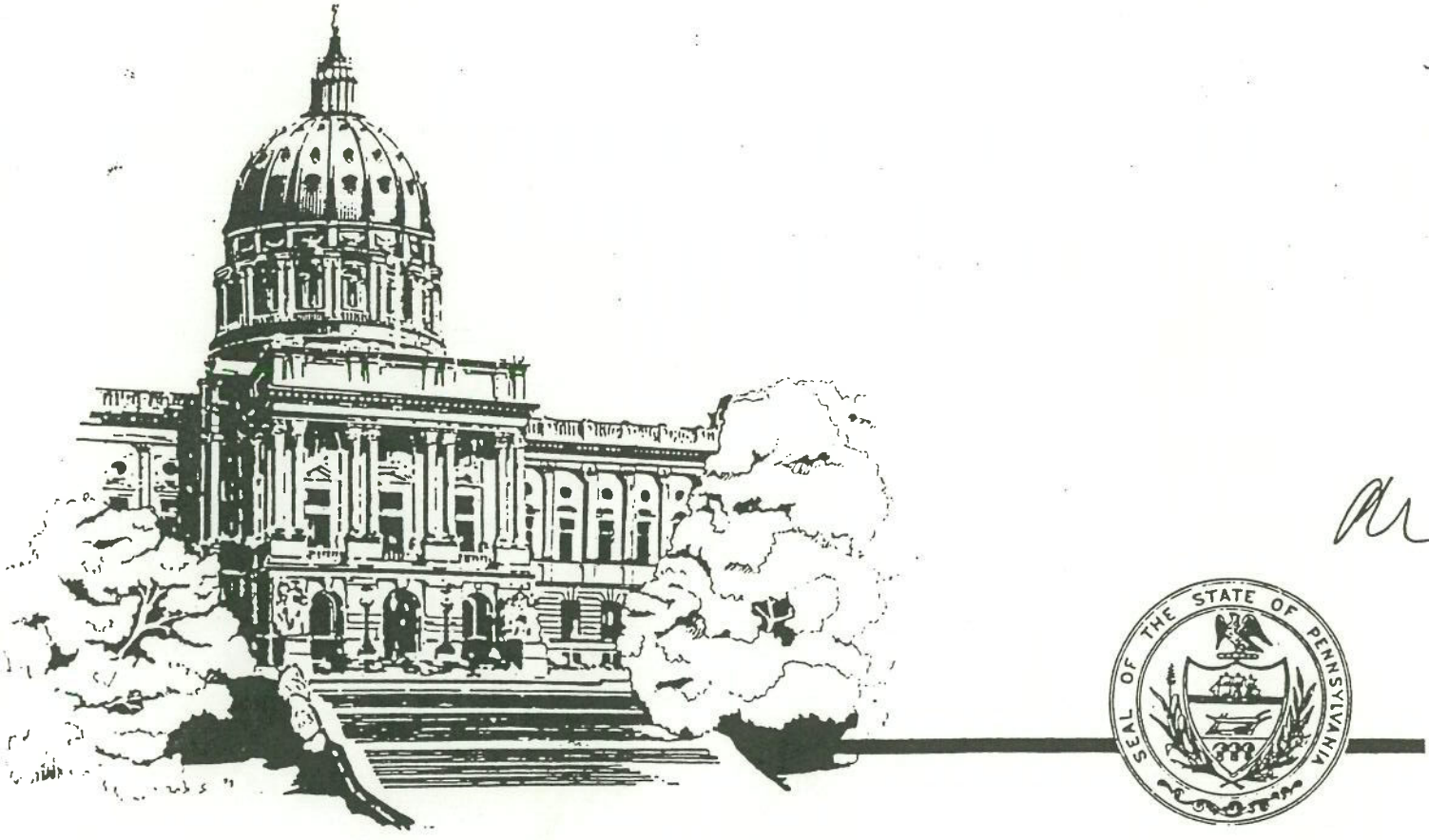
PENNSYLVANIA BULLETIN

Volume 22 Number 52
Saturday, December 26, 1992 • Harrisburg, Pa.

Part II

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



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, Pennsylvania 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 is proposing to move 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 non-State operated intermediate care facilities for the mentally retarded). The Department is also proposing to delete Chapter 1181, Appendix Q currently appearing in the *Pennsylvania Code* at 1181-91 to 1181-93, serial pages (171927) to (171929). The new numbering format for Chapter 6211 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 NON-STATE OPERATED INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

GENERAL PROVISIONS

[§ 1181.301] § 6211.1. * * *

[§ 1181.302] § 6211.2. * * *

[§ 1181.303] § 6211.3. * * *

[§ 1181.304] § 6211.4. * * *

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. * * *

[§ 1181.352] (Reserved).

[§ 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.

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).

[§ 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. * * *

[§ 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 MA-11 form shall be individualized for each program. At time of tentative and final settlements, amounts shall be issued on an agency basis to reflect the sum of amounts either due to or from each of the agency's ICF/MR programs.

§ 6211.135. Rate setting.

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

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

[Pa.B. Doc. No. 92-2576. Filed for public inspection December 24, 1992, 9:00 a.m.]

PROPOSED RULEMAKING

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), under the authority of section 443.1(2) and (3) of the Public Welfare Code (62 P. S. § 443.1(2) and (3)), proposes to add Chapters 6210 and 6211 (relating to participation requirements for the intermediate care facilities for the mentally retarded program; and allowable cost reimbursement for non-State operated intermediate care facilities for the mentally retarded).

Purpose of the Amendments

The Department proposes to revise portions of Chapter 1181, Subchapter A (relating to nursing home care) and create a new chapter of regulations applying exclusively to ICFs/MR. The new chapter entitled "Participation Requirements for the Intermediate Care Facilities for the Mentally Retarded Program" will be at Chapter 6210. The purpose of these regulations is to specify the requirements for State operated and non-State operated ICFs/MR to receive payment for services through the Medical Assistance (MA) Program.

The Department also proposes to make minor content changes and renumber Chapter 1181, Subchapter C (relating to allowable cost reimbursement for non-State intermediate care facilities for the mentally retarded) as new Chapter 6211. Content changes include clarification and codification of existing Departmental policy. The Department proposes to relocate this subchapter to the mental retardation section of Title 55, since these regulations apply exclusively to intermediate care facilities for the mentally retarded (ICFs/MR). The purpose of these regulations is to specify the requirements for MA reimbursement and allowable costs for non-State 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 other types of nursing facilities. Due to new changes in Chapter 1181, Subchapter A as a result of the Omnibus Budget Reconciliation Act of 1987 that will be made in the future, Chapter 1181, Subchapter A is no longer an appropriate location for participation requirements for ICFs/MR. These proposed 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 are specified in the Summary of Major Changes portion of this preamble. These regulations are necessary to retain Federal ICF/MR funding in both State operated and non-State operated ICFs/MR.

The content changes proposed for Chapter 1181, Subchapter C are minor technical revisions to clarify existing regulations, eliminate unnecessary regulations and codify existing Departmental policy. The relocation of the requirements for allowable cost reimbursement for non-State 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 have been distributed for review and comment to all ICF/MR providers and State associations. The draft amendments were also reviewed and discussed at the Statewide ICF/MR Provider Task Force meetings. Comments received from providers and associations have been carefully reviewed, and incorporated where appropriate, into the proposed amendments.

Summary of Major Changes

Annex A contains the proposed new Chapter 6210. The Department proposes to eliminate applicability to ICFs/MR from Chapter 1181, Subchapter A. The Department intends to eliminate all specific language relating to ICFs/MR in Chapter 1181, Subchapter A in an upcoming *Pennsylvania Bulletin* publication. Until official revisions to Chapter 1181, Subchapter A are made, the new Chapter 6210 will supersede Chapter 1181, Subchapter A as Chapter 1181, Subchapter A relates to ICFs/MR.

The Department proposes to delete Chapter 1181, Appendix Q (relating to intermediate care for the mentally retarded assessment) since this Appendix will be relocated in new Chapter 6210. Appendix Q will be reserved.

The Department proposes to renumber Chapter 1181, Subchapter C to Chapter 6211. Sections 1181.301—1181.304 will be renumbered as §§ 6211.1—6211.4; §§ 1181.331—1181.338 will be renumbered as §§ 6211.11—6211.18; §§ 1181.351—1181.355 will be renumbered as §§ 6211.31—6211.34; §§ 1181.361—1181.368 will be renumbered as §§ 6211.41—6211.48; §§ 1181.391—1181.394 will be renumbered as §§ 6211.61—6211.64; §§ 1181.401—1181.420 will be renumbered as §§ 6211.71—6211.87; § 1181.431 will be renumbered as § 6211.101; §§ 1181.441—1181.444 will be renumbered as §§ 6211.111—6211.114; and §§ 1181.451—1181.454 will be renumbered as §§ 6211.121—6211.124.

New Chapter 6210 contains some minor revisions in format, language and content from the current Chapter 1181, Subchapter A. Following are the significant content revisions in the proposed Chapter 6210 regulations.

§ 6210.4. Definitions.

A definition of "reserved bed day" has been added.

§§ 6210.61—6210.65. Assessment.

The requirements relating to ICF/MR assessments currently located in Chapter 1181, Appendix Q has been relocated to §§ 6210.61—6210.65.

§ 6210.71(b). Limitations on payment for reserved bed days.

A change to the requirements for payment for hospital leave for non-State operated ICFs/MR is proposed. Since 1982, problems have persisted related to the treatment of hospital reserve bed days in the audit and final cost settlement of non-State operated ICFs/MR. The general problem was that costs associated with hospital leave

days were included in the total allowable costs of the facility for cost settlement purposes, and additionally, the Department reimbursed one-third of the interim per diem rate payment, thus resulting in excess reimbursement. The Department is proposing to eliminate the one-third "bonus" payment for non-State operated ICFs/MR and to revise the reimbursement procedure for non-State operated ICFs/MR regarding hospital reserve bed days.

Under the proposed regulations, the Department plans to reimburse providers at the full pier diem cost for a maximum of 15 consecutive reserve bed days per hospitalization. The basic proposal is that a non-State operated ICF/MR can bill its full per diem for 15 days per hospitalization. These days are included in the facility's census as client days, as if the bed was occupied, up to the 15-day per hospital visit limit. Costs, again subject to the limit on the number of days, are to be included in the MA-11 cost report. Once past this limit, for example, on the 16th day, the facility cannot bill for a hospital reserve bed day, nor count the 16th day as a client day on the census. If the facility has enough vacant days to bring it below the 98% bed occupancy currently contained in § 1181.391, the facility's fixed and variable costs will be reduced upon audit per § 1181.393, unless a waiver is granted in accordance with § 1181.394. The waiver of the minimum occupancy requirement allows the facility to recover its fixed costs only, not variable costs.

This change in procedure will allow the facility to bill for hospital reserve bed days in accordance with the limit and therefore maintain timely cash flow. This proposal will also eliminate excess reimbursement and avoid future audit disallowances.

§ *6210.71(b). Limitations on payment for reserved bed days.*

A definition of hospital leave has been added.

§ *6210.71(c). Limitations on payment for reserved bed days.*

A definition of therapeutic leave has been added.

The new Chapter 6211 contains some minor revisions in content from the current Chapter 1181, Subchapter C. Following are summaries of the proposed revisions to Chapter 6211.

§ *1181.352. Departmental decision.*

This section is being proposed to be deleted. The original intent of this section was to assess waiver requests to determine if the conditions specified in § 1181.351 existed and not to determine a new rate. However, this section has caused confusion and has been misunderstood. Based on the Department's experiences, this section is not necessary for the processing of waivers and that the criteria specified in § 1181.351 are clear on their own merit.

§ *1181.355 (to be moved to § 6211.34). Upper limit of payment if a waiver is granted.*

In subsection (b), the terms "projected cost" have been revised to "approved budget level." This change is proposed to clarify the upper limit of payment upon final audit, based on current practice.

§§ *6211.131—6211.135. Movement of funds.*

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.

Current Chapter 1181, Subchapter C allows for providers to request increases that may occur during the fiscal year using a waiver mechanism (§ 1181.351). Additionally, a provider may move funds within the approved funding level under a standard interim per diem rate or through a budget modification request if the rate has been established through waiver (§ 1181.454).

Due to changes that typically occur during the fiscal year, many providers request waivers to address increases which cannot be accommodated within the established, approved funding level for individual programs. Providers that operate multiple programs have indicated that many waivers could be eliminated if there was some degree of flexibility to move funds from one program to another without exceeding the overall sum of the approved levels for each program that has been established.

In response, the Department is proposing to establish the flexibility to move funds across programs, within certain limits. The procedures are expected to lead to a decrease in the number of waivers and the paperwork and workload associated with the current waiver process used to request increases.

Affected Individuals and Organizations

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

Benefits of Proposed Amendments

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

The proposed § 6210.71(b) which relates to hospital leave will allow ICFs/MR to bill for hospital reserve bed days in accordance with the limit and therefore maintain timely cash flow. This amendment will also eliminate excess reimbursement and avoid future audit disallowances.

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

Fiscal Impact

These proposed amendments will allow the ICFs/MR, non-State operated facilities, 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 will not increase costs but is expected to result in a temporary cash flow impact.

The current regulations allow non-State operated ICFs/MR to bill for one-third their per diem rate for hospital days up to a maximum of 15 consecutive days per hospitalization. Several new sections have been proposed 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.

Paperwork Requirements

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

Effective Date

The Department proposes that these amendments be effective on July 1, 1993.

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 all providers and State associations. During those meetings, the impact of these amendments will be continually reviewed and discussed.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), the agency submitted a copy of these proposed amendments on December 16, 1992, to the Independent Regulatory Review Commission (IRRC). Submittal to the House Committee on Health and Welfare and the Senate Committee on Public Health and Welfare will be effected on January 25, 1993, in the 1992-1993 Session of the General Assembly.

In addition to submitting the proposed amendments, the agency has provided IRRC and will provide the Committees with a copy of a detailed regulatory analysis form prepared by the agency in compliance with Executive Order 1982-2, "Improving Government Regulations." A copy of this material is available to the public upon request.

To assure the fullest possible participation in the rulemaking process, it is the intention of the agency to regard the 20-day review period by the Committees, under section 5(b.2) of the Regulatory Review Act, and the 30-day review period by IRRC under section 5(b.3) of the Regulatory Review Act (71 P. S. § 745.5(b.3)), as commencing on the closing date of the public comment period.

If IRRC has any objections to any portion of the proposed amendments, it will notify the agency within 30 days of the close of the public comment period. The notification shall specify the regulatory review criteria which have not been met by that portion. The Regulatory Review Act specifies detailed procedures for review, prior to the final publication of the amendments, by the agency, the General Assembly and the Governor of objections raised.

Contact Person

Interested persons are invited to submit written comments, suggestions or objections on these proposed amendments to: Karen E. Kroh, Chief, Section of Regulatory Administration, Office of Mental Retardation, Room 512, Health and Welfare Building, Harrisburg, Pa. 17120, (717) 783-3636.

Comments must be submitted within 30 calendar days from the date of this notice of proposed rulemaking in the *Pennsylvania Bulletin*. Comments received within 30 days will be reviewed and considered in the preparation of the final amendments.

KAREN F. SNIDER,
Secretary

Fiscal Note: 14-396. (1) General Fund; (2) Implementing year 1993-94 is $285,000; (3) 1st succeeding year 1994-95 is $0; 2nd succeeding year 1995-96 is $0; 3rd succeeding year 1996-97 is $0; 4th succeeding year 1997-98 is $0; 5th succeeding year 1998-99 is $0; (4) FY 1990-91: $79,640,000, FY 1989-90: $66,883,000, FY 1988-89: $57,259,000; (7) Department of Public Welfare—Interme diate Care Facilities for the Mentally Retarded; (8) recommends adoption. The regulations are intended to go into effect July 1, 1993, and will result in a cash flow shift into the 1993-94 Fiscal Year of $285,000. Some savings will also result from these regulations which are estimated to be approximately $265,000 in 1993-94.

Annex A

TITLE 55. PUBLIC WELFARE

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 non-State operated ICFs/MR to receive payment for services through the MA Program.

§ 6210.2. Applicability.

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

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

(c) If a regulation specified in this chapter is inconsistent with Chapter 6211 (relating to allowable cost reimbursement for non-State 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 non-State 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.

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 non-State 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—1396r) 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 non-State 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 non-State operated facilities.

(a) Non-State operated ICFs/MR shall submit cost reports, or if a waiver is granted in accordance with Chapter 6211 budgets, 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 non-State 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 the managing recipients' funds that is in compliance with the regulations at 42 CFR 483.420 (relating to conditions of participation: Client protections), shall be in operation.

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

(2) Paragraph (1) applies only in circumstances where there is no will, if this is ascertainable, and if no relative or friend of the decedent takes responsibility for the burial. Under 20 Pa.C.S. § 3101 (relating to payments to family and funeral directors), a facility making such a payment is released from responsibility to the same extent as if payment has been made to an appointed personal representative of the decedent and the facility is not required to oversee the manner in which the funeral director applies the payment.

(c) A cost report shall be filed with the Department's Office of Mental Retardation for non-State 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 non-State operated ICF/MR, the person who certifies the need for continued care specified in subsection (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) Medical, social and psychological evaluations shall be recorded in the recipient's medical record and if applicable on forms specified by the Department.

(c) The facility shall send medical, social and psychological evaluations to the Department for evaluation of the need for admission and for authorization of payment for the appropriate level of care.

§ 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' 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 the time period specified on the advance notice issued by the Department, the Department will make payment to the facility for the level of care the recipient is presently receiving pending the outcome of the hearing. 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 the effective date specified on the advance notice to the date that the appropriate change in the level of care for which payment is authorized is made.

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.

§ 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) 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 non-State 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 non-State 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 non-State 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 non-State operated ICFs/MR, allowable costs shall be determined based on Chapter 6211 (relating to allowable cost reimbursement for non-State 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) Non-State 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 non-State 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 non-State 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 non-State 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 non-State 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 non-State 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 specified 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 follow-up 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