ODP Announcement

Chapter 51: Office of Developmental Programs Home and Community-Based Services Regulation Questions and Answers

ODP Communication Number 021-17

The mission of the Office of Developmental Programs is to support Pennsylvanians with developmental disabilities to achieve greater independence, choice and opportunity in their lives.

AUDIENCE: Individuals and Families, Medical Assistance (MA) waiver Home and Community-Based Settings (HCBS) and providers of targeted services management (TSM), Administrative Entity (AE) Administrators and Directors, Supports Coordination Organization (SCO) Administrators or Directors, Supports Coordinators (SC), and other interested parties.

PURPOSE: The purpose of this communication is to provide updated clarification of 55 Pa. Code Chapter 51, *Office of Developmental Programs Home and Community-Based Services,* related to provider requirements to be eligible to receive federal financial participation (FFP) and for maintaining documentation to support service delivery.

BACKGROUND: The Office of Developmental Programs (ODP) published 55 Pa. Code Chapter 51 “Office of Developmental Programs Home and Community- Based Services” regulations at 42 Pa. B. 3230. After the regulations were published, the Department received many questions with regards to implementation of the regulations and subsequently published Informational Memo 069-13.

Since this ODP communication was released, ODP has continued to receive requests to clarify progress notes and service or “encounter” notes. Therefore, ODP is publishing this communication and is developing a bulletin that includes procedure code specific guidance to explain the differences between progress and service notes, clarify the documentation requirements that must be present to submit and substantiate a waiver service claim, and clarify standards for provider documentation to support service delivery. **New questions and**

answers replace the previous information related to Section 51.16. The new questions and answers are underlined and are in bold font. Please note that the updated questions and answers may apply to various sections of the Chapter 51 regulations, but they are grouped together.

In addition, provider documentation requirements for the Consolidated and Person/Family Directed services are currently specified in 55 PA Code Chapter 1101, Chapter 51 and ODP Bulletin 00-07-01, *Billing Documentation Requirements for Waiver Services*.
Hyperlinks to the regulations and other web-based resources are included as appropriate. Any text that is underlined is a hyperlink when viewing an electronic version of this document.
Subchapter A. GENERAL PROVISIONS

Regulation	Question	Answer
Updated Information as of 03/11/2017		
§ 51.3 Definitions.	**What is a service note?**	**Service notes are written statements that accurately record details related to service delivery. Completed when services are provided, this is documentation by staff, when, for example, they leave their shift or before they leave a person's home. Service notes are not typically an assessment of progress, and may have multiple purposes, including notation of important information so that there is communication amongst team members and service providers and providing information that can be used in the assessment of "progress." Service notes may be recorded on an "encounter" form or a checklist that indicates the assistance, supports and/or guidance provided to the participant or on behalf of the participant.**

§ 51.3 Definitions, § 51.15 Provider records and § 51.17 Incident Management	Are there other documentation standards/requirements providers are expected to meet?	Yes. In addition to documentation required to substantiate a claim and assess progress (progress notes) providers must maintain other records that note information essential to support service delivery and that is in accordance with any applicable regulatory or licensing requirements. Documentation standards/requirements are assessed through monitoring and oversight activities with identified deficiencies addressed and remediated through provider corrective action plans. If in the course of these activities, there is an indication that the service was NOT provided, there shall be further investigation. If investigation reveals that the billed service was not provided, the claim must be disallowed
§ 51.16 Progress notes	When is a progress note required?	A progress note shall be completed during the calendar month for services that are provided during that month and when services occur on a periodic and intermittent basis. Periodic and intermittent means that the service occurs less frequently than monthly for example, every six weeks or every 90 days.
§ 51.16 Progress notes	Are service notes and progress notes required when a participant is self-directing his or her own services in the AWC or VF/EA FMS models?	Yes, both service notes and progress notes are required when a participant self-directs his or her services. When an individual is self-directing services through the AWC Model, the managing employer, or if necessary, the AWC organization will ensure that service documentation is completed and retained in the participant's record. In the VF/EA FMS model, the common-law employer is responsible to ensure service documentation and progress notes are completed as specified in Attachment 1 which is

		included in Bulletin 00-17-XX and for retaining the documentation in the participant's record.
§ 51.45 Provider billing	**What documentation must a provider have/maintain to substantiate a claim/bill for a waiver service?**	**Provider documentation requirements to substantiate a claim include:** - **Date of service;** - **Name of the recipient;** - **Medicaid identification number;** - **Name of provider agency; and** - **The place of service.** **Additionally, each waiver claim must be supported by documentation of the nature, extent, or units of service.**
§ 51.45 Provider billing	**Is a service note required for each 15 minute unit of service that is provided?**	**A service note must be included for each continuous span of 15 minute units that describes service activities. This means that a service note must be completed for each encounter on each specific date. The service note should cover the total number of units of service provided from the beginning to the end of the service on the specified date. If there is an interruption of service on that date, a new service note should be completed when the service is again initiated on that date. If there is a change in staff providing the service on the specific date, a new service note should be completed.**

Office of Developmental Programs Home and Community-Based Services Regulation Questions and Answers released in Informational Memo 069-13 on August 29, 2013

Regulation	Question	Answer
51.3 Definitions	Does the definition of staff include Lifesharing families?	Under these regulations, the definition of "Staff" includes employees, contractors or consultants. Since Lifesharers that provide Lifesharing/Family Living services are employees, contractors or consultants of

		a provider agency and provide an HCBS through direct contact with a waiver participant, they are included in this definition.
51.3 Definitions	Does System Award Management (SAM) replace the Excluded Parties List System (EPLS) and does the provider have to continue checking EPLS since it no longer appears to be a functional website?	As of November 21, 2012, the EPLS was retired and is no longer to be used. All exclusions capabilities should be checked through www.sam.gov EPLS is also mentioned in § 51.62, § 51.141 and § 51.152 and the information in these regulations should be utilized.

Subchapter B. PROVIDER QUALIFICATIONS AND PARTICIPATION

Regulation	Question	Answer
51.11 Prerequisites for participation	Can you explain the difference between "Qualified" and "not qualified?"	• If a provider meets all requirements in the approved waivers and the Chapter 51 regulations and completes the qualification process, then the provider would be "qualified" to offer the services for which they were qualified. • If the provider does not meet procedural requirements and/or does not complete the process, then the provider would be considered "not qualified" to offer those services. • Please note that qualification varies for each waiver service. For this reason, providers may be "qualified" to provide one service they apply to provide, while being "not qualified" to provide another service they apply to provide.
51.11 (b) Prerequisites for participation	What is the process for qualification of new providers? How does this process apply to SCOs?	The provider monitoring documentation can be found on MyODP https://www.myodp.org/. The process for SCOs can be found on MyODP.
51.11 (i) Prerequisites for participation	What is meant by a provider not influencing a participant's choice?	A new or current provider may not influence a participant's choices by taking advantage of the provider's

		potential or current relationship with the participant. This can include requiring a participant to choose the provider for multiple services.
51.12 SSW provider enrollment	Would you explain the language in the regulations that refers to an SSW as an SSW provider?	The SSW provider is an individual who provides direct services to waiver participants that has to meet the qualifications for the service(s) he or she will provide as enumerated in Appendix C of the Waivers. The SSW provider also must complete all paperwork required in the VF/EA model.
51.13 (d) Ongoing responsibilities of providers.	How does this regulation apply to SCOs?	In conjunction with § 51.13(c), an SCO has to be qualified annually as specified in Appendix C of the approved Consolidated and Person/Family Directed Support (P/FDS) waivers, effective July 1, 2012.
51.13 (h) Ongoing responsibilities of providers.	In Home and Community Services Information System (HCSIS), once a provider is authorized for a Provider Type (PT)and Specialty a provider can add services under a Provider Type (PT) without submitting verification to the helpdesk. Does the term service in this subsection reflect the higher level (provider type) so this practice can continue?	In HCSIS, once a provider is authorized for a Provider Type and Specialty, a provider can add services under a Provider Type (PT) without submitting verification to the HCSIS Helpdesk. The term "HCBS" in this subsection of the regulations refers to the provider type. The document in the Learning Management System (LMS)on adding services does not change under the regulations.
51.13 (h) (3) and (4) Ongoing responsibilities of providers.	Does this regulation apply to all services?	Yes, in addition, residential service locations require "clearance" as non-contiguous. All Consolidated Waiver Licensed and Unlicensed Residential Habilitation service settings/locations require non-contiguous site clearance. Chapter 6400 settings require approval

		(approved program capacity) when providing services to waiver participants. To add a HCBS, providers must complete the necessary information in HCSIS and the PROMISe™ application. Please refer to the ODP Provider Handbook for Intellectual Disability Services for more information.
51.13 (j) Ongoing responsibilities of providers.	Is this regulation referring to a Quality Management (QM) Plan per agency or per service?	A QM Plan is required per agency, not per service type or location.
51.13 (o) Ongoing responsibilities of providers.	How should providers validate that staff members possess a valid Social Security Number (SSN)?	Unless the provider is an individual practitioner, a provider must have a Federal Employment Identification Number (FEIN). An I-9, Employment Eligibility Verification, is an example of a form that can be used to validate the SSN for staff members. Please consult with your attorney for further clarification of other methods.
51.13 (o) Ongoing responsibilities of providers.	Does this regulation concerning the application of SSNs apply to Lifesharing families?	This regulation applies to Lifesharing families.
51.13 (p) Ongoing responsibilities of providers.	There are occasions when an emergency occurs and an authorization cannot be issued prior to the delivery of a service (for which the provider is qualified). Do the regulations preclude this contingency?	A provider shall only deliver and provide an HCBS after the provider is qualified and authorized to provide the HCBS. If there is an unusual circumstance that results in a service being provided before the authorization is in HCSIS, the AE must approve the service, document the circumstances, and provide written confirmation to the provider.
51.13 (q) Ongoing responsibilities of providers.	How can a provider be accountable for the delivery of services that are not consistent with the waivers if they are in an approved ISP?	No waiver service may be authorized unless that service is consistent with the service definitions and qualification standards in the waivers. The content of the ISP is a shared responsibility and the AE is responsible to authorize services that are consistent with the approved waiver and related requirements. Providers are part of the ISP team and, as such, should communicate any

		changes that need to be made to the Supports Coordinator. The questions that are part of the provider monitoring tool focus on provider requirements and performance. In this instance, the focus will be on assessing whether services are delivered in accordance with the ISP. A provider who is willing and qualified is responsible in accordance with their signed Consolidated and P/FDS Provider Agreement to understand the Medical Assistance regulations and waiver requirements.
51.13_(x) Ongoing responsibilities of providers.	Would you provide more information about the provider's role in the Supports Intensity Scale (SIS®) assessment?	Providers, including SCO, who are identified as qualified respondents as defined in the SIS® manual must participate in the department assessment. The SC is responsible for assuring that all providers are notified and coordinating the scheduling of an assessment. SCs have included providers as a "participant to invite" to the assessment. The obligation to attend the assessment is the provider's.
51.13_(x) Ongoing responsibilities of providers.	Are the department assessments the same or different from the assessments required by the Chapter 2380 and Chapter 2390 regulations?	The department's assessment is the SIS®. For more information regarding an assessment required for licensing, please contact your Licensing Administrator.
51.14_(a) Residential habilitation service providers	If prior written approval is required to open or close a home, how will emergencies be handled?	Since prior written approval is required to open or close a home, all providers should contact the Regional Waiver Capacity Manager concerning an emergency or change in status of a home. In emergency situations, providers should act in the best interests of the individual and contact the Regional Waiver Capacity Manager at the earliest possible time.

51.14 (c)(2) Residential habilitation service providers	Is this regulation in conflict with § 51.13 (p)? How will immediate needs be handled?	See comment above related to section § 51.13 (p). Please read ODP Informational Packet 039-12 on Supplemental Habilitation (SH)/Additional Individualized Staffing (AIS) for information on the authorization process in general and the process regarding immediate needs. As services must be authorized for payment to be rendered, this is not in conflict with § 51.13 (p).
51.14 (f) Residential habilitation service providers	Is this merely a monthly monitoring by the SCO at the six month mark or is this a summary bi-annual review?	The six month review referenced in § 51.14 (f) should occur during a monitoring visit. If a change is identified, based on the team discussion, a meeting should be convened. Residential habilitation providers are required to participate in the six-month review of services. Please refer to ODP Informational Packet ISP Review Checklist Informational Packet 020-13 and training for additional information about the six month review. (Please refer to the applicable licensing regulations for attendance requirements for Chapter 2390 providers.)
51.15 Provider records	How is the transfer of records handled when there is a new provider?	Please refer to the Chapter 1101 regulations (specifically § 1101.51) for additional requirements.
51.15 (e) Provider records	What specific federal and state laws does § 51.15 (e) refer to? What kind of back up for electronic records is acceptable?	There are several resources available to individuals to locate information about HIPAA compliance and audit requirements. Providers considering using electronic records should refer to the provider's legal counsel and accountant to ensure the electronic record system complies with any and all applicable Federal and state requirements. Some resources include, but are not limited to:

		• U.S. Department of Health & Human Services website • Internal Revenue Service website • Internal Revenue Code • Uniform Electronic Transactions Act (UETA) • The Electronic Transactions Act • Federal regulations, including 45 CFR Chapters 160, 162, 164, and 170 • 36 CFR 36, Chapter XII (relating to the National Archive and Records Administration) • 26 CFR (relating to Internal Revenue) • Administrative Bulletin OA-05-04 • HIPAA Privacy Implementation Manual ●The DHS Website
51.15 (e)(7) Provider records	What types of back-up systems are acceptable?	It is the provider's responsibility to determine what type of back-up system their agency requires to satisfy the Chapter 51 regulations. It is important to maintain historical information regarding the person and his/her history when there is a new provider. The provider should have a policy regarding electronic records that includes the process used to back-up participant records.
51.15 (g) Provider records	Does § 51.15 (g) apply only to licensed providers?	The regulation regarding documentation of when the participant voluntarily chooses to use the participant's personal funds to purchase items applies to all providers who are managing participants' personal funds. Please refer to 55 Pa. Code Chapter 6000, Subchapter F regarding Administration and Management of Client Funds for information on the policies and procedures for the

		administration and management of a participant's funds.
51.15 (g) Provider records	Does § 51.15 (g) include basic personal care items or is the provider still expected to pay for basic personal care items through room and board?	The provider is expected to pay for basic generic personal care items and comply with licensing regulations. However, if the individual chooses to use other brands that are different than the basic brands supplied by the provider, the individual would use their personal funds for this purchase and this must be documented in the ISP.
51.17 (a) Incident management	Which incidents require a certified investigation?	Incidents that require a certified investigation are referenced in the Incident Management statement of policy at 55 Pa. Code Chapter 6000, Subchapter Q Incident Management.
51.17 (b) Incident management	Where are health, safety and rights referenced?	Health, safety, and rights are referenced in the Incident Management statement of policy at 55 Pa. Code Chapter 6000, Subchapter Q Incident Management, 55 Pa. Code Chapter 6400, 55 Pa. Code Chapter 6500, 55 Pa. Code Chapter 2380, and 55 Pa. Code Chapter 2390. A Statement of Policy on Participant Rights was also published in the Pennsylvania Bulletin on February 9, 2013 http://www.pabulletin.com/secure/data/vol43/43-6/235.html.
51.17 (c) Incident management	Are there other policies that providers need to comply with?	All providers need to comply with the Incident Management statement of policy at 55 Pa. Code Chapter 6000 Subchapter Q and ODP Bulletin #6000-11-04, *Incident Management*.
51.17 (c) (17) Incident management	Does this subsection apply to Consolidated and P/FDS Waiver providers?	Subsection (c) (17) does not apply to a provider of HCBS in the Consolidated and P/FDS Waiver. This only applies to Adult Autism Waiver.

51.17 (d) Incident management	Is this regulation applicable to the common-law employer?	No, § 51.17 (d) does not apply to common-law employers. Under § 51.17 (o), the SSW is responsible to report incidents to the common-law employer.
51.17 (f) Incident Management	How would providers extend the deadline, if needed?	In order to extend the deadline, a provider must submit an extension request in HCSIS.
51.17 (h) Incident management	Are there specific staff positions that are required to review and analyze the events?	There are no specific staff positions that are required to review and analyze the events. The expectation is that the provider will use staff members who have the appropriate skills to perform this review and analysis.
51.17 (h) Incident management	How does the quarterly review and analysis of incidents relate to the current submission to AEs, which is to be submitted semi-annually?	Regular review is critical and essential to timely analysis, the identification of any patterns and effective implementation of systemic interventions. The semi-annual analysis requirement is being eliminated.
51.17 (m) Incident management	How will the Department determine if the risk management plan of a provider is acceptable or unacceptable?	Section 51.17 (m) does not require the development of a risk management plan. Section 51.17 (m) requires that providers analyze data on a participant to improve service delivery and to mitigate and manage risk factors. For more information about mitigating risk factors for the participant, refer to § 51.18 (b) (1) (i-vii).
51.17 (o) Incident management	Does this regulation apply to common-law employers?	This regulation is stated in the common-law employer agreement used in the Vf/Ea model.
51.18 Risk management	How does § 51.18 apply to SCOs?	SCOs are considered providers of service and are required to comply with this section regarding incidents involving their own staff. The SC will record other incidents not involving the SCO at the direction of ODP.
51.18 (a) (1)-(5) Risk management	Does § 51.18 (a) (1)-(5) refer to incidents reported by the provider?	Section 51.18 (a) (1)-(5) refers to incidents reported by the provider. Please also reference § 51.17 (m).
51.18 (b) Risk management	Does each participant need to have risk mitigation strategies identified?	The provider should consider the risk factors of each participant as specified in § 51.18 (b) (1) (i)–(vii) and develop risk mitigation strategies based on the individual's risk factors.

51.18 (b) (3) Risk management	Who trains the participant and staff? What content should be included in the training?	The provider is responsible for the staff and participant training within the purview of the service being delivered. The content is determined by the ISP team and specified in the ISP.
51.19 Certified investigations	Where can more information be found regarding incident management investigations and/or peer review?	ODP standards are communicated in ODP IM Bulletin, Chapter 6000, Subchapter Q, the Certified Investigators Manual, Certified Investigation Peer Review (CIPR) manual and established policy and protocols.
51.19 (a) Certified investigations	What is the provider's responsibility regarding certified investigations?	Please reference§ 51.17 (a) which states: "In accordance with Chapter 6000, Subchapter Q (relating to incident management) and the Department's Certified Investigator Manual on the Department's web site, a provider shall report incidents to the Department and ensure that a certified investigation is conducted."
51.22 Provisional hiring	Does staff include contractors and Family Living caregivers?	Yes, the definition of staff includes contractors. Under these regulations, the definition of "Staff" includes employees. Since Lifesharers that provide Lifesharing/Family Living services are employees of a provider agency and provide an HCBS through direct contact with a waiver participant, they are included in this definition.
51.23 Provider training	Do all of the training requirements for employees apply to Lifesharing families?	All training requirements apply to Lifesharing/Family Living caregivers.
51.23 Provider training	Is there a template for the training regarding accurate billing and documentation for staff?	No, there is not a template, but a provider may develop and update training (based on a provider's self-review, new policies, etc.). Providers should reference the applicable sections of the Chapter 51, Chapter 1101, and Chapter 1150 regulations as they are developing training.

51.23 Provider training	Define "annual". Must all staff be trained each year?	The annual training year for providers must be a 12 month period. The regulation states that the provider and all staff must be trained annually. Therefore, all employees that meet the definition of "staff" as detailed in § 51.3 Definitions must be trained within a 12 month period.
51.23 Provider training	Are the trainings referenced in § 51.23 required for SCOs as part of, or in addition to, the hours of ODP required SC training?	For SCOs, the training elements listed in the regulations are required annually. The SC Training bulletin and Appendix C of the approved P/FDS and Consolidated Waivers outline additional requirements. The annual training topics outlined in the waiver regulations will count towards the total number of ODP required training hours. The annual training year for SCOs shall follow the calendar year.
51.23 (a) (1) Provider training	What is meant by "intellectual disability principles and values"?	Please reference ODP Bulletin #00-03-05, *Principles for the Mental Retardation System* and the values listed in ODP Bulletin #00-10-02 *Quality Management Strategy of the Office of Developmental Programs*.
51.23 (a) (3) Provider training	What should the training on the Quality Management (QM) plan include?	Training regarding the QM plan should address the ODP QM priorities as communicated in the public notice, published on December 1, 2012 (42 Pa.B. 7350), as well as the strategies, priorities, objectives, and actions taken by the provider and why the objectives were selected for the provider's own QM plan. The public notice can be found at: http://www.pabulletin.com/secure/data/vol42/42-48/2331.html.
51.23 (a) (7) Provider training	What is meant by "Department-issued policies or procedures"?	Department-issued policies and procedures are distributed through the ODP listserves as they are developed and can be found on the following websites: ODP Bulletins at http://www.dhs.pa.gov/publications/bulletinsearch/index.htmand ODP Communications at https://www.myodp.org/.
51.23 (a) (8) Provider training	What would constitute training in accurate billing for direct care staff?	Staff should be trained specific to the function that they provide in billing (for example, documenting the provision of service delivery).

51.23 (d) Provider training	Will the department issue statements on a regular basis that include current policies and procedures and emerging practices that the department expects to be included in the annual training?	Providers must have a process to review all ODP issued policies and procedures. As stated above, department-issued policies and procedures are distributed through the ODP list serves and available at the following websites: MyODP at https://www.myodp.org/ ; Department of Human Services at http://www.dhs.pa.gov/index.htm , The Pennsylvania Code at http://www.pacode.com/index.html , and DHS Bulletin Search at http://www.dhs.pa.gov/publications/bulletinsearch/index.htm.
51.24 Provider monitoring	Where can I find more information on the Corrective Action Plan (CAP) process?	Please refer to the Corrective Action Plan (CAP) information on MyODP.
51.24 (a) Provider monitoring	The regulations state that the department monitors providers, but AEs do this monitoring. Please explain.	The department delegated the function of provider monitoring to the AEs per the waivers and Operating Agreement.
51.24 (b) Provider monitoring	What performance data will be provided to providers by the Department?	Data is provided by DHS to providers through various reports that are currently available in HCSIS. Providers should use existing HCSIS reports to analyze performance data.
51.24 (m) Provider monitoring	What does “follow-up monitoring” mean in this regulation?	Follow-up monitoring is described in ODP’s Provider Monitoring Process Manual available on MyODP. For SCOs, information is available in the SCO Monitoring webcast on MyODP.
51.25 Quality management	What are the requirements for the quality management plan and what should providers be ready to provide to licensors?	Information about the quality management plan is contained in § 51.25 d (1)-(6). Providers must include how they will meet department priorities. The department priorities were published as a public notice in the *Pennsylvania Bulletin* on December 1, 2012 (42 Pa.B. 7350). The public notice can be found at: http://www.pabulletin.com/secure/data/vol42/42-48/2331.html Providers must comply with the requirements under section § 51.25. Providers can access examples of a QM Plan and Action Plan Template on MyODP. The QM Plans will be reviewed during provider and SC monitoring, however

		providers should comply with any request for documentation during licensing.
51.25 (c)(2) Quality management	Do we know when reports in HCSIS and performance review data will be available for the providers?	Currently, data is provided by the DHS to providers through various reports that are available in HCSIS. Providers should use existing HCSIS reports to analyze performance data. Please refer to MyODP and the public notice that details the ODP QM priorities. The public notice can be found at: http://www.pabulletin.com/secure/data/vol42/42-48/2331.html
51.25 (c)(3) Quality management	The regulation states that in developing the QM plan, the provider is expected to review the results of provider and SCO monitoring. Should this read "or"?	No, all monitoring results that relate to provider performance should be reviewed and considered.
51.25 (c)(3) Quality management	Would ODP be responsible for providing the results to the provider? If so, at what phase?	For provider monitoring, the lead AE notifies the provider of the results of provider monitoring by issuance of a CAP at the conclusion of the monitoring. For SCO monitoring, the ODP regional office notifies the SCO of the results at the conclusion of the monitoring.
51.26 (a)(1) Grievance procedures	Would you provide more details about the 21 day timeframe in this regulation?	Grievance procedures should include processes to resolve a grievance within 21 days from the date of the filing of the grievance.
51.26 (a)(2) Grievance procedures	What should be included in the provider's procedures related to instructions for participants and families?	Providers' procedures should include how and how often providers provide the instructions to participants and their families.
51.27 (e) Misuse and abuse of funds and damage of participant's property	What does DHS mean by personal property that is "lost or damaged" by the provider? Does it include property lost or damaged as a result of provider "inaction" or failure to provide staffing supports in accordance with the ISP?	Personal property that is "lost or damaged" by the provider includes property that is lost or damaged as a result of provider "inaction" or failure to provide staffing supports in accordance with the ISP.

51.27 (e) Misuse and abuse of funds and damage of participant's property	Who is responsible to replace or pay for new property in the event a housemate damages/destroys an individual's property?	The answer to who is responsible to replace or pay for new property in the event a housemate damages/destroys an individual's property is situational and dependent on the result of an investigation. If the damage is the result of provider/staff negligence as determined by the Certified Investigation (as required by Incident Management Statement of Policy 6000-04-01), the provider would be expected to replace the property of a housemate. If the individual is held directly responsible, then a plan for restitution needs to be addressed in the ISP.
51.28 SCO requirements for Consolidated and P/FDS Waiver	Is the six month review of the need for residential habilitation HCBS addressed under the SCO requirements for Consolidated and P/FDS Waiver section to be a team process, as in § 51.28 (d), or is it to be done independently by the SC during a monitoring visit, as in § 51.28 (h)?	The SC will review the status of the person's services during a monitoring visit. If the six-month review during a monitoring visit identifies a change in need, an ISP meeting will be convened to discuss potential changes to the ISP. For more information about the six-month review, please refer to the ISP Manual, specifically the sections on Residential Habilitation Services.
51.28 (b)(3) SCO requirements for Consolidated and P/FDS Waiver	Additional information is needed regarding risk factors and mitigation strategies. What is expected?	When risk factors for an individual are known or identified by a provider rendering HCBS, the SC must include those issues and the mitigation strategies in the ISP as well as the specific training to be provided if required and who is to provide that training. 55 Pa Code § 51.18 (b) (1) - (5) outlines the risk mitigation strategies that providers are required to implement. The ISP team should collaborate to get the information included in the ISP. In addition, ODP is using certain components of the Annotated ISP that speak to risk migration areas to evaluate an individual's risk factors. The area of the Annotated ISP under which the components fall is Health and Safety. The component focus areas are: • General Health & Safety Risks • Fire Safety • Traffic • Cooking/Appliance Use

		• Outdoor Appliances • Water Safety • Safety Precautions • Knowledge of Self-Identifying Information • Stranger Awareness • Sensory Concerns • Meals/Eating • Supervision Care Needs • Reasons for Intensive Staffing • Staffing Ratio – Day • Staffing Ratio – Home • Staffing Ratio • Behavioral Support Plan • Crisis Support Plan • Health Care • Health Promotion
51.28_(c) (3) SCO requirements for Consolidated and P/FDS Waiver	What does an SCO do if an individual needs to be enrolled in the waiver due to an emergency situation and an ISP meeting is required to be held before the 30 calendar day advance notice provided by the invitation letter?	It is not necessary to provide at least 30 calendar days advance notice in emergency situations for new enrollees that require ISP meetings to be held more quickly to meet health and safety assurances.
51.28_(c) (5) SCO requirements for Consolidated and P/FDS Waiver	The 30 day timeline for submission of the ISP to the AE for review and approval is inconsistent with the timeline in the licensing specific program regulations. Would you please explain?	The licensing timeline, as specified in § 6400.187, only applies when there is no SC. If the individual has an SC, the SC is the Plan Lead.
51.28_(e) SCO requirements for Consolidated and P/FDS Waiver	Would you provide more information about the residential habilitation service criteria? How does the team determine the appropriate "size" of the program?	Please refer to the ISP Manual, ISP Review Checklist Informational Packet and related trainings, including the *ISP Review Checklist* course, for more information. For current training information, visit MyODP.
51.28_(f) SCO requirements for Consolidated and P/FDS Waiver	Does family living have to be offered twice a year to individuals receiving residential habilitation services?	This only applies for individuals who do not have an authorized residential habilitation service. For those who have an authorized residential habilitation, family living must be explored once per year during the annual ISP review.

51.28 (f) and (g) SCO requirements for Consolidated and P/FDS Waiver	Is the distinction here that § 51.28 (f) occurs at an ISP meeting and § 51.28 (g) at an alternative time?	The requirement in § 51.28 (f) can occur at any ISP team meeting. Subsection (g) is the next step after subsection (f) is considered not applicable; it can occur at any ISP team meeting. The need for a service can be the result of a change in circumstances that can occur at any time.
51.28 (j) SCO requirements for Consolidated and P/FDS Waiver	Would you provide more information about the process to request enhanced staffing?	Please refer to the Supplemental Habilitation (SH/ Additional Individualized Staffing (AIS) User Guide which can be found on MyODP .
51.28 (k) SCO requirements for Consolidated and P/FDS Waiver	Would you provide more information about risk factors and risk mitigation strategies?	Please refer to the ISP Manual, specifically the sections on ISP Preparation and Monitoring of Services and section 51.18 (b).
51.28 (l) SCO requirements for Consolidated and P/FDS Waiver	Where can I find more information about services that require a more frequent review?	Please refer to the approved Consolidated and P/FDS Waivers, specifically page 58 of the Approved Consolidated Waiver and page 57 of the Approved Person/Family Directed Support Waiver, and ODP Informational Packet 020-13, “ISP Review Checklist”, which includes information on services requiring a more frequent review.
51.28 (m) and (n) SCO requirements for Consolidated and P/FDS Waiver	Where can I find more information about SC documentation?	Please refer to ODP Bulletin #00-10-16, *Supports Coordination Services*.
51.28 (o) SCO requirements for Consolidated and P/FDS Waiver	Where can I find more information about documentation of use of personal funds?	Please refer to the ISP Manual and ODP Informational Memo #049-10, “Individual Purchases and Item Storage.” Section 51.28 (o) applies to all ISPs as required under this Chapter.
51.29 SCA requirements for Adult Autism Waiver	Does this section apply to intellectual disability services?	51.29 does not apply to intellectual disability services.
51.30 AWC/FMS requirements	Where can I find more information about AWC/FMS requirements?	Please refer to the ODP Bulletin #00-08-08, *Agency with Choice Financial Management Services (AWC)*. Section 51.30 applies to Agency with Choice (AWC/FMS). Public Partnerships, LLC (PPL) is the State’s Vendor/Fiscal Financial Management Services (V/F FMS) contractor.
51.31 Transition of participants	If the provider is no longer a "willing" provider, why must they provide a service for 30	The expectation is that the provider continues to support the person/people until they are able to transition to a new provider. Notification of at least 30 days

	days when they are no longer willing, or able to do so?	prior to ceasing services is the minimum requirement. However; if the provider cannot continue to provide the HCBS until another willing provider is selected due to emergency circumstances, they would need to provide written notification to the Department and AE.
51.31_(b) (5) Transition of participants	Can providers talk about the positives of staying with their organization/staff? Who determines "exerting undue influence"?	"Undue influence" is any act of persuasion that overcomes the free will and judgment of another. The provider may promote the positive aspects of its services to both prospective and current consumers. Anything that could be considered a "bribe, threat or manipulation" would not be acceptable. For instance, threatening to terminate one service if the participant does not choose that provider for a second service is unacceptable.
51.31_(f) Transition of participants	What is the definition of emergency circumstances?	The provider must notify the department if an emergency occurs and they are no longer able to provide services. An example would be the provider is unable to financially continue providing services.
51.31_(i) Transition of participants	There is a requirement that records be transitioned to the new provider. Is this expected to occur within seven days of selection of the new provider or does this relate to the effective date of the transfer?	Records must be provided to the selected willing provider seven days prior to the date of transfer. ODP would encourage records to be transferred as soon as possible to ensure a seamless transition.
51.31 (i) Transition of participants	Is there any guidance on what records are permitted to be released?	Please refer to HIPAA for guidance on record release. Documents that should be transferred include but are not limited to: lifetime medical histories, medical records, behavior support plans, assessments, psychological evaluation(s), an individual's personal identification documents, medical insurance information, and Social Security Award letters

51.32_Back-up plans	What are the expectations for SCs and providers regarding back-up plans? How does the SC monitor the effectiveness of the back-up plan? How often does the back-up plan need to be reviewed? Where should this back-up plan be found in the ISP?	Direct service providers are obligated to render services according to the approved and authorized ISP. A back-up plan is the strategy developed by a provider to ensure the HCBS the provider is authorized to provide is delivered in the amount, frequency, and duration as referenced in the individual's ISP. These back-up plans are developed with the unique needs and risk factors of the participant in mind and discussed and shared with the individual and team. A provider shall develop and provide detailed information on the back-up plan when individuals are supported in their own private residence or other settings where staff might not be continuously available. The ISP should include a backup plan to address contingencies such as emergencies, including the failure of a direct care support worker to appear when scheduled to provide necessary services when the absence of the service presents a risk to the participant's health and welfare. Back-up plans are then discussed and updated if necessary, during the ISP plan year or during the next ISP meeting. SC's should monitor that the individual is receiving the appropriate type, amount, duration, and frequency of services to address the individual's assessed needs and desired outcomes as documented in the approved and authorized ISP. If services are not rendered per the ISP due to the individual not being available because they are in hospital/rehabilitation care for an extended period of one week or more, the provider should notify the SC and AE immediately. Individuals that self-direct their services already complete a DP #1009 emergency back-up designation form. All other back-up plans should include the following: • The name and phone number of the provider to be called if the worker does not present as scheduled.

		• The name and phone number of the primary caregiver, and if available two natural support persons that may be called in the absence of a primary caregiver if the individual cannot get in touch with the provider. • A description of what things need to occur if no one is available to assist the individual (the individual's urgent needs and any actions that need to take place). • How the service will be rendered at the duration and frequency authorized. A participant's back-up plan can be included in the provider's written protocol. For SCs - Please refer to the back-up plan section of the ISP Manual for more information and where the information should be located in the ISP. The 24-hour response system is accepted as the SCO back-up plan.
51.32_(d) Back-up plans	A deviation in the provision of services per the ISP due to failure to implement a back-up plan when a participant is available requires reporting as an incident of neglect under Section 51.17. Does this include variances resulting from individual or family issues?	The back-up plan should apply when a participant is available to receive the service. An example of when a participant is not available is when the participant is on vacation or hospitalized. This section applies to all providers of waiver services, including providers of home-based services. Waiver providers are required to develop back-up plans to ensure the delivery of authorized services. Failure to institute a back-up plan that results in a deviation in the frequency or duration of services as specified in the ISP would require a provider to file an incident report of neglect and investigate.
51.32_(e) Back-up plans	As per the Participant Directed Services Guide, individuals whose staff is paid through Acumen are expected to have back-up plans (DP 1004). Why is this section not applicable?	Under the VF/FMS model the obligation to develop and institute a back-up plan is the Employer's, not the SSW. This requirement is noted on the department's form titled "Common-law Employer/Surrogate Agreement Form".
51.33_Conflict of interest	What are the requirements for board membership?	As specified in Supports Coordination service definition in the Consolidated and P/FDS Waivers, a provider's board of directors cannot exceed a maximum of

		49% of members who have a business or fiduciary relationship with a direct provider of Consolidated, P/FDS, or ID Base Services other than SC or TSM.
51.33_Conflict of interest	What does the department consider a conflict of interest that needs to be disclosed?	Conflict of interest is defined as a situation in which a person, corporation or entity has a personal or professional relationship which is able to be exploited by that person, corporation or entity for personal, professional or financial benefit or gain.
51.34_Waiver of a provision of this chapter	Would you provide more information about requesting a waiver?	Please see ODP Informational Packet 002-13 "Request for Waiver of a Provision of Chapter 51"_for more information about submitting waiver requests.
51.34_Waiver of a provision of this chapter	What is the relationship between provider appeal rights under Chapter 41 and the request for a waiver of Chapter 51?	A provider has its appeal rights under Chapter 41 (relating to Medical Assistance provider appeal procedures). Under Chapter 51, the department may grant a waiver to a provision of this chapter which is not otherwise required by federal, state or local requirements and does not jeopardize the health, safety or well-being of the participant. A provider who sends in a request for a waiver to a provision under Chapter 51 and gets a denial from the department may appeal that decision under Chapter 41.

Subchapter C. PAYMENTS FOR SERVICES

Regulation	Question	Answer
51.42_Definitions	Where can I find more information about reserved capacity?	For more information about Reserved Capacity, refer to the Reserved Capacity webcast posted on MyODP.
51.43_(a) (2) Department rates and HCBS classification	Why is the term "vendor goods and services" not explained here?	Please refer to § 51.62 which includes a definition of vendor goods and services.
51.44_(a) and (b) Payment policies	What provisions in Chapters 1101 or 1150 do not apply because they are inconsistent with this Chapter?	Chapter 51 prevails when there is a conflict with Chapter 1101 and Chapter 1150 relating to the general provisions of the Medical Assistance payment policies.

51.44 (c) Payment policies	Where can I find more information about what should be included in the ISP?	Please refer to the approved Consolidated and P/FDS Waivers and ISP Manual.
51.44 (d), (e), (f) Payment policies	What services are considered "allowable under a third party resource"? How will this work when the provider is not part of the managed care plan or insurance provider network?	You would need to contact the third party insurance to identify which services are allowable and non-allowable. If the waiver provider is not a qualified provider under private insurance, company, state MA plan and/or state managed care company, the provider can choose to enroll with third party medical insurance.
51.44 (f) Payment policies	What is the denial related to?	The denial is related to the waiver participant and/or the service, not the provider's eligibility as a provider.
51.44 (g) Payment policies	Where can I find more information about payments made under MA?	Please refer to the Chapter 1101 regulations for additional requirements.
51.44 (h) Payment policies	Would you please explain "supplemental payments"?	"Supplemental" is defined as compensation in excess of the rate for the HCBS. Needed services must be provided under the waivers, based on the assessed needs of the individual. Some examples of supplemental payments may be SNAP, energy assistance, rent rebates and similar benefits. Supplemental payments related to room and board (e.g. SNAP, etc.) are not considered in excess of the rate and do not need to be returned to DHS by the provider. These payments are to be used to offset the occupancy expenses. An example of a supplemental payment that is required to be returned is if a family member was paying extra money to the provider for additional staffing. The provider would need to return this payment to the family as the department's payment for the service must be accepted as payment in full.
51.44 (i) Payment policies	What are the 1101 references?	Please refer to the Chapter 1101 regulations (Part III of the Medical Assistance Manual, General Provisions) for additional information.
51.45 Provider billing	How does this section relate to the progress note requirements?	Providers must have documentation to support the billing of a claim.

51.45 (b) Provider billing	What is the department's Medicaid Management Information System (MMIS)?	The Department's MMIS is PROMISe™. Please refer to DHS's PROMIS*e*™ Manual.
51.45 (c) and (d) Provider billing	Where can I find additional information about provider billing documentation?	The information regarding provider billing documentation is contained in this regulation, Chapter 1101, and Chapter 1150.
51.47 Reporting requirements for ownership change	What process should be used to report changes in ownership?	Anytime a provider changes their ownership, the provider needs to update the Ownership and Disclosure form that is used by Office of Medical Assistance Programs (OMAP). However, if a provider changes its FEIN, it will be considered a new provider and will have to start the enrollment process from the beginning. The link to the Ownership and Disclosure form is: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994 On the webpage you will see the following wording: "PLEASE NOTE: Click here for the enhanced ownership or controlling interest form. It is mandatory for most provider applications. Please check your requirements page to see if it applies to you."
51.53 Fee schedule rate reimbursement	How does this section relate to audit requirements?	The fee reimbursement is not considered sub-recipient funds for audit purposes. See Section 51.46 for more information. Providers receiving payments for services based on a department-established fee are considered vendors, not sub-recipients as the term is defined in OMB Circular A-133, and the resulting payments are not to be considered federal awards.
51.61 Vendor goods and services applicability	Will ODP accept language within a vendor agreement with their representative's signature attesting that no employee is listed on List of Excluded Individuals/Entities (LEIE) or EPLS? Is this solely a business decision and ODP is only stating reimbursement will not occur if this is determined? How would the "provider of goods and services" know if an "entity or	Section 1903(i)(2)(A) and (B) of the Social Security Act (42 U.S.C. § 1396b(i)(2)(A) and (B)) and 42 CFR 1001.1901(b) provide that Medicaid payment cannot be made for items and services delivered by an excluded party. Please refer to Medical Assistance Bulletin # 99-11-05, *Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs and the Effect of Exclusion on Participation* and ODP Announcement 031-13 Migration of the

	participant" "employs staff that are listed on the LEIE or EPLS"? The provider we use to make payments to contractors (ex: environmental adaptations) checks the list for the contractor, but they would have no way of knowing who the contractor has hired to do the actual adaptations.	Excluded Parties List System to the System for Award Management for more information.
51.62 (i) Vendor goods and services reimbursement	What are the "applicable provisions" to which it is expected a subcontractor adhere?	All of Chapter 51 applies unless otherwise noted.
51.62 (j) Vendor goods and services reimbursement	Is "a provider of vendor goods and services" different than a "vendor". Also, does attestation only apply to a vendor? When do we need to get a copy of the attestation? If a periodic service is an attestation needed each time or is one attestation sufficient?	Please refer to the definitions of "vendor" and "vendor of goods and services." Under § 51.62, a "provider" of vendor goods and services is the same as "vendor". The attestation is provided by the vendor to the SCO and the department's designee (the appropriate AE) prior to the inclusion of the vendor in the participant's ISP. The attestation is needed prior to the vendor of goods and services being added to the participant's ISP. A published copy of the vendor's public rates for the goods and services may be substituted for the attestation.
51.72 Cost-based rate assignment	Services that we understand that are now fee-based are listed within the cost based services. Would you please clarify?	The regulations were effective July 1, 2011. Within § 51.72, the end date is indicated for when the service is no longer a cost-based service. A public notice establishing which services were to be included on the fee schedule effective July 1, 2012 was published in the Pennsylvania Bulletin on June 30, 2012.
51.73 (d) Cost report requirements	Section 51.73 (d) references allowable administrative fee in the Cost Report. Schedule D-3 of the Cost Report, however, has no reference to an admin fee. Where would documentation of the administrative fee be located?	Please refer to the cost report instructions on MyODP. for more information about the allowable administration fee and where to report the administration fees.

51.74 (13) Approval of a cost-based rate for non-transportation HCBS	Please clarify "necessary household goods and furniture provided for the participant."	Section 51.74 applied through June 30, 2012. Effective July 1, 2012, the following items are included in the residential ineligible fee: household goods and furniture necessary for the individual to live comfortably including, but not limited to bedroom windows with drapes, shades, blinds, or shutters; a bed of a size appropriate to meet the needs of the individual; a clean comfortable mattress; bedding including a pillow, linens and blankets; a chest of drawers; a closet or wardrobe; mirror; dresser; sufficient amount of living and family room furniture sufficient to seat all individuals at the same time; dining tables with seating for all individuals at the same time; basic cable and basic phone.
51.74 (15) Approval of a cost-based rate for non-transportation HCBS	What process should a provider use to request additional staffing costs?	SH and AIS are specific waiver services that address an individual's need for additional staff. Please refer to the SH/AIS User Guide on MyODP and the "ODP Informational Packet 020-13 "ISP Review Checklist" for more information. In some circumstances, a provider may request additional staffing for more than one person by using the high cost rate request process. Information about the high cost process can be obtained from your Regional Fiscal Officer (RFO).
51.86 (b) (1) Corporate boards	What meals are allowable expenses?	The Management Directive for DHS travel should be followed for the expenses to be an allowable cost.
51.92 (d) (1) and (2) Rental of administrative, residential and nonresidential buildings	Where can I find more information about capital lease requirements?	Please see the definition of a capital lease under Financial Accounting Standards Board (FASB) Accounting Standards Codification Section 840-10-25-1. Capital lease requirements under Generally Accepted Accounting Principles (GAAP) require an operating lease to be treated as a capital asset and be depreciated. We suggest consulting your auditor for applicability to your lease arrangements.
51.94 (i) (3) Fixed assets	The fixed asset regulation requires an annual physical inventory at the end of the funding period. Would an	Yes, this would suffice as long as each item has been inventoried at least once per year.

	annual inventory performed throughout the funding period ensuring that all programs have been inventoried prior to the end of the funding period suffice?	
51.95 Motor vehicles	What is the procedure for pay back regarding the personal use of a provider's vehicle?	The provider shall review Internal Revenue Service publication 15-B (Employers Tax Guide to Fringe Benefits) for guidance on how the provider should establish a procedure within its organization for employee personal use of company vehicles. If an employee violates the policy on the personal use of company vehicles, the provider shall have an internal protocol to address these instances and a method for pay back to the department per the cost report process.
51.96 (c) Capital assets – administrative and nonresidential buildings	What is the process for approval?	A protocol regarding this is being developed and will be released when completed. Until this protocol is released, contact your RFO for information about the current interim process.
51.96 (f) Capital assets—administrative and nonresidential buildings	Please clarify.	Non-residential services have moved to Fee Schedule; therefore, the department will not recoup the funded equity either directly or through rate setting. The provider is not responsible to calculate the amount reimbursed or request funds be reinvested. For assets that remain cost-based (e.g., administrative buildings) these provisions still apply.
51.97 (5) Capital assets – residential buildings	Please clarify.	Residential ineligible services have moved to department established Fee; therefore, the department will not recoup the funded equity either directly or through rate setting. The provider is not responsible to calculate the amount reimbursed or request funds be reinvested.
51.98 Residential habilitation vacancy	How does a provider request a waiver of the vacancy factor?	For more information, refer to ODP Informational Memo 003-13 "Vacancy Factor and Vacancy Exception Process".
51.100 Moving expenses	Will a procedure be sent out for requesting prior written approval for moving expenses?	A protocol regarding this is being developed and will be released when completed. Until this protocol is released,

		contact your RFO for information about the current interim process.
51.100_(b) Moving expenses	In order for participant costs to be allowable, a provider must receive authorization from the department when moving participant's to another service location when § 51.100 (a) applies. If an internal move is taking place to fill a vacancy with a new participant we interpret that moving expenses are allowable and § 51.100 (b) does not apply to this one internal move.	If a provider is planning on the moving expenses for internal moves to be considered allowable costs, then the provider will need to notify the department or the department's designee prior to the move. In these cases, the department's designee is the AE who would authorize services at the new service location code. Therefore, if the provider receives prior approval from the Regional Program Manager before the move, the obligation would be met to notify the department or designee and the moving expenses would be considered allowable costs. Please refer to ODP Informational Packet 098-12 "ODP Procedure for Residential Vacancy Management" for more information.
51.100_(b) Moving expenses	If an individual moves from one residential provider to another and is served by both providers at different times on the same day, which provider may bill for that day of service?	The new residential provider will bill for that day of service, as the current provider will not receive payment for the day of discharge.
51.111_Start-up costs	Can a provider bill for start-up costs for Lifesharing (staff time and travel, paying potential families during visits...)?	Residential habilitation homes may receive start-up costs, which are capped at $5,000 per new participant to the provider. Staff time and travel time is included; please refer to Statement of Policy (SOP) 98-5 issued by the American Institute of Certified Public Accountants for further guidance. Paying potential Family Living/Lifesharing families during visits for further guidance is not included.
51.111_Start-up costs	Where will the housing stock and other necessary real estate come from? Can start-up be used for leases and down payments?	Please refer to SOP 98-5 issued by the American Institute of Certified Public Accountants for a description of start-up costs.
51.121_Room and board	Do we need a denial for SSI on file? If a participant already receives more in Social Security than SSI permits, do we have to apply?	Even if a participant already receives more in Social Security than SSI permits, the provider must apply for all benefits for which the individual might be eligible. If an individual is denied Social Security

<table>
<tr><td></td><td></td><td>benefits, the denial letter should be maintained in the individual's file.</td></tr>
<tr><td>51.121 Room and board</td><td>How are food stamps or other income to be used? Is it an offset to the person's contribution or the provider's expenses?</td><td>SNAP or other income is an offset to the room and board/ineligible costs of the provider. The fee for residential ineligible may always be billed. Please reference section 51.128.
Example 1:
<table>
<tr><td>Room and board costs before SNAP benefit is received</td><td>$750</td></tr>
<tr><td>Monthly SNAP benefit</td><td>$50</td></tr>
<tr><td>Monthly rent rebate or energy assistance (Total amount received divided by 12) not to exceed actual cost of heating bill or rent</td><td>$50</td></tr>
<tr><td>Room and board costs after SNAP, rent rebate and energy assistance benefits are received</td><td>$650</td></tr>
<tr><td>72% of SSI Maximum ($698+$22.10)*72%</td><td>$518.47</td></tr>
<tr><td>Consumer contribution</td><td>$518.47</td></tr>
</table>
Example 2:
<table>
<tr><td>Room and board costs before SNAP benefit is received</td><td>$550</td></tr>
<tr><td>Monthly SNAP benefit</td><td>$50</td></tr>
<tr><td>Monthly rent rebate or energy assistance (Total amount received divided by 12) not to exceed actual cost of heating bill or rent</td><td>$50</td></tr>
<tr><td>Room and board costs after SNAP,</td><td>$450</td></tr>
</table>
</td></tr>
</table>

rent rebate and energy assistance benefits are received	
72% of SSI Maximum ($698+$22.10)*72%	$518.47
Consumer contribution	$450

51.121 (a) Room and board	Will the department be reissuing a new room & board contract based on the changes in the regulations?	The department has issued a room and board contract for individuals receiving waiver services (DP 1051). This form is part of ODP Announcement 015-13 and can be found on MyODP. Please note that if a provider agency has a current, accurate room and board contract in the participant's file, ODP is not requiring provider agencies to complete the new Room and Board Contract Under 55 Pa. Code Chapter 51 form. The intent is for provider agencies to begin using the Room and Board Contract Under 55 Pa. Code Chapter 51 form when a new contract is needed as specified in §§ 51.122 and 51.125.
51.121 (d) (2) Room and board	How exactly are providers to prorate the board cost when an individual is on leave? Does this include family visits and therapeutic and medical leave?	Proration of board costs can occur monthly, quarterly or semiannually. The provider must keep a record that the board costs were returned to the participant for every day of leave. This applies to all absence/leave types, both medical and therapeutic. Therapeutic leave includes family visits.
51.121 (f) Room and board	If there has been an SSI over-payment and the person's benefit is temporarily adjusted to re-coup, how is this to be treated?	If there has been an SSI over-payment and the person's benefit is temporarily adjusted to re-coup, no change should occur in the expected obligation/payment although there may be an understandable delay in the participant's room and board payment. The provider must assure that the individual has at least $30 per month for personal needs. With

		the change in practice effective July 1, 2012, providers no longer have to wait for SSI payments to bill residential ineligible services in PROMISe™.
51.121 (g) Room and board	Is this amount $30 as per Chapter 6200.17?	The current amount is at least $30. The commonwealth and Social Security set the amount for facility based services.
51.121 (l) Room and board	How does the room and board regulation work for Lifesharing programs?	The contract between the providers and the person providing Lifesharing should stipulate the manner in which room and board payments are collected and utilized.
51.121 (m) Room and board	What are the expectations regarding compensation for any costs related to participants that are tube fed?	Costs related to participants that are tube fed should be covered by medical insurance. Room would be charged at 40 percent of the maximum SSI plus State Supplemental Payment (SSP) as per 51.124.
51.122 Room and board contract	How are actual room and boards costs in Lifesharing figured out?	Room and board costs for Lifesharing are determined by the contract between the provider and the life sharer. The actual charge to the individual cannot exceed 72 percent of the maximum SSI plus the SSP.
51.123 Actual room and board costs	To which programs does this room and board regulation apply?	This regulation applies to providers participating in the Adult Autism, Consolidated and P/FDS Waivers as well as base funded individuals receiving services in a waiver funded service location.
51.128 (b) SNAP, energy --assistance, rent rebates and similar benefits	How is room and board calculated if additional benefits are received?	Room and board is calculated as follows if additional benefits are received: Take the actual cost for room and board at the home for each individual and first subtract the additional benefits received (SNAP, rent rebates, etc.). If the remaining cost for room and board, after subtracting the additional benefits, exceeds the maximum 72percent of SSI plus SSP then the agency can collect the maximum 72percent of SSI for the individual. If the remaining cost for room and board, after subtracting the

		additional benefits, does not exceed the maximum 72percent of SSI plus SSP, then the agency can only collect the remaining cost from the individual. The department-established fee (residential ineligible) can always be billed when the service has been rendered.
51.128_(b) SNAP, energy --assistance, rent rebates and similar benefits	Are providers required to apply for SNAP? What is meant by "A provider shall assist a participant in applying for SNAP, energy assistance, rent rebates and similar benefits"?	Section 51.128 applies to benefits that may be available to a waiver participant. A waiver participant must apply, and a provider must assist if needed, with gathering financial information, taking the waiver participant to the County Assistance Office, and supporting the waiver participant through the application process.
51.141_(c) Organized health care delivery system	The utilization of the Excluded Party System appears to be only referenced in regards to vendor services (Section 51.140 (c)). Is this accurate? Does this mean that we are not required to run it with our other exclusion checks, if we do not offer vendor services?	Section 51.141 (c) applies to all MA providers as established under § 51.152 "Termination of provider agreement" and vendor services as established under § 51.62(g) "Vendor goods and services reimbursement".
51.141_(f) Organized health care delivery system	Are we expecting vendors to have a "subcontract"?	It is not expected that vendors have a "subcontract". There needs to be documentation regarding what is to be purchased (the item, supply or good) and compensation, but no subcontract is required.

Subchapter D. CLOSURES AND TERMINATION

Regulation	Question	Answer
51.153_Sanctions	If the provider is required to submit an audited financial statement, is the provider then not required to submit an attestation engagement, fiscal review, or compliance attestation unless specifically requested by the department?	Yes, submitting provider-audited financial statements would meet this requirement.
51.155_Provider closure requirements	What is the timeframe for provider closure?	The Department requires 30 days' notice for providers of HCBS services, as referenced in § 51.31_(c), and 90

		days’ notice for SCOs, as referenced in § 51.154 (b).

Additional resource links:
• Approved Adult Autism Waiver
• Approved Consolidated Waiver
• Approved Person/Family Directed Support (P/FDS) Waiver
• Chapter 1101 Regulations
• Chapter 1150 Regulations
• DHS Bulletins Search
• DHS PROMIS*e*™ Manual
• ODP Informational Packet 002-13 “Request for Waiver of a Provision of Chapter 51”
• ISP Bulletin and Individual Support Plan (ISP) Manual for Individuals Receiving Targeted Services Management, Base Funded Services, Consolidated Waiver Services, P/FDS Services or Who Reside in an ICF/ID: 00-16-06
• MyODP
• The Pennsylvania Code Online
• Pennsylvania Bulletin Online

Additional helpful information:
• General regulatory information
o Unless otherwise stated, a day is a calendar day.
o If a term (e.g. provider) is stated in the singular, this also includes the plural (e.g. all providers).
o Unless a section specifies that a regulation is not applicable to a particular entity, the regulation is applicable.
• Chapter 51 applies to providers of MA waiver HCBS and MA-funded TSM. It also applies when the agency provides a HCBS to both waiver and base-funded participants from a waiver service location. Specific citations regarding whether a subchapter applies to an SCO are included at the end of each subchapter.
• Specific effective dates are contained in the Source section of the Chapter 51 regulations.
o For billing purposes, a day unit is defined in the ISP Manual for Individuals Receiving Targeted Services Management, Base Funded Services, Consolidated Waiver Services, P/FDS Services or Who Reside in an ICF/ID

Obsolete Documents:
Informational Memo 069-13, Chapter 51. Office of Developmental Programs Home and Community-Based Services Regulation Questions and Answers