but shall work in collaboration with the recipient's physician.

(c) The recertification specified in subsection (a) shall be completed at least once every 365 days after initial certification.

§ 6210.44. Evaluations.

(a) Before admission to a facility, or before authorization for payment, an interdisciplinary team of health professionals shall make a comprehensive medical, social and psychological evaluation of each applicant's or recipient's need for intermediate care for the mentally retarded. The psychological evaluation shall be completed within 3 months prior to admission.

(b) If a recipient moves from one facility to another facility, this is not considered a new admission and new evaluations as required in subsection (a) are not required, if the prior evaluations are transferred with the recipient.

(c) Medical, social and psychological evaluations shall be recorded in the recipient's medical record and if applicable on forms specified by the Department.

§ 6210.45. Payment authorization.

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

(b) The notice from the Department will indicate the effective date of coverage and the amount of money the recipient has available to contribute toward the interim per diem rate.

(c) Obtaining the recipient's share of the interim per diem rate is the responsibility of the facility.

§ 6210.46. Plan of care.

Before admission to an ICF/MR, 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.

§ 6210.47. Continued review of plan of care.

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.

§ 6210.48. Reviews by the utilization review committee.

(a) 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.

(b) If the utilization review committee recommends that a recipient's level of care be changed, 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 kept in the recipient's medical record.

§ 6210.49. 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.

§ 6210.50. Recipient notice of adverse decisions.

Upon notification of the recommended change in 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.

§ 6210.51. Attending physician decision on level of care.

(a) 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.

(b) If the attending physician recommends that a recipient's level of care be changed, the attending physician shall document the change in the recipient's medical record and notify the Department of the level of care recommendation on the Attending Physician Request for Change Summary Form. A copy of the form shall be kept in the recipient's medical record.

(c) If the recipient's level of care is changed as a result of a determination by the Department's Inspection of Care Team, 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.

(d) The physician shall date and sign the documentation of the change in the recipient's medical condition and state the alternate care recommendation in the recipient's record.

§ 6210.52. Payment pending appeal.

If the recipient or the 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 10 calendar days from the date the notice is mailed, the Department will make payment to the facility for the level of care the recipient is presently receiving pending the outcome of the hearing. If the Department is sustained in its action, the Department will recover from the facility payment 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 10 calendar days from the date the notice is mailed, to the date that the appropriate change in the level of care for which payment is authorized is made.

ASSESSMENT

§ 6210.61. Eligibility for an ICF/MR level of care.

An applicant or recipient shall receive active treatment to be determined eligible for an ICF/MR level of care. The ICF/MR Program shall have only one level of care. The level of care determination is based upon the developmental needs of each applicant or recipient.

§ 6210.62. Level of care criteria.

(a) There are three fundamental criteria which shall be met prior to an applicant or recipient qualifying for an ICF/MR level of care. The ICF/MR level of care shall be indicated only when the applicant or recipient:

(1) Requires active treatment.

(2) Has a diagnosis of mental retardation.

(3) Has been recommended for an ICF/MR level of care based on a medical evaluation.

(b) A physician shall certify the ICF/MR level of care on a form specified by the Department and that ICF/MR services are needed, for each applicant and current ICF/MR resident. Before the facility requests payment from MA, the certification shall have been made at the time of admission, or at the time a resident applied for assistance while in an ICF/MR.

(c) For purposes of an ICF/ORC, subsection (a)(2) means a diagnosis of other related condition.

§ 6210.63. Diagnosis of mental retardation.

The facility shall document the applicant's or recipient's diagnosis of mental retardation by meeting the following requirements:

(1) A licensed psychologist, certified school psychologist or a licensed physician who practices psychiatry shall certify that the applicant or recipient has significantly subaverage intellectual functioning which is documented by one of the following:

(i) Performance that is more than two standard deviations below the mean as measurable on a standardized general intelligence test.

(ii) Performance that is slightly higher than two standard deviations below the mean of a standardized general intelligence test during a period when the person manifests serious impairments of adaptive behavior.

(2) A qualified mental retardation professional as defined in 42 CFR 483.430 (relating to condition of participation: facility staffing) shall certify that the applicant or recipient has impairments in adaptive behavior as provided by a standardized assessment of adaptive functioning which shows that the applicant or recipient has one of the following:

(i) Significant limitations in meeting the standards of maturation, learning, personal independence or social responsibility of his age and cultural group.

(ii) Substantial functional limitation in three or more of the following areas of major life activity:

(A) Self-care.

(B) Receptive and expressive language.

(C) Learning.

(D) Mobility.

(E) Self-direction.

(F) Capacity for independent living.

(G) Economic self-sufficiency.

(3) It has been certified that documentation to substantiate that the applicant's or recipient's conditions were manifest before the applicant's or recipient's 22nd birthday, as established in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C.A. § 6001).

§ 6210.64. Medical evaluation.

Applicants or recipients meeting the criteria for ICF/MR level of care shall have a medical evaluation completed by a licensed physician not more than 60 days prior to admission to an ICF/MR or before authorization for payment. The physician shall recommend the applicant or recipient for an ICF/MR level of care based on the medical evaluation.

§ 6210.65. Recertification.

(a) Recertification shall be on a form specified by the Department and based on the applicant's or recipient's continuing need for an ICF/MR level of care, progress toward meeting plan objectives, the appropriateness of the plan of care and consideration of alternate methods of care.

(b) Recertification of need for an ICF/MR level of care shall be made at least once every 365 days after the initial certification.

PAYMENT LIMITATIONS

§ 6210.71. Limitations on payment for reserved bed days.

(a) Hospital leave is a reserve bed day, limited in number, during which a client is temporarily absent from the facility for hospitalization.

(b) For each hospitalization, a recipient receiving intermediate care for the mentally retarded, except for a recipient in a State operated ICF/MR, is eligible for a maximum 15 consecutive reserve bed days for hospital leave. The Department will pay a facility at the interim per diem rate on file with the Department for a hospital reserve bed day. Subject to this limit, a facility may include hospital reserve bed days in its census as client days, and costs associated with hospital reserve bed days shall be included in the facility's cost report. A reserve bed will be available for the recipient upon the recipient's return to the facility.

(c) Therapeutic leave is a reserve bed day, subject to limits, during which the recipient is temporarily absent from the facility due to the need to obtain a component of the recipient's individual program plan which cannot be provided directly by the facility. Therapeutic leave is included in the recipient's individual program plan, and the facility is required to monitor and document therapeutic leave. Therapeutic leave is primarily intended to maintain and further enhance relationships between the recipient and his family. Therapeutic leave includes leave for camp or other special programs.

(d) The Department will make payment to a facility for a reserved bed day when the recipient is absent from the facility for a continuous 24-hour period because of therapeutic leave. Each reserved bed day for therapeutic leave shall be recorded on the facility's daily census record and invoice. A reserved bed shall be available for the recipient upon the recipient's return to the facility.

(e) 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.

(f) For each continuous 24-hour period the recipient is absent from the facility, the facility shall bill the Department for a therapeutic leave day, under the limitations in this chapter. When the continuous 24-hour period is broken, this will not count as a reserved bed day.

§ 6210.72. Limitations on payment for prescription drugs.

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

§ 6210.73. Limitations on payment during strike or disaster situations requiring recipient evacuation.

(a) Payment may continue to be made to a facility that has temporarily transferred recipients, as the result or threat of a strike or disaster situation, to the closest medical institution able to meet the recipients' needs, if the institution receiving the recipients is licensed and certified to provide the required level of care.

(b) If the facility transferring the recipients can demonstrate that there is no certified facility available for the safe and orderly transfer of the recipients, the payments may be made so long as the institution receiving the recipients is certifiable and licensed to provide the required level of care.

(c) If the facility to which the recipients are transferred has a different interim per diem rate, the transferring facility will be reimbursed at the lower rate.

(d) The facility shall immediately notify the Department, Office of Medical Assistance Programs, in writing of an impending strike or a disaster situation and shall include a listing of MA recipients and the facility to which they will be or were transferred.

§ 6210.74. Services included in the interim per diem rate.

The Department's interim per diem rate of reimbursement includes allowable costs for routine services. Services include the following:

(1) Regular room, habilitation services, personal care services, social services, therapeutic services, dietary services, general nursing services, other services required to implement the recipient's plan of care and to meet certification standards, medical supplies and the use of equipment and facilities.

(2) Items furnished routinely and relatively uniformly to recipients, such as personal clothing, furniture and recreational equipment.

(3) Items furnished, distributed or used individually in small quantities such as personal hygiene supplies, health care supplies and nonprescription drugs ordinarily kept on hand.

(4) Items used by recipients but which are reusable and expected to be available, such as household furniture, therapeutic equipment and durable medical equipment.

(5) Special dietary supplements used for tube feeding or oral feeding, such as an elemental high nitrogen diet, even if written as a prescription item by a physician.

(6) Laundry services including the laundering of the recipient's personal clothing.

(7) Other special medical services of a rehabilitative, restorative or maintenance nature, designed to restore or sustain the recipient's physical and social capacities.

§ 6210.75. Noncompensable services.

Payment will not be made for:

(1) Services provided to a recipient who no longer requires the level of care for which payment is authorized by the CAO.

(2) Reserved bed days that exceed the limits specified in § 6210.71 (relating to limitations on payment for reserved bed days).

(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 CAO.

(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. Chapters 1101 and 6211 (relating to general provisions; and allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded).

(6) Services directly reimbursable under the MA Program.

§ 6210.76. Cost reporting.

(a) 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 § 6210.91 (relating to annual reporting).

(b) The time frame for submission of cost reports may be extended for an additional 30 days with written approval from the Department's Office of Mental Retardation for nonState operated ICFs/MR and from the Department's Bureau of Financial Operations for State operated ICFs/MR.

(c) Cost reports shall be submitted on Department form MA-11.

(d) The cost report shall be prepared using the accrual basis of accounting and shall cover a fiscal period of 12 consecutive months.

(e) Facilities beginning operations during a fiscal period shall prepare a cost report from the date of approval for participation to the end of the facility's fiscal year.

(f) The cost report shall identify costs of services, facilities and supplies furnished by organizations related to the provider by common ownership or control.

§ 6210.77. Cost finding.

(a) The direct allocation method of cost finding shall be used.

(b) The costs of ancillary and administrative services shall be apportioned directly to the appropriate level of care based on appropriate statistical data.

(c) A facility's direct or indirect allowable costs related to care shall 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 recipients so that the share borne by MA is based upon actual services and costs related to MA recipients. For purposes of MA reimbursement, the return on net equity and net worth is not reimbursable.

§ 6210.78. Allowable costs.

(a) For State operated ICFs/MR, allowable costs shall be determined by the Department's "Cost Apportionment Manual for State Mental Hospitals and Mental Retardation Centers" and HIM-15.

(b) For nonState operated ICFs/MR, allowable costs shall be determined based on Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded) and HIM-15.

(c) State operated ICFs/MR shall be reimbursed actual allowable costs under the Statewide Cost Allocation Plan and Medicare principles, subject to MA regulations.

(d) NonState operated ICFs/MR shall be reimbursed actual, allowable reasonable costs under Chapter 6211 and other applicable MA regulations.

§ 6210.79. Setting interim per diem rates.

(a) For State operated ICFs/MR, interim per diem rates shall be established by the Department based on the latest adjusted reported costs and approved budgets.

(b) For nonState operated ICFs/MR, interim per diem rates shall 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 Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded).

§ 6210.80. 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 recipients for the same level of care.

(2) The facility's final interim per diem rate.

§ 6210.81. Upper limits of payment.

(a) The upper limits of payment for State operated ICFs/MR are the full allowable costs as specified in the Department's "Cost Apportionment Manual for State Mental Hospitals and Mental Retardation Centers" and HIM-15.

(b) The upper limits of payment for nonState operated ICFs/MR are the lower of costs or the total projected operating cost or if a waiver is granted under Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded) an approved budget level as specified in Chapter 6211.

§ 6210.82. Annual adjustment.

(a) An annual payment adjustment shall 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.

(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 in accordance with Chapter 1101 (relating to general provisions).

REPORTING AND AUDITING

§ 6210.91. Annual reporting.

The fiscal year, for purposes of MA payments, is July 1 through June 30.

§ 6210.92. Final reporting.

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 shall 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 § 6210.78 (relating to allowable costs).

§ 6210.93. 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 conduct either a field audit or desk review of each cost report within 1 year of the latter of its receipt in acceptable form, as defined in § 6210.78 (relating to allowable 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 Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded).

(4) The Department's "Cost Apportionment Manual for State Mental Hospitals and Mental Retardation Centers" for State operated ICFs/MR.

(5) HIM-15.

(6) The Department's cost allocation plan for State operated ICFs/MR.

(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 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) Financial and statistical records to support cost reports shall be available to State and Federal agents upon request.

§ 6210.94. Auditing requirements related to recipient fund management.

(a) Records relating to the facility's management of MA recipients' personal funds shall be maintained for at least 4 years.

(b) Records relating to the facility's management of MA recipients' personal funds shall be available to Federal and State representatives upon request.

(c) MA recipients' fund accounts shall be audited at the time the annual cost reports are validated for a facility.

(d) If discrepancies are proven and the facility is found to be at fault, the facility shall make restitution to the recipients for funds improperly handled, accounted for or disbursed.

(e) The facility has the right of appeal in accordance with §§ 6210.121—6210.125 (relating to right of appeal).

UTILIZATION CONTROL

§ 6210.101. Scope of claims review procedures.

Claims submitted for payment under the MA Program are subject to the utilization review procedures established in Chapter 1101 (relating to general provisions). In addition, the Department will perform the reviews speci-

fied in this section and §§ 6210.102—6210.109 for controlling the utilization of ICF/MR services.

§ 6210.102. Review of need for admission.

The Department's Inspection of Care 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 shall be notified of the decision on forms designated by the Department.

§ 6210.103. Inspections of care.

(a) The Department's Inspection of Care Team will inspect the care and services provided to each recipient in a participating facility at least annually.

(b) The Department will not give the facility more than 48 hours notice of the time and date of the schedule arrival of the team.

(c) The facility shall make available to the team, in a readily reviewable format, the recipient's complete medical records for the year since the last review of the team.

§ 6210.104. Content of inspections of care.

(a) The inspection by the Inspection of Care Team shall include:

(1) Personal contact with and observation of each recipient.

(2) Review of each recipient's medical record. The record shall 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 shall indicate time limits and measurable care objectives and goals to be accomplished and who is to give each element of care.

(b) The team shall determine in its inspection if:

(1) The services are available and adequate to meet the recipient's physical, mental and psychosocial needs.

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

(3) Each recipient is receiving active treatment.

(4) The recipient's medical and social evaluations and the plan of care are complete and current, are followed, and ordered services are provided and recorded.

(5) The recipient receives adequate services based on personal observations of the Inspection of Care Team.

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

(7) The recipient needs continued placement in the facility or there is an appropriate plan to discharge the recipient to an alternative living arrangement.

§ 6210.105. Inspection of care summary report.

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

(1) The alternate care determinations.

(2) 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.

(b) Within 45 days following the conclusion of the inspection, two copies of the summary report shall 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 shall give written responses to each area identified as deficient and to narrative recommendations.

(c) In advance of forwarding the summary report to the facility, the Inspection of Care Team shall notify the CAO and the facility of alternate care determinations made by the team.

§ 6210.106. Facility course of action.

(a) The 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 followup visit to determine if the deficiencies and recommendations are corrected.

§ 6210.107. Recipient right of appeal of alternate care determinations.

(a) The recipient or the person or the facility acting on the behalf of the recipient, in accordance with Chapter 275 (relating to appeal and fair hearing), has 30 days in which to appeal the Inspection of Care Team's alternate care determination.

(b) 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 its own behalf.

(c) 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 CAO issues the advance notice, payment for the present level of care will continue pending the outcome of the hearing subject to § 6210.52 (relating to payment pending appeal).

§ 6210.108. Facility utilization review.

(a) Each 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, 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 shall send written notice of adverse final decisions on the need for continued stay to:

(1) The facility administrator.

(2) The qualified mental retardation professional of the recipient.

(3) The CAO.

(d) The CAO shall 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 accordance with Chapter 275 (relating to appeal and fair hearing). Neither the facility nor the attending physician may appeal the decision of the utilization review committee on its own behalf.

§ 6210.109. Provider misutilization.

Facilities determined to have billed for services inconsistent with MA 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).

ADMINISTRATIVE SANCTIONS

§ 6210.111. Failure to file a cost report.

(a) Failure to file a cost report, other than a final cost report, 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 § 6210.76 (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 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 § 6210.92 (relating to final reporting) shall result in payment to the provider for the cost reporting periods involved being determined on the basis of the lowest audited rate for a provider, including a rate limited by §§ 6210.80 and 6210.81 (relating to maximum rate of payment; and upper limits of payment) for the same level of care without regard to the type of provider for services rendered during the 6 months immediately preceding the beginning of the fiscal periods involved. Payment will not 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 § 6210.92 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.

§ 6210.112. Failure to maintain adequate records.

(a) If the Department determines that the 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 shall be notified, by certified mail, that it has 60 days to correct the problem.

(b) The facility shall be advised that for failure to comply with the Department's notice, the Department will terminate the MA Provider Agreement, unless the problem is corrected within the 60-day period.

§ 6210.113. Failure to correct deficiencies.

(a) 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 United States Department of Health and Human Services on the Department, the penalty shall be imposed on the facility.

(b) Failure to correct deficiencies in recipient care and services within 6 months following the receipt of the Inspection of Care Team's review report may result in the termination of the facility's MA Provider Agreement.

§ 6210.114. 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 §§ 6210.42 and 6210.43 (relating to certification of initial need for care; and recertification of continued need for care) results in a penalty being imposed by the United States Department of Health and Human Services on the Department, the penalty will be imposed on the facility.

§ 6210.115. 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 § 6210.42 (relating to certification of initial need for care), which results in a penalty being imposed by the United States Department of Health and Human Services on the Department, the penalty will be imposed on the facility.

§ 6210.116. Failure to comply with requirements of maintaining recipient's funds.

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

RIGHT OF APPEAL

§ 6210.121. Decisions that may be appealed.

(a) The 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.

(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.

(b) Facilities participating in Medicare and the MA Program that are denied renewal of a 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 at 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.

§ 6210.122. Additional appeal requirements.

The appeal is subject to the requirements specified in § 1101.84 (relating to provider right of appeal).

§ 6210.123. Time limit for submission of appeal.

An appeal shall be taken within 30 days of the date that the facility is notified of the decisions specified in § 6210.121 (relating to decisions that may be appealed). 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 a subsequent appeal proceeding.

§ 6210.124. Submission of appeal.

An appeal shall be mailed to the Director, Office of Hearings and Appeals, Department of Public Welfare, Harrisburg, PA 17120, with a copy to the Office of Legal Counsel. The appeal request shall specify the issues presented for review.

§ 6210.125. Right to reopen audit.

(a) The Department may reopen a prior year's audit if an appeal is filed.

(b) 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 shall be bound by § 1101.84(b)(4) and (5) (relating to provider right of appeal).

(*Editor's Note:* The Department has moved the text of 55 Pa. Code Chapter 1181, Subchapter C, §§ 1181.301—1181.304, 1181.331—1181.338, 1181.351—1181.355, 1181.361—1181.368, 1181.391—1181.394, 1181.401, 1181.403, 1181.406—1181.406.12a, 1181.413—1181.420, 1181.431, 1181.441—1181.444 and 1181.451—1181.454, *Pennsylvania Code* pages 1181-102—1181-139, serial pages (138456), (135977)—(136000), (138457)—(138460), (136003)—(136012) and (141233) to new Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded). The new numbering format for Chapter 6211 is as follows. The appearance of three asterisks indicates that the text of the section remains the same. The complete text of amended sections has been printed.)

CHAPTER 6211. ALLOWABLE COST REIMBURSEMENT FOR NONSTATE OPERATED INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

GENERAL PROVISIONS

[§ 1181.301] § 6211.1 * * *

[§ 1181.302] § 6211.2. Applicability.

(a) This chapter applies to nonState operated intermediate care facilities for the mentally retarded and nonState operated intermediate care facilities for persons with other related conditions.

(b) The following chapters apply to nonState operated intermediate care facilities for the mentally retarded and nonState operated intermediate care facilities for persons with other related conditions: Chapter 1101 (relating to general provisions) and Chapter 6210 (relating to participation requirements).

(c) In addition to this chapter, the Medicare Provider Reimbursement Manual (HIM-15) applies for costs that are included in this chapter as allowable and for reimbursable costs that are not specifically addressed in this chapter.

(d) If this chapter is inconsistent with Chapter 6210 or HIM-15, this chapter shall prevail.

[§ 1181.303] § 6211.3. * * *

[§ 1181.304] § 6211.4. Definitions.

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

Allocate—To designate a specific task, service or supply to a specific cost center because of its direct relationship to client care and identifiable measure of application.

Allowable cost—The cost reimbursed under Medical Assistance, that is the facility's actual audited allowable cost after appropriate adjustments are certified by Commonwealth auditors.

Apportion—To divide costs that are necessary to program operation but that cannot be directly or entirely charged to a specific cost center.

Arms-length transaction—A transaction including independent unrelated parties (no interest such as equity, control, contracts, interlocking directorates, officers, and the like); and, a willing buyer and a willing seller.

Assets—Economic resources that are owned by a business and are expected to benefit future operations.

Budget—A plan of financial operation for some future period expressed in monetary terms.

Capital asset—An item with a useful life of more than 1 year or that would not meet Internal Revenue Service standards for nondepreciable assets. The term includes buildings, renovations and building improvements, and moveable items such as furniture and fixtures, computers and transportation equipment. Land is not a depreciable capital asset.

Change of ownership—The sale or transfer of a facility and all of its assets to another person, corporation, organization or partnership, with the expectation that the facility will continue to operate for the same purpose for which it is currently being used.

Closed audit—An audit is closed when the written audit report has been distributed and one of the following occurs:

(i) The period for appeal has passed.

(ii) An appeal has been concluded and finalized. The closed audit results in final settlement, which is either additional payments due to the provider or a repayment of funds dispersed to the provider for disallowed costs.

Compensation—The total remuneration paid to an individual employe, including wages or salaries and benefits.

Competitive bidding process—The method used to procure goods or services by obtaining three or more vendor cost proposals and selecting the proposal with the lowest responsible bid.

Cost center—A group of services or employes, or both, or another unit or type of activity into which functions of a facility are divided for purposes of expense assignment and allocations.

Cost report—A summary of client occupancy, income and expenses for a given period, presented in a manner prescribed by the Department. In the ICF/MR program, this is an annual preparation of a Departmental form, titled Financial and Statistical Report for Skilled Nursing and Intermediate Care Facilities, for fiscal year operation.

Cost settlement—A retroactive adjustment based on a cost report, made at the end of a reporting period, to bring the interim payments made to the provider during that reporting period into agreement with the reimbursable amount payable to the provider for the allowable services actually rendered to program beneficiaries during that period. Final adjustment is made after an audit is closed.

Current fiscal year—The fiscal year in which the interim per diem rate is to be used.

Depreciable assets—Equipment, buildings and fixtures that have a purchase price of more than $500 and are expected to have a useful life of more than 1 year.

Depreciation—Apportionment of the value of an asset over its useful life.

Direct care staff—Staff assigned to perform direct responsibilities related to activities of daily living, self-help and socialization skills. Staff involved in regularly scheduled specialized developmental programs with clients are not included in direct care staff. Professional staff may be included in direct care staff.

Efficiency incentive—A remuneration to a provider that may be earned by spending less than projected operating expenses within specified guidelines.

Facility—A nonState operated intermediate care facility for the mentally retarded or a nonState operated intermediate care facility for persons with other related conditions.

Fair market rental appraisal—The determination of reasonable payment to a lessor for a rented space by a qualified real estate appraiser.

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

Interest on capital indebtedness—The direct cost incurred for funds borrowed for capital purposes. Examples of interest on capital indebtedness include 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 a relatively short term, usually for purposes such as working capital for normal operating expenses.

Investment income—Return on funds not expended by the facility and placed with a third party. The term includes interest income from bonds and savings accounts, premiums and dividends on stock purchases, and income from trust agreements.

Major object of expenditure—A generic classification of costs within cost centers including personnel, equipment, operating costs, depreciation and interest, and apportioned costs.

Management fee—A charge for general administrative services incurred for a common or joint purpose not readily assignable to a specific cost center.

Practitioner—Salaried or contracted practitioners including physicians, dentists, podiatrists, occupational therapists and physical therapists.

Prudent buyer—A term for the price paid for items by a cost-conscious purchaser in the open market under competitive conditions.

Reasonable costs—Necessary and proper costs incurred by the provider, based on the expectation that the facility is operated efficiently and economically.

Related party—An organization related to the provider by common ownership or control. Related to the provider means that the provider, to a significant extent, is associated with, affiliated with or has control of or is controlled by the organization furnishing the services. Common ownership exists when an individual possesses significant ownership or equity in the provider and the institution or organization serving the provider. Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

Request for proposal—A formal document describing services requested that is provided to interested contractors along with information to enable the preparation and submission of proposals for evaluation and selection.

Service contract—An obligation between a provider and supplier in which the nature and cost of service is specified, and reimbursement is not based upon actual units of service provided.

Standard 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.

Start-up costs—Costs incurred by the provider in developing its ability to furnish client care services prior to certification of the facility or admission of the first client.

Unit of service contract—An obligation between a provider and supplier in which the unit is defined, a price for the unit is stipulated, the basis for the price and unit is justified and reimbursement is based upon actual units of service provided.

STANDARD INTERIM PER DIEM RATE

[§ 1181.331] § 6211.11. * * *

[§ 1181.332] § 6211.12. * * *

[§ 1181.333] § 6211.13. * * *

[§ 1181.334] § 6211.14. * * *

[§ 1181.335] § 6211.15. * * *

[§ 1181.336] § 6211.16. * * *

[§ 1181.337] § 6211.17. * * *

[§ 1181.338] § 6211.18. * * *

WAIVER OF STANDARD INTERIM PER DIEM RATE

[§ 1181.351] § 6211.31. * * *

[§ 1181.353] § 6211.32. Approved waiver.

(a) After the Department has notified the provider that a waiver has been granted, the Department will establish the total approved revised budget level.

(b) If a waiver is granted, the Office of Mental Retardation will establish budget levels by major object of expenditure and cost center. The budget level will be based on this chapter and HIM-15.

(c) If a waiver is granted, the Office of Mental Retardation will establish an interim per diem rate by dividing the total approved budget level minus offsetting income, by 98% of the maximum potential certified occupancy or the occupancy percentage requested by the provider in the budget, whichever is higher.

(d) If a waiver is granted, the interim per diem rate shall be used for billing purposes throughout the fiscal year.

[§ 1181.354] § 6211.33. Denied waiver.

(a) After the Department has notified the provider that a waiver has been denied, the provider shall use the standard interim per diem rate, as specified in § 6211.16 (relating to establishment of standard per diem rate).

(b) If a waiver is denied, the provider may appeal the denial within 30 calendar days of the mailing date of the Department's notice of the waiver denial.

[§ 1181.355] § 6211.34. Upper limits of payment if a waiver is granted.

(a) If a waiver is granted and the budget is used to establish the interim per diem rate, the provider shall operate within 10% of the approved budget levels for major object of expenditure and cost center as defined in § 1181.453 (relating to major objects of expenditure and cost centers within the budget).

(b) Actual, allowable and reasonable costs shall be determined at the time of the audit in accordance with this subchapter. Total reimbursement is limited to the sum of audited actual allowable costs or the total approved budget level, whichever is lower.

(c) An efficiency incentive is not available if a waiver of the standard interim per diem rate is granted.

REIMBURSEMENT

[§ 1181.361] § 6211.41. * * *

[§ 1181.362] § 6211.42. * * *

[§ 1181.363] § 6211.43. * * *

[§ 1181.364] § 6211.44. * * *

[§ 1181.365] § 6211.45. * * *

[§ 1181.366] § 6211.46. * * *

[§ 1181.367] § 6211.47. * * *

[§ 1181.368] § 6211.48. * * *

BED OCCUPANCY

[§ 1181.391] § 6211.61. * * *

[§ 1181.392] § 6211.62. * * *

[§ 1181.393] § 6211.63. * * *

[§ 1181.394] § 6211.64. * * *

ALLOWABLE COSTS

[§ 1181.401] § 6211.71. * * *

[§ 1181.403] § 6211.72. * * *

[§ 1181.406] § 6211.73. * * *

[§ 1181.407] § 6211.74. * * *

[§ 1181.408] § 6211.75. * * *

[§ 1181.409] § 6211.76. * * *

[§ 1181.410] § 6211.77. * * *

[§ 1181.411] § 6211.78. * * *

[§ 1181.412] § 6211.79. Depreciation allowance.

(a) Depreciation on capital assets used to provide compensable services to medical assistance clients, including assets for normal, standby or emergency use, and specialized equipment such as wheelchairs, is allowable.

(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 that participated in the Medical Assistance Program prior to July 1, 1984, that are not part of a related organization and that are not the recorded holder of legal title to the facility, are considered to meet the recorded holder of legal title requirement and 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 primarily funded through an Industrial Development Authority bond issue, or tax exempt funding sources established under State statute.

(2) The facility provided the Department with all documents relating to the 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 that participated in the Medical Assistance Program prior to July 1, 1984, that are part of a related organization and that are not the recorded holder of legal title to the facility, are considered to meet the recorded holder of legal title requirement and 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 primarily funded through an Industrial Development Authority bond issue, or tax exempt funding sources established under State statute.

(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) 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 that the Department is unable to collect directly from the facility.

(e) The straight-line method of depreciation shall be used. Accelerated methods of depreciation are not 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 of 1986 (26 U.S.C.A. § 168(c)) and any other accelerated filing system will not be permitted.

(f) Depreciation expense for the year of acquisition and the year of disposal is computed by using either the half-year or actual time method of accounting. The number of months of depreciation expense may not 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) 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 part of the cost of the asset. If 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. Depreciation may not 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 and movable assets are considered to be equal to the salvage value which shall be established prior to the sale of the item. Gains on the sale of fixed and movable assets shall offset allowable costs for the period in which the gain was realized, but the offset may not exceed the amount of the facility's total depreciation expense for the last 12 months prior to the date that the asset was either sold, retired from service, or otherwise permanently taken out of services. If the amount of the offset is greater than the total allowable cost for the period in which the gain was realized, the difference shall be refunded to the Department. 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) Depreciation that was taken or could have been taken by the prior owners shall be subtracted.

(iii) Subsections (r) and (s) will 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)—(3) and (5) may not exceed the seller's basis under this subchapter, less all 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 allowable cost basis of the asset to the first owner of record on or after July 18, 1984, 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 payment was previously made under Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396u). This paragraph does not apply to changes in ownership under an enforceable agreement entered into prior to July 18, 1984.

(n) The reasonable cost of depreciation will be recognized for the construction and renovation of buildings to meet applicable Federal, State or local laws and building codes for intermediate care facilities for the mentally retarded. Costs are allowable if the facility has either a certificate of need or a letter of nonreviewability for the project from the Department of Health under 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 purchase 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 that 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 the following:

(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 depreciation cost.

(7) The estimated useful life of the asset.

(8) The depreciation for the year.

(9) The accumulated depreciation.

(q) Effective July 1, 1984, for nonState ICF/MR 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 the following apply:

(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.

(ii) The facility substantially implements the project as defined at 28 Pa. Code § 401.5(j)(2) (relating to certificate of need) within the effective period of the original Section 1122 approval or the original certificate of need.

(2) Depreciation on replacement beds is allowable 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, 1984, allowable depreciation and interest costs for new, renovated or purchased facilities shall be held to a per bed limitation based on construction standards obtained from published standards.

(1) For facilities governed by the Institutional Occupancy Section of the National Fire Protection Association's Life Safety Code, depreciation costs are limited to a maximum cost per bed based upon the *"Repair and Remodel Quarterly"* published by Marshall and Swift, Post Office Box 26307, Los Angeles, California, 90026-9954, current at the time of construction or acquisition, except as limited by other provisions of this chapter.

(2) For facilities governed by the Lodging and Rooming Houses Section of the National Fire Protection Association Life Safety Code, depreciation costs are limited to a maximum cost per bed based upon the *Marshall Valuation for Single Family Residences—Type D*, published by Marshall and Swift, Post Office Box 26307, Los Angeles, California 90026-0307, current at the time of construction or acquisition, except as limited by other provisions of this subchapter.

(t) Depreciation cost is not allowable for assets expensed under another State or Federal funding stream.

[§ 1181.412a] § 6211.80. * * *

[§ 1181.413] § 6211.81. * * *

[§ 1181.414] § 6211.82. * * *

[§ 1181.415] § 6211.83. * * *

[§ 1181.416] § 6211.84. * * *

[§ 1181.417] § 6211.85. * * *

[§ 1181.419] § 6211.86. * * *

[§ 1181.420] § 6211.87. * * *

NONREIMBURSABLE COSTS

[§ 1181.431] § 6211.101. * * *

CONFLICT OF INTEREST

[§ 1181.441] § 6211.111. * * *

[§ 1181.442] § 6211.112. * * *

[§ 1181.443] § 6211.113. * * *

[§ 1181.444] § 6211.114. * * *

BUDGET

[§ 1181.451] § 6211.121. * * *

[§ 1181.452] § 6211.122. * * *

[§ 1181.453] § 6211.123. * * *

[§ 1181.454] § 6211.124. * * *

MOVEMENT OF FUNDS

§ 6211.131. Conditions for movement of funds.

(a) Agencies that operate multiple programs shall be permitted to move up to 10% of the approved funding level of a program across other programs the facility operates.

(b) Movement of funds shall be permitted only once per Commonwealth fiscal year.

(c) The request for movement of funds shall be submitted to the Office of Mental Retardation by May 31 of the fiscal year for which the movement of funds is requested.

(d) Movement of funds will not be approved if there is an increase in the sum of the already approved funding levels for each of the programs the agency operates.

(e) Movement of funds shall be limited to 10% of a program's approved funding level.

(f) Movement of funds may be directed from several programs to a single program.

§ 6211.132. Documentation.

(a) Agencies requesting the movement of funds shall submit revised program budget pages to the Office of Mental Retardation for affected programs.

(b) For programs affected by the change with standard interim rates, a program budget page is not required. The agency shall document to the Office of Mental Retardation the change in the total projected operating cost as a result of the movement of funds.

§ 6211.133. Related procedures.

The Office of Mental Retardation will not process gross adjustments as a result of an approved request to move funds across programs, and revised interim rates will not be issued.

§ 6211.134. Cost reporting.

Cost reporting on the form specified by the Department shall be individualized for each certified program. At the time of tentative and final settlements, settlement amounts will be issued for each certified program, reflecting the amount either due to or from the Department. Both tentative and final cost settlements will incorporate each certified program's approved funding level, including any revisions as a result of an approved movement of funds request, as specified in § 6211.131 (relating to conditions for movement of funds). Payment amounts to providers at the time of tentative cost settlement will be 80% of the amount due to the provider. Collection at the

time of tentative cost settlement will be 100% of over**payments due to the Department. At the time of final** cost settlements, amounts will be 100% of amounts either due to or from the Department.

§ 6211.135. Rate setting.

(a) Subsequent year's rate setting will be based upon the revised approved levels resulting from requested and approved movement of funds.

(b) Rate setting will use the immediate preceding year **as base if a requested movement of funds has** been approved, and, therefore, the revised approved funding levels will be reflected in rate setting for the upcoming fiscal year.

[Pa.B. Doc. No. 94-2052. Filed for public inspection October 28, 1994, 9:00 a.m.]

See correction in PA Bulletin dated 2/11/95

1181.418 (transportation) → 6211.86
1181.419 (return on equity) → 6211.87
1181.420 (start up costs) → 6211.88

} no change in text