

RULES AND REGULATIONS

Title 28—HEALTH AND SAFETY

DEPARTMENT OF HEALTH
[28 PA. CODE CH. 4]

Head Injury Program

The Department of Health (Department) hereby adopts Chapter 4 (relating to head injury program) to read as set forth in Annex A.

Scope and Purpose

The regulations establish standards by which the Department will administer the Catastrophic Medical and Rehabilitation Fund (Fund). The Emergency Medical Services Act (act) (35 P. S. §§ 6921—6928) establishes the Fund. Section 14(e) of the act (35 P. S. § 6934(e)) states that the Fund “shall be available to trauma victims to purchase medical, rehabilitation and attendant care services when all alternative financial resources have been exhausted. . . .” Section 14(e) of the act also permits the Department to adopt regulations to prioritize the distribution of moneys from the Fund by classification of traumatic injury. The final-form rulemaking provides that the Department will use moneys from the Fund to provide designated services to persons who have incurred a traumatic brain injury (TBI).

The Department has established a Head Injury Program (HIP or Program), administered by its Division of Child and Adult Health Services (Division), to make distributions from the Fund. Parameters for participation in the Program, including eligibility requirements, are established in the final-form rulemaking. The regulations also address Program administration, including assessment procedures, services to be reimbursed by HIP, funding and time limitations on participation and appeal procedures.

Public Comments

Notice of proposed rulemaking was published at 29 Pa.B. 2671 (May 22, 1999), with an invitation to submit written comments within 30 days. Within the 30-day comment period, the Department received several comments. Subsequently, the Department received comments from the Independent Regulatory Review Commission (IRRC); Senator Vincent Hughes, Minority Chair of the Senate Public Health and Welfare Committee; and Representative Linda Bebko-Jones of the 1st Legislative District. A meeting to discuss these comments prior to the preparation of the final-form rulemaking was held on July 13, 1999, among representatives of the Department, IRRC, the House Health and Human Services Committee and the Senate Committee on Public Health and Welfare.

It should be noted that, although the final-form regulations and the underlying Program have not substantively changed, the final-form version of the regulations virtually rewrites and reorganizes the proposed regulations to improve organization and clarity. The final-form regulations have been restructured first to follow the process of the applicant’s placement on the waiting list, applying, being assessed and enrollment in the chronological order that each actually takes place. This enables an individual seeking to understand the Program to get a clearer picture of “what happens next.” Although this process is no different than it was when the regulations were originally proposed, it was not presented in serial fashion at that time.

The final-form regulations also clarify the two separate stages of evaluating eligibility for the Program, with the first stage being consideration of requirements that can be evaluated on paper, including domicile, general financial situation and absence of certain preexisting medical conditions. Meeting these requirements makes an applicant eligible for an in-depth assessment. The outcome of this assessment will determine whether the applicant is eligible to be accepted into the Program and receive rehabilitation services. Again, this is how the Program was conceived at the time the regulations were first proposed; the process is simply made clearer in the final-form version.

A considerable amount of the information in the final form version of the regulations was taken from the regulations as they were first proposed. Although detail has been added in a number of areas, those details are largely not ones that have been newly conceived. Rather, it was determined that the addition of the information would assist readers of the final-form regulations to understand how the Program works.

In addition, a number of changes have been made in response to comments. Because the changes in form, if not in content, are so sweeping, the comments to the proposed regulations are addressed under the current section in which the subject matter addressed by the comment appears. Following is a discussion of the comments received by the Department and the Department’s response to them.

Section 4.1—Scope and purpose

No comments addressing this section were received.

The proposed section was revised to remove the statement that the Department will provide rehabilitation services “facilitated through case management.” This phrase was inserted elsewhere because it is a substantive provision that is too specific to be included in a section addressing the scope and purpose of the chapter. Language is inserted to follow the statute more closely by specifying that the Fund may be used to pay for “medical, rehabilitation and attendant care services” for persons with TBIs.

Section 4.2—Definitions

This section contains definitions of terms used in the chapter.

Comment

The definition of “day services” should be revised to include physical abilities as one of the abilities day services are designed to improve.

Response

The Department accepts the recommendation, and has made the suggested change to the definition of “day services.”

Comment

The Division should be specifically mentioned in the proposed definition of “Division” as the division that will be responsible to administer HIP.

Response

The Department accepts the recommendation.

Comment

It is proposed that the term “exhausted” be defined as the point at which alternative financial resources (AFRs) have been applied for and denied or fully utilized. It is unclear what “exhausted” means in terms of AFRs. This term may not be necessary if the financial eligibility criteria are specified in more detail.

Response

The Department agrees with the comment. The term “exhausted” is not defined in the final-form regulations. The financial eligibility criteria for participation in HIP are now specified in § 4.6(a)(1)(v) (relating to assessment), which requires applicants to have AFRs not in excess of 300% of Federal Poverty Income Guidelines to participate in the Program. AFRs are defined as all income subject to Federal income tax, funds available to an individual by virtue of experiencing a TBI and funds available to an individual through other State or Federal programs. These are resources that must be used to pay for HIP services until these resources are reduced to the threshold amount. Because the final-form regulations now make clear that an applicant or client cannot have AFRs in excess of 300% of the Federal poverty level, it is not necessary to require that AFRs be “exhausted.”

Comment

The term “legal representative” is used but not defined in the proposed regulations. This term should be defined to refer to one who is legally empowered to act for a head injury applicant or client. This will clarify who can act in this capacity and will also avoid repeatedly iterating a list of persons who may or may not be so empowered.

Response

The Department agrees with the comment. The term “authorized representative” is now defined in this section to include any individual authorized by law to make a decision for an applicant or client. Defining “authorized representative” as one who is legally authorized to act for an applicant or client clarifies that the input of an authorized substitute decision maker is acceptable. Whether or not an authorized representative exists, the applicant or client, of course, is free to share information with, and solicit the assistance of, parents, guardians or anyone else the applicant or client chooses.

Comment

The definition of “legal representative” should include a reference to “minor.”

Response

The Department disagrees. The final-form regulations provide that only individuals who are 21 years of age or older may participate in HIP. Therefore, no reference to minors is needed.

Comment

The definition of “rehabilitation” should include “home facilitation” in the list of services that are included.

Response

The Department accepts the recommendation. The defined term that appears in the final-form regulations is “rehabilitation services,” as opposed to “rehabilitation.” “Home facilitation” is included in the list of services contemplated by the term “rehabilitation services.” Additionally, part of the remaining substance of the proposed definition was moved to § 4.9 (relating to rehabilitation period).

Comment

The final sentence of the definition of “rehabilitation service plan” should be deleted, as it inappropriately contains substantive provisions and duplicates language found in the substantive portions of the final-form regulations.

Response

The Department agrees with this comment. The final sentence has been deleted.

Comment

The definition of “rehabilitation service plan” should include “the client’s parent, guardian or representative” among those who collaborate in the development of the rehabilitation service plan.

Response

The Department agrees with the recommendation in part. Much of the proposed definition of “rehabilitation service plan,” including the part that addressed with whom the provider could collaborate in developing the plan, has been moved to § 4.8 (relating to rehabilitation service plan). The term “authorized representative” is now used. It is more comprehensive than “parent, guardian or representative.” Section 4.8 does state that the provider may collaborate with the applicant’s or client’s significant others, such as family or healthcare providers, in the development of a rehabilitation service plan. This permits the provider the flexibility to consult with members of the individual’s support system, who may be most aware of the individual’s needs, when developing and revising a rehabilitation service plan for an applicant or client.

Comment

The definition of “rehabilitation services” should include therapeutic recreation and prevocational services. These services assist community integration and community reentry skills.

Response

The Department agrees with the comment, and has incorporated these services in the definition of “rehabilitation services.”

Section 4.3— Services eligible for payment

This section lists the services that may be paid for through HIP.

Comment

Proposed § 4.7 appears to limit payment for services to “clients.” However, the services that will be paid by HIP include assessments. It would seem that assessments are for applicants, who are not necessarily clients. This should be revised to be consistent.

Response

The Department agrees. Paragraph (1) states that assessments of applicants by providers are among the services for which HIP will pay.

Comment

Case managers should be reimbursed for travel time.

Response

The Department disagrees. The fee schedule utilized by HIP establishes the rate at which case managers can be reimbursed for their time. This rate assumes delivery of services to clients, and does not reimburse for travel time. The fee schedule

does, however, allow for reimbursement for mileage. Because HIP funds are limited, the Department has determined that case management reimbursement will be limited to actual services delivered.

Comment

Education and training sessions should be offered to case managers to improve their knowledge, resource bases and facilitate information exchange among them.

Response

The Department disagrees. It will be the responsibility of the providers with whom the Department contracts to ensure that useful educational opportunities are available to case managers and other staff in their employ.

Section 4.4— Requirements for provider participation

Comment

The proposed regulations do not indicate what the “appropriate National accrediting [bodies] as approved by the Department,” referred to in proposed § 4.7(4) are, or how a member of the public could find out what they are. The final-form regulations should specify approved National accrediting bodies, or should state how a list of these may be obtained.

Response

The Department agrees. Subsection (a) states that a list of Department-approved National accrediting bodies will be published from time to time in the *Pennsylvania Bulletin*. Additionally, a list can be obtained by contacting the Division. At this time, the only National accrediting body approved by the Department is the Commission for Accreditation of Rehabilitation Facilities (CARF). CARF is currently the predominant National accrediting body for rehabilitation providers in the field of brain injury rehabilitation. The Department will certainly consider other qualified bodies for approval as the opportunity arises.

Comment

Requiring rehabilitation facilities to obtain accreditation makes voluntary accreditation mandatory. A requirement of specific accreditation of HIPs could result in lack of access to HIP and head injury services for patients in some regions of this Commonwealth. Minimum standards for HIPs should be defined in the final-form regulations and not deferred to accreditation.

Response

The Department rejects the recommendation. The Department believes that the requirement that HIP providers be certified by qualified accrediting bodies assures that uniform National recognized standards of care are available to all enrolled HIP clients, and serves as a continued quality assurance tool and measure.

Section 4.5— Application for enrollment as a HIP client

This section addresses the procedures for securing and filing an application for enrollment in HIP.

Comment

Is there a specific application form? How do applicants obtain a copy?

Response

Subsection (a) provides a contact address at the Department and also states that individuals may contact the Department by electronic mail or facsimile. Individuals who are interested in enrolling in HIP or arranging enrollment for another should write to the Eligibility Specialist at the address provided, by e-mail at: eterrell@state.pa.us or by fax at (717) 772-0323. If there is not sufficient funding to enable HIP to consider accepting a new client at the time the individual makes contact with the Division, the individual will be placed on a waiting list under subsection (c). Subsection (d) makes clear that the Division will provide application materials, including an application form, when the individual qualifies to receive an application; that is, whenever there is sufficient funding for HIP to be able to consider new applicants and the individual is next on the waiting list.

Comment

What verifying documentation must accompany the application form?

Response

The application must be accompanied by a physician’s statement (the format for which will be provided by the Department), a completed Commonwealth income tax form, documentation of insurance including copies of any insurance cards and documentation of citizenship and residency. This will be explained to the applicant or the applicant’s authorized

representative at the appropriate time. The explanation will be in the instructions the Division provides for completing the application form.

Comment

The final-form regulations should contain a provision that clearly addresses the status of the individuals currently on the waiting list. This provision should also outline the process of notifying those individuals of the Department's changes to HIP policy.

Response

The Department accepts the recommendation in part. Subsection (c) states that individuals on the waiting list will be asked to submit applications in the order that their requests to be placed on the list were received by the Division. Consequently, those individuals who are on the waiting list as of the date these final-form regulations are adopted will be able to apply for enrollment before individuals who are placed on the list after them. The section also states that individuals who are on the waiting list who have already received case management services through HIP, but never received rehabilitation services through HIP, will be given first priority. This class of individuals, those who receive case management services before receiving rehabilitation services, will cease to exist after the individuals who currently comprise the class are handled by the Program. This section further states that those persons who have never received rehabilitation services through HIP will be given priority over those who have previously received rehabilitation services through HIP.

The Department will send letters to all current HIP clients upon the adoption of these final-form regulations, explaining the new policies and the benefits to which they will be entitled. The Department will also send letters to all individuals on the waiting list. Additionally, the final-form rulemaking will be published in the *Pennsylvania Bulletin* and will be posted on the Department's website.

Comment

The Department should clarify how the waiting list referenced in proposed § 4.5(b) will be prioritized—for example, by date of application, degree of injury or some other criteria.

Response

As previously stated, individuals on the waiting list will be asked to submit applications in the order that their requests to be placed on the waiting list were received. The exceptions to this are individuals who are receiving or have received case management services prior to formal enrollment in HIP, who will be given first priority as stated in subsection (c), and individuals who previously received HIP services and who are reapplying. Individuals who have never received HIP rehabilitation services will be given priority over former HIP clients, as stated in subsection (e).

Comment

The Department should clarify whether an applicant must reapply once the applicant is placed on the waiting list, and how reapplicants will be prioritized.

Response

As explained in subsection (a), individuals do not formally begin the application process until the Division notifies them that it is their turn to apply. They are placed on the waiting list because there are no funds available to add them to the Program when they initially contact the Division. Their addition to the waiting list is accomplished via a signed letter sent to the Division. Individuals on the waiting list are then invited to submit an application for enrollment in HIP as funding becomes available and their turn arrives. If an application were to be filed at the time an individual is placed on the waiting list, it would probably be stale by the time the Division is ready to consider the individual for enrollment in HIP.

Section 4.6— Assessment

This section first sets forth the criteria an applicant must meet to be eligible for an assessment, and then explains the assessment process.

Comment

According to proposed § 4.4(f), the Department will notify an applicant of eligibility within 30 days from the receipt of a complete application. How will the date when an application is "complete" be determined and recorded?

Response

Information dealing with the application process is now included in § 4.5 (relating to application for enrollment as a HIP client). An application will be considered to be complete on the day that the Division has received all of the information

necessary to process the application. For example, an applicant is permitted to claim that the applicant's income as it appears on the Federal income tax form or other reporting document is no longer representative, as long as the applicant is able to support that claim. If the applicant fails to include supporting documentation, the Division may have to request it in order to verify that claim. The Division will record the date that it has received all of the required and requested information so that it is able to proceed with evaluating the application. When the application is complete, the Division will determine whether an applicant is eligible for an assessment.

Comment

Proposed § 4.6 states that the Department will conduct evaluations to determine an applicant's initial eligibility for HIP, as well as a client's eligibility for continuing enrollment. Proposed § 4.4 does not refer to these evaluations. The referenced language in proposed §4.6(a) should be placed in the section dealing with eligibility.

Response

The Department agrees with this comment and has revised this section to fully describe the assessment process.

Comment

The use of the phrase "the Department will deem" in proposed § 4.4(a)—(c) is unnecessary and should be deleted.

Response

The Department agrees with the comment, and has deleted the phrase.

Comment

The requirement in proposed § 4.4(a)(1) that an applicant must have sustained a TBI "on or after" July 3, 1985, in order to be eligible, is confusing. It should simply read "The applicant suffered a TBI after July 2, 1985."

Response

The Department agrees with the comment. Subsection (a)(1)(i) now reads, "[t]he applicant sustained a TBI after July 2, 1985."

Comment

It is unclear why it is necessary, as required by proposed § 4.4(a)(2), for an applicant to demonstrate the intent to maintain a permanent home in this Commonwealth for the indefinite future, and how the Department would enforce this requirement.

Response

The Department disagrees with the comment, but has revised the final-form regulations to improve clarity. The final-form regulations no longer require the applicant to "demonstrat[e] the intent to maintain a permanent home in this Commonwealth for the indefinite future." Rather, subsection (a)(1)(ii) states that an applicant must have been domiciled in this Commonwealth both at the time of the injury and at the time application is made, to be eligible to participate in HIP. "Domicile" is a generally accepted legal concept. It is defined as an individual's true, fixed and permanent home to which that individual intends to return. A person can have only one legal domicile at any given time. If a person goes to a place and intends to make it a permanent home for an indefinite period, the person is domiciled there. If an individual takes up temporary residence in this Commonwealth, but intends to return to a fixed address elsewhere, the person is not a domiciliary of this Commonwealth.

The Department believes that the domicile requirement is reasonable, and may be ascertained rather simply. The Division need only ascertain where the applicant resided when the accident occurred, whether the applicant resides in this Commonwealth at the time of application and the applicant's intentions regarding place of future residence. The requirement is difficult to enforce only in that one cannot keep an applicant from taking up temporary residence in this Commonwealth and misrepresenting the applicant's true intentions. However, the requirement that an individual must have been a domiciliary of this Commonwealth at both the time of the injury and the time of application to HIP goes a long way to ensuring that only true domiciliaries can present themselves. This requirement has been established to ensure that HIP's limited funds are used to assist Commonwealth residents. It would not be appropriate to allow HIP funds to be utilized by domiciliaries of other states when there are eligible Commonwealth domiciliaries whom HIP will be unable to assist due to financial limitations.

Comment

The Department proposes to restrict enrollment in HIP to individuals who are 21 years of age or older, and has stated that individuals under 21 years of age are eligible to receive services through other programs administered by the Departments of Education (DOE), Labor and Industry (L&I) and Public Welfare (DPW). However, individuals under 21 years of age are not automatically eligible for these programs. The Department should clarify the need to restrict eligibility for HIP to individuals who are 21 years of age or over, as stated in proposed §4.4(a)(4), and explain how the programs provided by DOE, L&I and DPW are appropriate alternatives for head injured individuals under 21 years of age. Note, for example, that individuals who are under 21 years of age, but have graduated from high school, may not be eligible for services from DOE.

Response

Due to limitations on the amount of funding available for HIP, the Department seeks to serve underserved individuals through the Program. Because there are a number of programs that make services similar to those afforded by HIP available to individuals under 21 years of age, the Department has elected to make HIP available only for individuals who are at least 21 years of age.

The Office of Social Programs of DPW has established the Community Services Program for Persons with Physical Disabilities (CSPPPD). The CSPPPD provides services to individuals who have severe, chronic disabilities that have manifested before 22 years of age, including disabilities due to head injuries, and who are residents of or applicants to nursing facilities. Clients of this program have substantial functional limitations. Through CSPPPD, they live in the community and are provided with services such as service coordination, advocacy, peer counseling and support groups, community-integration activities, equipment-related assessment and transportation.

The Office of Social Programs of DPW also offers the Attendant Care Program and Centers for Independent Living (CILs), both of which are funded through the Federal Rehabilitation Act of 1973 (P. L. 93-112). Although the primary focus of the Federal legislation is on vocational rehabilitation, the Attendant Care Program provides for care services for severely disabled persons without job potential. Services include personal care attendants. The legislation additionally establishes CILs that serve people with all types of disabilities, including those stemming from head injury. These centers offer housing referral, training in independent living skills, training for personal assistants, assistive technology and peer counseling.

All children under 21 years of age with disabilities, including those due to TBI, are guaranteed a free, appropriate education in the least restrictive environment under the Federal Individuals with Disabilities Education Act (IDEA) (P. L. 101-476). DOE has the responsibility for public education, including education under IDEA. Schools must prepare an Individual Education Plan (IEP) for each child with a disability in cooperation with the parents. The IEP is very important to the brain-injured child who requires a high level of repetition, cueing and practice. While it is true that individuals who are under 21 years of age who have graduated from high school are no longer eligible for services from DOE, an alternative source of services to head-injured minors is the Office of Medical Assistance, which provides a broad range of medically necessary services to enrolled children under 21 years of age.

DPW now works closely with the Department, DOE and L&I to ensure that the service needs of children with disabilities are met. Further, L&I's Office of Vocational Rehabilitation (OVR) administers joint State and Federal-funded vocational rehabilitation services to assist persons with mental and physical disabilities to find jobs. The Federal Rehabilitation Act of 1973, which establishes this program, includes provisions for supportive employment so that all persons have the opportunity to work in jobs in the community, regardless of the level of their disability. According to its 1998-2000 State and Strategic Plans, OVR has a number of plans, policies and procedures regarding the transition of students with disabilities to vocational rehabilitation services. Students are to receive transition services. These services, as defined in the 1992 amendments to the Rehabilitation Act and the IDEA, are a coordinated set of outcome-oriented activities designed to promote movement from school to post-school activities, including post-secondary education, vocational training and integrated employment (including supported employment), continuing and adult education, adult services and independent living or community participation. Transition services are based on the student's preferences and interests, and include instruction, community experiences, the development of post-school adult living objectives and, when appropriate, the acquisition of daily living skills and functional vocational evaluation. OVR partners with DOE to coordinate these programs and services to assist students through the transition out of the public education system.

Comment

The proposed regulations limit participation to individuals over 21 years of age, but do not state an upper age limit. The maximum age of participation in HIP should be limited to individuals under the age of 60—65. Scientific studies of head-injured patients indicate that those over 55—60 years of age do not benefit meaningfully from aggressive inpatient

rehabilitation. Limiting participation in this way would save funding for younger individuals who would be far more likely to benefit from HIP services.

Response

The Department disagrees with the recommendation. A maximum age limit is both unnecessary and unfair to older head trauma sufferers. The individual applicant's potential to benefit from HIP services is gauged through an assessment prior to enrollment in the Program. If the completed assessment indicates that HIP services will not be beneficial, the applicant will not be enrolled as a client in HIP.

Comment

Proposed § 4.4(a)(3) refers to "HIP financial eligibility criteria," but fails to state what those criteria are. The final-form regulations should define this term and specify these important criteria so potential applicants are on notice as to the requirements that they will have to meet.

Response

The Department agrees with the recommendation. Although "financial eligibility criteria" is not a defined term, the final-form regulations state what financial eligibility criteria applicants must meet. Subsection (a)(1)(v) provides that an applicant's AFRs must be at or below 300% of Federal poverty level. Subsection (a)(1)(v)(A) and (B) state how AFRs will be assessed.

Comment

Proposed § 4.3(c) states that the Department "will use the Fund to pay for clients' HIP services which would not otherwise be available to clients with TBI who have exhausted alternative financial resources." The last part of this sentence is redundant and unnecessary because, under the eligibility requirements found in proposed § 4.4(a)(3), AFRs must be exhausted for a person to become a client in the first place.

Response

The Department agrees with this comment. The final-form regulations do not contain the referenced statement. The final-form regulations also do not require AFRs to be "exhausted." Rather, subsection (a)(1)(v) establishes a requirement that applicants have AFRs in the amount of 300% of the Federal poverty level or less.

Comment

The proposed regulations are not clear as to the extent that a client must use resources before becoming eligible for HIP services. For example, the definition of AFRs that must be "exhausted" includes income that must be used for needs other than rehabilitation services, and seems to indicate that an individual must be impoverished before being considered eligible for HIP. The final-form regulations should specify the income and/or assets that the Department will consider in making a determination of financial eligibility.

Response

The Department agrees with the comment. Because of the confusion engendered by the use of the term "exhausted," the final-form regulations do not include it. Instead, the final-form regulations provide simply that individuals must have AFRs in the amount of 300% or less of Federal poverty level. AFRs include: any income subject to Federal income tax; funds available to the individual by virtue of having experienced the TBI; and funds available to the individual through other State or Federal programs. AFRs do not include other assets.

Comment

The Department should describe the procedures and standards it will use for the evaluations to determine an applicant's initial eligibility.

Response

The final-form regulations distinguish between an individual's eligibility for an assessment and enrollment. An applicant is initially determined to be eligible for an assessment, which assessment will be used to determine whether HIP services would be appropriate for that person. An applicant's eligibility for an assessment will be evaluated based on the application form and its accompanying documentation. Subsection (a) contains all of the criteria that must be met for an applicant to be eligible for an assessment. The requirements of subsection (a)(1) are largely self-explanatory. The application form will require the applicant to identify the date the TBI was sustained. Documentary proof of residence and United States citizenship will be required. Although the applicant can answer as to age, documents, including insurance forms, will be required and will serve as a check on the other information provided. Documentary proof of income must be provided and will be evaluated as explained in subsection (a)(1)(v)(A) and (B). The required proof will include, but will not be limited to, a

completed Federal income tax form. Subsection (a)(2) provides that, to be eligible for an assessment, an applicant cannot have an impairment that is attributable to certain listed conditions. A physician's statement will be requested under subsection (a)(1)(iv). It will be on a form provided by the Department and is to be completed by the applicant's physician. It will ask whether the applicant's impairment is attributable to any of the enumerated conditions. The physician is, therefore, responsible to provide this information. The Division will use that statement in determining whether the applicant is eligible for an assessment. Subsection (a)(3) states that an applicant must not manifest any symptom that would prevent the applicant from participating in the assessment or would prevent the provider from completing a full assessment. Again, the Division will request the applicant's physician to provide this information on the physician's statement.

Finally, subsection (a)(4) requires the applicant to complete an assignment agreement assigning to the Department rights in future proceeds which may accrue to the applicant as a result of the TBI, up to the amount expended for HIP services for that individual. If an applicant refuses to complete it, the applicant will not be deemed eligible for enrollment in HIP.

Comment

An applicant is ineligible for HIP if the applicant has significant preexisting psychiatric, organic or degenerative brain disorders, under proposed § 4.4(c)(4). Who makes the determination that an applicant's impairment is the result of a preexisting condition?

Response

Ultimately, the Division makes that determination. The subject matter addressed in proposed § 4.4(c)(4) is addressed in subsection (a)(2) in the final-form regulations. As previously stated, the Division will require applicants to submit a statement that must be completed and signed by their attending physicians. Additionally, the Division may request access to an applicant's medical record. The applicant will be ineligible for HIP due to a preexisting condition if either the physician's statement or the patient record demonstrates that the applicant's impairment is due to one of the conditions listed in subsection (a)(2).

Comment

What if an individual with a history of emotional illness sustains a TBI?

Response

Proposed subsection (c)(4), now subsection (a)(2)(iv), specifically makes patients with certain conditions, including significant preexisting psychiatric disorders, ineligible for HIP.

Comment

An applicant is ineligible for HIP if the impairment is due to a "cerebral vascular accident" under proposed § 4.4(c)(5). The Department should define this term, which has previously been defined in *Stedman's Medical Dictionary* (Williams & Williams, 1982) as "an obsolete and inappropriate term for 'stroke.' "

Response

The Department agrees with this comment, and has replaced the term "cerebral vascular accident" with "stroke" in subsection (a)(2)(v).

Comment

How will an individual's eligibility be affected if the individual has a TBI and then sustains a stroke as a result of the TBI?

Response

Subsection (a)(2)(v) provides that applicants are not eligible for HIP services for any impairment which is the result of a stroke. However, if an individual has sustained a stroke subsequent to the TBI, the affected individual could still apply for HIP services. Eligibility for an assessment would depend upon whether the impairment is attributable to the TBI rather than the stroke. If an assessment is necessary in order to be able to make this determination, the applicant will be assessed. If the applicant's impairment is determined to be due to TBI, eligibility will depend upon the applicant's ability to benefit from HIP services, just as it would for an applicant who had not suffered a stroke subsequent to the TBI.

Comment

How will an individual's eligibility be affected if the individual is transitioning through an agitated phase of Ranchos Level IV? Is there a duration level?

Response

Subsections (b)(4) and (d) provide that applicants who demonstrate suicidal or homicidal behavior or potentially harmful aggression are precluded from participating in HIP. Therefore, applicants who are transitioning through an agitated phase of Ranchos Level IV would be ineligible for the Program if they exhibit aggressive or homicidal behavior because of it. Individuals who are transitioning through an agitated phase of Ranchos Level IV have to demonstrate the ability to benefit from HIP services at the time the application is made, just like any other applicant. The duration of the agitated phase is therefore irrelevant except as it affects the applicant at the time application is made. The applicant is free to reapply if the applicant is initially rejected due to transitioning through an agitated phase of Ranchos Level IV.

Comment

What are the criteria and the process by which an applicant's eligibility for enrollment in HIP is evaluated?

Response

As discussed previously, an applicant is eligible for an initial assessment if the applicant meets the criteria specified in subsection (a)(1), if the impairment is not caused by the conditions described in subsection (a)(2), if the applicant does not exhibit the symptoms described in subsection (a)(3) and signs the assignment agreement as required by subsection (a)(4). A HIP provider will then perform an assessment to enable the Division to determine whether the applicant is eligible for HIP enrollment. The applicant will choose the provider who will perform the assessment from a list of approved providers that will be supplied by the Division. As providers are approved, they will be added to the list.

The Division will determine whether the applicant is eligible for enrollment, and the period during which the applicant will be enrolled and receive rehabilitation services, based upon the outcome of the assessment. The assessment process includes face-to-face interviews with both the applicant and the applicant's significant other, close family members or authorized representative, if appropriate. The part of the assessment directly involving the applicant may take place at the facility or at the applicant's home or the facility where the applicant is residing at the time. In addition to the interviews, under subsection (c), the applicant's medical records, including, but not limited to, all treatment records relating to the TBI, are examined.

The assessment process is intended to identify the applicant's areas of need, upon which rehabilitation will be focused. The assessment will identify: the applicant's physical, emotional and psychological needs; potential for improvement; areas to be addressed through rehabilitation services; facility and community resources needed; and how choices can be provided for the applicant. This identification of the applicant's needs and ability, and how to best serve the applicant, is accomplished by consulting several sources, including medical records, significant others and the applicant. A team of professionals from relevant disciplines who will be designated by the provider conducts the assessment, as required by the contract between the Department and the provider. If it is determined that the applicant can benefit from services offered by the provider, the assessment team will establish ultimate discharge goals, assign the applicant a treatment team of professionals from each identified area of need and draft a rehabilitation service plan for submission to the Department.

Best practice measures will be used to make the initial determination as to whether the applicant can benefit from services offered by the provider. Providers will be given a standardized intake form, developed by the Department and its consulting neuropsychologist, that measures the applicant's current functional living abilities, including degree of independence, as well as whether the applicant can make progress in various functional abilities, including physical, cognitive and psychosocial functions. If appropriate, the applicant's readiness for vocational training is assessed. The form draws upon a number of generally accepted performance measures, and will be revised as best practice standards change.

Comment

The statement in proposed § 4.4(b) that an applicant's eligibility will be determined based on a case manager's recommendation and "other neuropsychological evaluations as deemed appropriate by the Department" is confusing and unclear. If the Department intends to require each applicant to undergo a neuropsychological evaluation, the requirement should be clearly established.

Response

At this time, a neuropsychological evaluation no older than 1 year is necessary as part of the assessment. In many cases, the provider will not need to perform an evaluation because one may have already been done at the acute-care facility and will be part of the applicant's medical record. The Department's contract with the provider will require that, if a current neuropsychological evaluation is not available, the provider will perform one or ensure that one is performed. Ordinarily, the Department's consulting neuropsychologist will not perform the evaluation.

Comment

The Department should provide more information about the role and term of its neuropsychological consultant and the role of the Department's neuropsychological consultant in providing neuropsychological evaluations should be clarified.

Response

The Department's neuropsychological consultant provides technical assistance and advice to the Program on clinical issues as requested. The Department presently contracts with the consultant for a term of 3 years. As previously explained, the Department's consulting neuropsychologist will not ordinarily perform the neuropsychological evaluation necessary to the assessment.

Comment

The Department should explain how applicants' medical histories would be utilized in the evaluation process.

Response

Provider examination of the applicant's medical history is an important part of the assessment. It assists in determining whether the applicant can benefit from HIP services and, if so, what specific rehabilitation services the applicant needs. The Division may also request the applicant's medical records to use in making the determination as to whether an applicant meets the subsection (a)(2) and (3) symptom and condition criteria for enrollment.

Comment

It is inappropriate to have a determination of achievement of maximum medical improvement made by a case manager and/or neuropsychologist. A physiatrist, neurosurgeon, neurologist or other person with medical experience in brain injury rehabilitation should review applicants to determine their potential to benefit from HIP services. These board-certified professionals are best qualified to recognize subtle changes in a patient's neurologic recovery.

Response

The Department disagrees with the comment. HIP focuses upon rehabilitation. HIP providers are not medical facilities. Rather, they are facilities that provide post-acute rehabilitation services, which consist of physical and mental therapies that are most often directly provided by nonphysician professionals who may or may not be supervised by a physician. Although the facilities are all under the supervision of physicians who practice in relevant areas and who will be involved in the assessment process as appropriate, those physicians will not necessarily be neurosurgeons, neurologists or physiatrists. While the persons who directly provide HIP rehabilitation services are not likely to be neurosurgeons, neurologists or physiatrists, medical specialists may have worked with the applicant during the applicant's treatment in an acute care facility prior to entering the Program, and their expertise and conclusions as evidenced in the medical record are an important part of the evidence weighed in the assessment process.

Comment

The determination of ability to benefit and live more independently should be accomplished through the use of generally accepted performance measures such as the Functional Independence Measure. Specific outcome measures can show improvement when more global outcome measures show no change. A more systemized and careful determination of a patient's ability to benefit from rehabilitation services should be mandatory.

Response

The Department will use best practice measures to determine whether an applicant is able to benefit from HIP services. These may incorporate or include the use of the Functional Independence Measure and other specific outcome measures.

Comment

Proposed § 4.4 states that an individual would be ineligible for HIP if the Department deems that the individual lacks the potential to benefit and live more independently as a result of HIP services. Individuals who suffer from TBI may not show improvement in a consistent fashion. The final-form regulations should stipulate that the patient should be given 3 months over which to demonstrate progress when the eligibility determination is being made.

Response

The recommendation is rejected. Substantial funding would be needed to pay for a 3-month assessment period. The Department lacks sufficient funds to provide HIP services to all persons who may benefit from the services. The Fund can be used to serve more persons with TBI if the applicants are ready and able to benefit from rehabilitation services at the time of the assessment. An applicant who is initially found ineligible is free to reapply, and may later qualify to participate in HIP if progress is made after the initial application.

Section 4.7— Enrollment

This section discusses client enrollment, including determination of eligibility and maximum term of enrollment.

Comment

Proposed § 4.4(f) should provide that applicants will be notified when they are ineligible, as well as when they are eligible.

Response

The Department accepts the recommendation. This matter is addressed in subsection (a). It states that an applicant will be notified of the Division's decision on an application for enrollment (whatever that decision may be) within 16 days of the Division receiving the completed assessment from a provider.

Comment

Under proposed § 4.4(b), a case manager with only 2 years of experience makes the critical determination as to the applicant's potential to benefit from HIP services. This is inappropriate. The Department should clarify the case manager's role in determining an applicant's potential to benefit from HIP services.

Response

The Department agrees with the comment. The Department has removed from proposed § 4.4(b) the reference to the case manager's recommendation. Subsection (b) states that the provider shall assess the applicant and determine whether the applicant can benefit from HIP services. Case managers employed by the provider may or may not participate in the assessment of the applicant as part of the assessment/treatment team assigned by the provider. In this capacity, the case manager would provide information and input relevant to the determination of whether an applicant can benefit from services. The team assigned by the provider will make recommendations to the Division. As clarified in subsections (a) and (b), the Division will make the ultimate determination of an applicant's potential to benefit.

Comment

The written notice referred to in proposed § 4.4(f) should include: the reasons that an applicant is ineligible; any time, dollar or other limits on services and the reasons for those limits; and a reference to the section relating to "Appeals."

Response

The Department agrees with the comment. Subsection (a) addresses the written notice the Department will send to applicants as to its determinations on their applications. It specifies that, if the Division determines that the applicant is ineligible to participate in HIP, the notice will include the reasons for that determination and will advise of appeal rights. The specific limit on the time that clients may receive services (1 year for rehabilitation services followed by a 6-month transition period during which case management services only may be provided) is now addressed in subsection (e). Section 4.12 (relating to funding limits) sets the maximum dollar amount for rehabilitation services at \$100,000 per rehabilitation period, plus \$1,000 for case management services during the transition period. Any additional limits on the duration of, or funds available for, a client's participation in the Program will be explained in the written notice of the determination of eligibility. Limits below the maximum dollar amount will be imposed where the necessary services for a client are ascertainable from the assessment and will cost less than the maximum permitted.

Comment

A time limit should be set within which the Division must approve or disapprove the proposed rehabilitation service plan.

Response

The Department agrees with the comment in part. Subsection (a) states that the Division will accept or reject the rehabilitation service plan within 16 days after receiving it from the provider and will provide written notice of that decision to the applicant. This is a time limit the Division will strive to meet with the utmost diligence. However, it should be understood that the plan would not be accepted by default should some extraordinary event prevent the Division from acting within that time.

Comment

Rehabilitation services are limited to a 12-month period, beginning with the date of the client's enrollment in HIP. Proposed § 4.8(a) indicates that development of a rehabilitation service plan will not begin until enrollment begins. A client could lose a significant amount of rehabilitation time while waiting for the rehabilitation service plan to be approved. The final-form regulations should provide that the 12-month rehabilitation period does not begin until actual rehabilitation services commence.

Response

The Department agrees with the comment. Subsection (d) clarifies that a client's enrollment begins on the day the client begins receiving rehabilitation services from a provider after the Division issues a written notification that the client will be enrolled. Section 4.6(d) of the final-form regulations provides that the rehabilitation service plan is developed prior to the beginning of enrollment.

Comment

The Department should clarify whether the notice of eligibility given to the applicant is considered to be the starting date for enrollment.

Response

The Department agrees with the comment. The notice of eligibility given to the applicant is not considered to be the starting date for enrollment. Under the final-form regulations, an applicant may actually receive two notices of eligibility. The first notice of eligibility informs an applicant that the applicant is eligible for an assessment. If the assessment demonstrates that the applicant would be able to benefit from HIP services under this section, the Division will notify the applicant of acceptance into HIP within 16 days of receiving the completed assessment, as stated in subsection (a). Neither of these notices is the starting date for enrollment. The starting date for enrollment is the date upon which a provider actually starts providing rehabilitation services, as stated in subsection (d).

Comment

The Department should clarify how and when the "maximum available funding and time limits for [HIP] services," as those terms are used in proposed § 4.5(a) and (f), are determined.

Response

The Department agrees with this comment. The maximum time limit on the enrollment period is 18 months, consisting of 12 months of rehabilitation and a 6-month transition period during which case management services only will be provided, as stated in subsection (e). The maximum available funding for each HIP client per enrollment period is \$101,000, as stated in § 4.12.

Comment

The Department should describe the procedures and standards it will use for the evaluations to determine a client's continuing enrollment.

Response

The Department agrees with this recommendation. The criteria for premature termination are set forth in subsection (e). Subsection (f) addresses the specifics of the notification that will be used to inform the client of the decision to terminate the client's participation in HIP. Reviews of a client's progress are required at least quarterly, as prescribed by § 4.8(d).

Comment

Evaluations to determine continuing enrollment should be discussed at the beginning of proposed § 4.5(f).

Response

The criteria to terminate participation in HIP are enumerated in subsection (e).

Comment

The Preamble to the proposed regulations states that the average head injury client completes a rehabilitation program in 1 to 3 years. Why, then, is it appropriate to limit rehabilitation in HIP to 1 year under proposed § 4.6(b)? For example, there are a number of people in their 20s and 30s who may require up to 3 years to realize maximum benefit from rehabilitation therapy. Limiting the duration of funding to 1 year would restrict the maximum potential recovery of those patients.

Response

The Department believes that it is appropriate to retain the 1-year limit on rehabilitation in the final-form regulations, which now appears at subsection (e). The greatest gains from rehabilitation services are generally experienced during the first year. Further, 1 year is a reasonable time in which clients may be expected to make significant progress, after which they may be able to transition to other programs or less intensive services to complete their recovery. Additionally, individuals who have been discharged from HIP may reapply. Also, restricting payment for rehabilitation services to 1 year will enable the Department to assist more people with TBIs.

Comment

Criteria should be established to allow a client to qualify for an exemption to the 1-year limit on the rehabilitation period. The criteria should include an exception for clients who are continuing to make tangible, concrete progress in rehabilitation.

Response

The Department rejects this recommendation. A number of commentators were concerned with the 1-year limit. The Department agrees that there are patients who could continue to benefit from rehabilitation services after 1 year. However, HIP funds are limited, and there are far more applicants to HIP than there is money available to help them. The greatest gains from rehabilitation services are generally experienced in the first year. In short, the limits established will enable HIP to do the greatest good for the greatest number. The final-form regulations therefore retain the 1-year limit and establish a \$100,000 cap on expenditures for rehabilitation services in a single rehabilitation period.

Comment

There is a lack of available, appropriate alternatives to HIP for those individuals who must transition out of HIP after 1 year. Many individuals who will be removed from HIP will of necessity be placed back in the family home or in a nursing home, neither of which can meet the needs of a young adult requiring significant assistance and continued rehabilitation and therapy. How will the chronic needs of patients be addressed, and how will they secure services beyond the 12 months funded by HIP?

Response

The Department acknowledges that in some cases there may be a lack of available and appropriate services for those who are transitioning out of HIP. The function of the Program, however, is to provide rehabilitation services, not chronic care. Providers are required to begin planning for the client's eventual transition out of HIP when they write the initial rehabilitation service plan. The rehabilitation service plan is reviewed and modified as needed on a quarterly basis. The goal of the rehabilitation service plan is to affect the smooth transition to other services as appropriate, based on the patient's need. To further address the transitional needs of clients, the final-form regulations establish a 6-month transition period immediately following the rehabilitation period. During the transition period, HIP will provide up to \$1,000 in case management services to help connect clients, including those with chronic needs, to other programs and services that may be available to them.

There are programs available through other State and Federal agencies that are geared toward meeting chronic needs. As previously discussed, L&I offers OVR services, for which individuals who have been HIP clients are frequently eligible, to train and assist individuals to become employable and employed. The Attendant Care Program and CILs, which provide a wide range of services to individuals with chronic needs, are available. The CSPPPD provides services to individuals who have severe, chronic disabilities that have manifested before the age of 22, including disabilities due to head injuries. The Office of Social Programs of DPW has proposed a Home and Community Based Waiver (CommCare Waiver) to allow Medicaid funds to be used for nonmedical home and community-based support services for individuals with TBIs. It is expected that many HIP clients who are not eligible for other programs would be eligible for this one. Funds from HIP are currently appropriated to DPW for State fiscal years 1999-2000 and 2000-2001 so that eligible HIP clients can be transferred to this program and other head-injured clients can be accepted into HIP.

Comment

The Department should clarify whether or not rehabilitation services can be continued, and for how long, following an interruption within the 12-month period.

Response

If there is an interruption that will last for an indeterminate period of time within the 12-month rehabilitation period described in subsection (e), rehabilitation services cannot be continued following the interruption. The Department has determined that the fairest, most reasonable and most administratively feasible course of action with regard to this issue is to limit enrollment in HIP to a 12-consecutive-month-rehabilitation period, followed by a 6-consecutive-month-transition period. The administrative demands of HIP do not permit a policy of tolling the enrollment period or holding funds. There are certainly circumstances, such as a temporary illness, where a client could reasonably be anticipated to resume participation in HIP within a short, determinable period of time. In such a case, the enrollment period would not be tolled, but the client would not be removed from HIP. The client could resume services upon recovering, if recovery occurs during the enrollment period.

Comment

There are some head injured patients who may initially benefit from a 6-week to 3-month course of inpatient rehabilitation therapy, be discharged to either home or a nursing home and at a later date experience a spontaneous recovery so that they

would again be able to benefit from inpatient rehabilitation. For this reason, funding should not be limited to consecutive months.

Response

The Department disagrees with the comment. A client who has been discharged whose return is not anticipated, as in the situation described, cannot automatically be readmitted to the Program at an unscheduled later date. The purpose of this Program is to facilitate client transition to appropriate care settings. It should be noted that clients may reapply for HIP services after being discharged from the Program.

Comment

HIP services should not be limited to consecutive months. It is critical that funding be intermittently available as persons with brain injury undergo life changes such as changes in support systems and normal developmental changes such as graduating from college or a vocational program. Services should therefore be scrutinized at 3 to 6 month intervals, and should be used at points in time when clients are most in need of those services.

Response

The Department rejects the recommendation. The Department does not prohibit reapplication to HIP after the client is discharged. Lifetime HIP services are therefore not capped, and may be available intermittently. The limits described in the final-form regulations are applicable to each enrollment period.

Comment

Proposed § 4.5(f)(5) results in stopping payments if it is “no longer feasible” to implement a rehabilitation service plan. It is not clear who would make the a determination or how the client would be notified. The Department should clarify the process and conditions under which it would discontinue payment for this reason.

Response

The Department agrees that clarification is necessary. The final-form regulations are more specific as to when a client’s enrollment in HIP will be discontinued. Subsection (e)(2) states that a client will be discharged from HIP if the client fails to cooperate or exhibits unmanageable behavior so that HIP cannot provide the appropriate services to meet the client’s needs. A provider who believes that the client is exhibiting behavior of this kind and feels that it can no longer appropriately provide services to the client must notify the Division. The Division will consider evidence presented to it, including quarterly patient status reports, and will request additional information as is necessary for it to determine whether to end the client’s enrollment in HIP. In all cases, efforts will be made to transition the client to appropriate settings as available.

Comment

The final-form regulations should contain a provision that clearly addresses the status of the individuals currently enrolled in the Program.

Response

The Department agrees with the comment. Subsection (g) is entitled “grandfather clause.” This subsection makes clear that clients who are receiving HIP rehabilitation services as of the effective date of the final-form regulations will be eligible for the maximum enrollment period of 18 months, which will begin on the effective date of the final-form regulations. Those who are receiving only case management services as of the effective date will be eligible for the 6-month transition period, also beginning on the effective date of the final-form regulations.

Other changes

The proposal listed triggers that would cause the Department to stop paying for HIP services. Subsection (e) states when a client’s enrollment will end. This is a significant distinction between terminating enrollment and stopping payment because the Department may stop paying for services while the client remains enrolled in HIP. For example, if a client receives or gains access to AFRs in excess of 300% of the Federal poverty level, the client is expected to pay for HIP services up to the amount of the AFRs received. If the client can pay for the HIP services, the Department will stop paying. However, the client will not be discharged from HIP, as the amount of AFRs received may not be enough to pay for services over the entire remaining enrollment period. It was also proposed that the Department would stop paying for HIP services if AFRs became available. As previously stated, the Department will stop paying for HIP services if that happens. However, that statement does not appear in the final-form regulations, as the availability of AFRs will not automatically end the client’s HIP enrollment. If the AFRs are legitimately exhausted due to paying for appropriate services, and the client becomes again financially eligible for HIP during the period of enrollment, the Program may resume paying for HIP services for the remainder of the enrollment period.

The final-form regulations state that a client's enrollment will end when the client reaches the maximum limits on funding and duration. Subsection (e)(1) states that a client's enrollment will end prior to the time designated in the client's rehabilitation service plan if the Division determines that the continuation of services will not enable the client to make further progress. This statement combines proposed § 4.5(f)(1) and (5), as it contemplates both that a client may make positive progress so that the services that HIP can offer are no longer needed or that a client's condition may deteriorate so that the client can no longer benefit from HIP services. Subsection (e)(4) states that a client's enrollment will end if the client becomes eligible for other services offered as a result of the TBI, and those services meet the client's needs so that HIP services are no longer necessary. This was not stated in the proposed version of the regulations because the availability of other services was included in the definition of AFRs. However, including other services in that definition caused a difficulty—that of trying to quantify "other services" in order to determine if the income cap was exceeded. This problem is solved by simply providing that, if a client can obtain other services that meet the client's needs, the client's HIP enrollment will terminate. If a client has access to other services that do not meet the client's needs entirely, the availability of the services will be taken into account when assessing the client's needs and writing and revising the rehabilitation service plan.

Section 4.8— Rehabilitation service plan

This section requires providers to develop a rehabilitation service plan for each HIP client, states what must be specified in each plan and sets a schedule for review and updates.

Comment

Proposed § 4.8(b) should be revised to require the rehabilitation service plan to state the specific anticipated outcomes to be achieved and the time frame for their achievement, and should specify that those outcomes should be stated in objective and measurable terms.

Response

The Department agrees with this comment. The recommendation has been incorporated into subsection (c)(1).

Comment

The proposed regulations require beginning and ending dates for each service. This is difficult to estimate, since it depends on the patient's progress.

Response

Subsection (c)(1) requires providers to establish estimated time periods for the client to meet goals based upon an individual client assessment. Therefore, the provider, the client, the Division and the Peer Review Committee (Committee) will have timed objectives by which to measure performance. However, the rehabilitation service plan is a planning document subject to quarterly review, evaluation and modification. As part of this process, it is expected that beginning and ending dates of services will be modified as necessary, as addressed in subsections (d) and (e).

Comment

Proposed § 4.8(c) requires an evaluation of client progress, but does not specify the content of the procedure. The outcome of an evaluation is significant, as it could result in the modification of the rehabilitation service plan or discontinuation of services. The final-form regulations should therefore specify the procedure and the requirements or criteria used for such an evaluation.

Response

The Department agrees. The treatment team assigned by the provider is primarily responsible for measuring client progress. Drawing on its experiences with the patient and the patient records, the team should use the quarterly reviews of the rehabilitation service plan required by subsection (d) to assess how the client has progressed towards the established goals. If the team becomes aware that satisfactory progress is not being made, additional reviews should be scheduled under subsection (e). The modifications to the rehabilitation service plan should closely track client progress. Reviews of the rehabilitation service plan are done in conjunction with the client and the client's family and/or authorized representative, as required by subsections (a) and (e). The ultimate goal is always for the client to be more independent, as stated in subsection (b). In addition to updating the rehabilitation service plan on a quarterly basis, providers must send to the Division quarterly written patient progress reports. The Division will be reviewing these progress reports against the rehabilitation service plan and plan modifications, to ensure that progress is being made and reported appropriately. In addition, the Committee will be reviewing the progress reports and rehabilitation service plans for at least one patient from every HIP provider each quarter. The Division will have access to the complete patient records of the facility, and may obtain for the Committee any

additional documents as appropriate. The reviews are intended to ensure that the patients of a given facility make appropriate progress toward timely transition to less restrictive environments.

Comment

Will HIP have a specific form with timeline guidelines for submission of periodic patient status reports?

Response

Yes. Providers are required to complete written patient status reports for the Division on a quarterly basis. This requirement is in addition to the provider's obligation to review the rehabilitation service plan on a quarterly basis.

Comment

The proposed regulations impose a number of requirements on the development of a rehabilitation service plan. These include participation by the provider, case manager, client and representatives of the client, approval by the Department and specific components that the plan must contain. However, no requirements are specified for modifications of the rehabilitation service plan, so it is unclear whether modifications must meet any of these requirements.

Response

Subsection (e) clarifies that all modifications must meet the regulatory requirements for the original rehabilitation service plan as established in subsections (a)—(d). As with the original rehabilitation service plan, modifications must be made by the provider's treatment team in collaboration with the client or authorized representative and significant others, if applicable, and contain the elements specified in subsection (c). Subsection (e) further provides that modifications must indicate whether previous goals were met. Where goals were not met, the modified plan must address the reasons why, and modify or change the goals appropriately. The provider will be required to submit all modifications to HIP along with the quarterly patient progress reports, so that the Program and, if applicable, the Committee, can consider those documents.

Section 4.9— Rehabilitation period

This section establishes requirements with which providers must comply when providing rehabilitation services and the purposes for which rehabilitation services may be provided.

Comment

The proposed definition of "rehabilitation" should address cognitive needs as well as physical, social and other aspects of a client's rehabilitation.

Response

The Department accepts the suggested change and has incorporated it in subsection (a). In addition, the final-form regulations have added a definition of "rehabilitation services," which includes cognitive remediation. The final-form regulations do not include a definition of "rehabilitation." This is pertinent to the next comment also.

Comment

The proposed definition of "rehabilitation" should be revised to enumerate the list of professionals who can supervise the provision of rehabilitation services; the list should include psychologists.

Response

The Department disagrees with the recommendation. The phrase "other appropriate health professional," as used in subsection (b), includes psychologists where the services provided may be supervised in accordance with standards prevailing in their field. The phrase adequately describes who can provide and supervise the provision of rehabilitation services. Further enumeration is not necessary.

Comment

The final-form regulations should indicate that physical therapy, occupational therapy, speech therapy and psychological services may be provided in a home setting.

Response

The Department agrees that it should be possible for services to be provided in a home setting. Neither the definition of "rehabilitation services" nor any other provision of the final-form regulations limits the setting in which services may be provided.

Comment

The treatment offered by rehabilitation facilities should be monitored more closely to ensure that clients are being given actual rehabilitation services and not just care and maintenance.

Response

The final-form regulations implement practices aimed at monitoring providers to ensure that patients are being provided with appropriate rehabilitation services. The final-form regulations require providers to be accredited by a National accrediting body approved by the Department.

The Department requires providers to send quarterly patient progress reports and to update rehabilitation service plans on a quarterly basis. These documents will be reviewed by the Division, and in some cases, by the Committee, to ascertain the appropriateness of services provided and progress made. Additionally, the Division will conduct annual onsite reviews.

Section 4.10 — Transition period

This section establishes a 6-month period immediately following the rehabilitation period, during which HIP will provide case management services to clients.

Comment

The Department should indicate how transition from the rehabilitation programs will be managed after the 12-month limit on HIP-funded services is up.

Response

Providers must address discharge planning in the initial rehabilitation service plan, as goals and outcomes must be established for the entire enrollment period under § 4.8(c)(1). Additionally, the Department has added a 6-month transition period that will follow the 12-month rehabilitation period, and affords a maximum of \$1,000 in funding to facilitate transition. Case management services will be provided during this time to assist the client with the transition from HIP-funded services to other existing programs.

Section 4.11 — Case management services

This section establishes requirements with which providers must comply when providing case management services for HIP.

Comment

The proposed definition of “case manager” states that a case manager is an individual “approved” by HIP to provide case management to HIP clients. The final-form regulations should contain a section describing the qualifications necessary for approval, and outlining the approval process.

Response

The Department accepts the recommendation in part. Case management services will be provided to HIP clients through their HIP providers. This enhances continuity of care and eliminates the need for the Department to contract with individual case managers. The Department believes this is more efficient and will result in appropriate oversight and more contact between the case manager and other care providers. It will further ensure continuity between the establishment of rehabilitation goals and discharge planning. The final-form regulations therefore do not include the requirement of HIP “approval” of case managers. A case manager is defined in the final-form regulations as “[a]n individual who delivers case management services to a client through a provider.” This section requires case managers to have at least 1 year of experience in TBI case management.

Comment

Case managers should be given full-time employment and be available on a full-time basis.

Response

The Department disagrees. The definition of “case management services” states that case management services will be provided to HIP clients through rehabilitation providers. Generally, those providers employ full-time case managers. Clients currently receiving HIP case management services will continue with their current case managers for the duration of their transition periods. The Department contracts with those case managers directly, on an as-needed basis. Consequently, some of them are part-time and some are full-time.

Section 4.12— Funding limits

This section establishes limits on HIP funding for rehabilitation and transition periods.

Comment

Proposed § 4.6 specifies time limits, but does not specify any limit on the money to be spent. If the Department intends to impose a per-client funding cap, this maximum limit should be specified in the final-form regulations.

Response

The Department accepts this recommendation. This section of the final-form regulations establishes that the maximum funding available is \$100,000 for rehabilitation services provided during the 12-month rehabilitation period, and an additional \$1,000 for case management services provided during the 6-month transition period.

Comment

The establishment of a monetary limit for services would be an incentive to rehabilitation centers to provide cost-efficient outpatient services.

Response

The Department agrees with the comment and has established a limit in this section of the final-form regulations.

Section 4.13— Payment for HIP services

This section addresses the Department-provided notice to a client regarding services and funding for which HIP will be responsible, client responsibility to update financial information, client responsibility for payment and when the Department will seek reimbursement for its use of HIP funds.

Comment

It is not clear what amount of AFRs will result in the discontinuation of HIP services. If a small amount of AFRs becomes available, or certain services can be obtained from another source, will that result in the discontinuation of HIP services? The final-form regulations should specify some reasonable threshold at which the availability of AFRs will result in HIP services being discontinued.

Response

The Department agrees with the recommendation. The Department will not discharge a client from the Program because AFRs in some small amount over the permitted 300% of the Federal poverty level become available to a client or limited services will be provided by another source. A client who receives AFRs over the threshold amount of 300% of the Federal poverty level will be expected to pay for services up to the excess amount, as provided in subsection (b)(2). HIP will, however, continue to pay for those services not covered by the excess AFRs. Likewise, the availability of services from another source will not result in the client's discharge from HIP unless they duplicate or otherwise render HIP services unnecessary. Rather, they will affect the determination of the client's needs, whether that determination is being made as part of the initial assessment or as part of modifying the service plan. Where appropriate, services available to the client through other programs will substitute for HIP-funded services in the rehabilitation service plan.

Comment

Will HIP have a fee schedule for reimbursement?

Response

The Department does have a fee schedule that establishes rates for specific HIP services. All providers will be paid the same set rate for services, which will encourage them to provide those services efficiently. The fee schedule is not set forth in the final-form regulations. It will be revised from time to time, as the need arises, and will be made a part of each contract between the Department and a provider.

Other Changes

The Patient Share of Cost (PSC) Table is included as an appendix to the final-form regulations so that affected parties can see what their potential share of the cost will be if they participate in HIP. The PSC is established based upon the percentage of the Federal Poverty Income Guidelines that the applicant's income comprises, up to 300%. For example, the PSC Table (Appendix A to the final-form regulations) states that a client who has an income between 225% and 250% of the Federal Poverty Income Guidelines will pay a total of \$250 for services received through HIP. The amounts currently established in the PSC Table will not increase, even though the amounts in the Federal Poverty Income Guidelines will.

For example, a client who is at between 225% and 250% of poverty currently may make between \$19,329 and \$21,475. Although those dollar amounts will increase when the Federal government revises the Poverty Income Guidelines, so that a person who is at between 225% and 250% of poverty level will have more income, the dollar amount assessed by HIP upon such a client (\$250) will not change. It may be that a person who currently makes \$19,329 (currently 225% of poverty level) will wind up making only 222% of the Federal poverty level when the Poverty Income Guidelines change. If that person then became a HIP client, the person would be assessed \$50 as the PSC, under the PSC Table (those making between 185% and 225% of poverty level are assessed \$50).

The Department does not anticipate raising the dollar amounts of the PSC. If it is determined for any reason that those amounts must be raised, the Department will go through the rulemaking process so that affected parties may have notice and an opportunity to comment. The Department will publish a notice in the *Pennsylvania Bulletin* if it lowers or eliminates the PSC.

Section 4.14— Peer review

This section states that the Department will establish a Committee. It establishes some procedures and duties of the Committee.

Comment

What are the specific criteria that the Committee will use to review rehabilitation service plans and recommend actions? Is there a specific form that will be used?

Response

The Department has developed forms for use by the Committee. Subsection (b)(1) provides that the Committee will, on a quarterly basis, review a random sampling of cases, including at least one client from each provider. The review may include the quarterly progress reports, the rehabilitation service plan and all modifications and any other documents deemed necessary by the Committee or by the Department. The review will be aimed at ascertaining whether best practices were followed in HIP-related service areas provided at the facility. The criteria envisioned at this time will include analyses of: whether the rehabilitation service plan is being followed; whether goals are being met; whether the rehabilitation service plan is properly modified in response to the changing needs of clients; whether the provider recognizes when clients have met goals and when further service in an area is not needed; and whether the provider is willing to transition clients to the next level of independence when appropriate. The Committee must provide written recommendations to the Department within 30 days of completion of any review of services.

Comment

The Department should provide more information on the membership of the Committee, and the process that will be used to select the Committee members.

Response

The Department will revise the number of members and the configuration of the Committee based upon its review of the Committee's performance and needs. Department plans for the Committee at this time are that it will include nine members, at least six of whom will be from the post-acute rehabilitation provider community. Since the rehabilitation services under review by the Committee are solely those provided in a post-acute setting by HIP providers, it is appropriate that the majority of Committee members should be experienced in providing rehabilitation services of this kind. The Department will try to fill at least two of the remaining three positions with individuals who work in the acute rehabilitation hospital community. Acute rehabilitation hospitals provide medical as well as rehabilitation services. The services provided in these facilities are aimed primarily at stabilizing the patient to a point where the patient can benefit from post-acute rehabilitation. Services provided in the acute setting are not funded by HIP. However, the input of individuals who work in this setting and who may be more medically oriented, is invaluable in reviewing the post-acute rehabilitation services provided to, and progress made by, HIP clients.

Committee members will be appointed by the Department. The Department will contact its providers and the Pennsylvania Association of Rehabilitation Facilities to solicit recommendations. Facilities not directly contacted by the Department, including both acute and postacute facilities, are welcome to recommend candidates for the Committee to the Department in writing. A member of the Committee may not participate in a review that presents a conflict of interest, including reviews of service provided to a client of the member or the member's employer or a close relative of the member.

Comment

The Committee should be made up of board-certified psychiatrists, neurosurgeons and neurologists. Comprising the Committee of social workers, psychologists or medical doctors who have specialties other than those previously named is inappropriate and leads to inaccurate assessments of neurologic progress of head-injured individuals who otherwise could make a good recovery. At the very least, there should be sufficient physician representation drawn from these specialties to ensure that the more global and holistic needs of brain-injured patients are addressed.

Response

As stated previously, the Department will revise the number of members and the configuration of the Committee based upon review of the Committee's performance and needs. Practitioners of specialties mentioned by the commentator, or the facilities they practice at, are welcome to contact the Division and recommend specialist candidates for membership on the Committee.

Section 4.15— Administrative review

This section establishes a two-step review process for applicants and clients who disagree with decisions made by the Division.

Comment

There is a discrepancy between proposed § 4.10(a)(1) and (2). Subsection (a)(1) states that an "applicant" may file a request for administrative review. Subsection (a)(2) states that the "applicant or client" must file the request within a specified time limit. This should be clarified.

Response

The Department agrees. Subsections (a)(1) and (b)(1) clarify that an applicant, client or authorized representative may file a request for "reconsideration" and may "appeal" the outcome of the request for reconsideration. These terms are used consistently throughout the section and throughout the chapter. Seeking reconsideration or an appeal is discretionary; compliance with the times specified for doing either is mandatory.

Comment

It should be clear in the final-form regulations that the person legally empowered to act on behalf of the applicant or client is also empowered to seek administrative review and file an appeal on behalf of the applicant or client.

Response

The Department agrees. Under subsections (a)(1) and (b)(1), an authorized representative, as well as an applicant or client, is permitted to file a request for reconsideration and appeal the outcome of that request.

Comment

It is unclear whether a person may immediately appeal an adverse determination, or whether an administrative review must first be requested. The final-form regulations should be rewritten to clarify this.

Response

The Department agrees and has revised the final-form regulations to address this concern. Subsection (b)(1) clarifies that, as a precondition to filing an administrative appeal, reconsideration by the Division must have been sought and the requested relief denied.

Comment

There should be a time limit imposed upon the Department for administrative review to ensure that adverse determinations are resolved expeditiously.

Response

The Department accepts the recommendation in part. The time for completing the adjudicatory process will vary based upon a number of factors, including the complexity of the case and the volume of reviews sought. However, the Department has set forth a time period for completion of a request for reconsideration so that requestors have some idea of when a decision should be forthcoming. Subsection (a)(4) states that when a request for administrative reconsideration is made, the Division will notify the requestor of its decision within 30 days of receiving the request. Every effort will be made to issue a decision within the stated time limits. If the Department fails to meet these time limits, however, the reconsideration is not automatically resolved in favor of the appellant. The request will be honored as expeditiously as possible. Subsection (c)

provides that 1 Pa. Code Part II (relating to the General Rules of Administrative Practice and Procedure) govern the administrative appeal.

Comment

The final-form regulations should indicate who is involved in an administrative review, and whether the applicant or client may attend or participate in a review.

Response

As set forth in subsection (a), the Division will perform the initial reconsideration. This is a paper review, so there is no opportunity for attendance. The request for reconsideration should contain any information the applicant, client or authorized representative wants the Division to consider, and must meet the requirements of subsection (a)(3). The applicant, client and authorized representative may attend any hearing held in connection with an appeal of the decision on reconsideration.

Comment

Proposed § 4.10 limits requests for administrative review to the eligibility determination, and fails in general to specify which other issues may be appealed. There are numerous other determinations that could be subject to appeal.

Response

The Department agrees with the comment and has addressed the concern. Subsection (a)(1) enumerates the decisions that may give rise to a request for reconsideration and then an appeal.

Comment

This section should explicitly state that the 1-year time limit is subject to appeal.

Response

The Department disagrees. The 1-year time limit for a rehabilitation period, as well as the 6-month limit on the transition period, are strict standards imposed by the final-form regulations. No hearing will be held in these matters.

Comment

Proposed § 4.10(b)(2) gives an applicant or client 15 days to file an appeal, beginning on the date the Division mails its determination. Postal delays could shrink this time considerably. To account for unforeseeable postal delays, the rule should provide that 3 days be added to the time for filing an appeal when the determination is sent by mail.

Response

The Department disagrees. The final-form regulations provide 15 days to request reconsideration. The Department initially intended to give appellants 10 days to make a request. That is the time afforded by 1 Pa. Code § 35.20 (relating to appeals from actions of the staff) to appeal to the agency head actions taken by subordinate officials (administrative appeal). The final-form regulations afford, not 10, but 30 days to file an administrative appeal.

Comment

The Department should indicate how it will communicate information on appeals and the rights of applicants and clients to individuals who may be unable to comprehend formal legal letters or who may have difficulty in doing so.

Response

The Department agrees. Subsection (a)(2) states that the Division will notify an applicant, client or authorized representative in writing of the right to seek administrative review. It further states that the notification will advise the recipient to seek assistance from legal counsel, family members and others who may serve in an advisory role, and will include contact information for a HIP representative who will be available to answer any questions the applicant, client or person assisting them may have.

Comment

The final-form regulations should include a provision similar to that proposed for the Women, Infants and Children Program, which requires that the hearing location be no further from the appellant than the county seat of the appellant's county of residence. That regulation further requires that the hearing be moved to an alternative location more accessible to the applicant or client under certain circumstances. Accessibility of a hearing location would be important to the population served by HIP.

Response

It is not administratively feasible for this program to hold hearings in the 67 counties of the State. The Department agrees that the hearing location should be as close to the appellant as possible, and will make every effort to be accommodating in this regard as resources allow.

Comment

Proposed § 4.10 allows an applicant or client to be represented at a formal hearing by a relative, friend or other person of their choice. This constitutes the unlawful practice of law under the Judicial Code, 42 Pa.C.S. § 2524, which practice cannot be authorized by an administrative agency.

Response

The provision has been removed.

Comment

The final-form regulations should state whether or not HIP services will continue during the pendency of a review or hearing. If services are not to continue, the final-form regulations should include a specific time limit for the administrative review.

Response

The Department agrees. Subsection (d) states that applicants, including those who were eligible for and received an assessment, are not entitled to receive HIP services during the time that a reconsideration or appeal is pending, and that services to clients continue while review or a hearing is pending. If the time or dollar amount of services to which a client is entitled is exhausted while the reconsideration or appeal is pending the reconsideration or appeal is, of course, mooted.

Comment

The final-form regulations should provide that, immediately upon the issuance of a favorable decision, HIP services will be reinstated for the remainder of the 12-month period based upon the date on which services were terminated.

Response

The final-form regulations do not need to provide for reinstatement of services, as subsection (d) provides that services continue for clients during the pendency of an appeal.

General Comments

Comment

A periodic review or audit of program expenditures would be useful to ensure that the limited dollars in the Fund are used as efficiently as possible to meet Program goals. The Department should explain how it would review Program expenditures to protect the financial integrity of the Fund.

Response

HIP funds are generally subject to the same control and audit procedures utilized in the administration of all Commonwealth funds. The Auditor General conducts audits of the Emergency Medical Services Operating Fund, which includes the Fund as a component. In addition, the Program itself conducts an annual site visit to each provider, at which time a representative sample of invoices is verified against the medical records, and compliance in a number of other areas is assessed. Further, the final-form regulations limit the duration of funding to 1 year and cap the amount of funding that can be spent during that time. The Program reviews quarterly reports and updated rehabilitation service plans submitted by providers; additionally, the Committee will review client progress in some cases, and submit recommendations to the Department as to all ongoing services. These reviews are intended to ensure that providers deliver necessary services to clients in an efficient manner, and that clients are getting results from utilizing these services. Once a review process is under way only providers whose performance has been deemed appropriate will remain on the list of approved HIP providers. Providers whose services or performance are unsatisfactory will be removed from the list until a time they are able to demonstrate through the Peer Review or other monitoring process that they are meeting best practice standards and clients are getting value for the time and money spent at the facility.

Comment

The DPW is seeking a waiver from the Federal Health Care Financing Administration to be able to use Medicaid funding for head injured individuals. How will the waiver program, and the transfer of funds from the Department to DPW, affect the operation of HIP?

Response

The DPW CommCare Waiver will complement HIP. HIP will fund eligible clients' rehabilitation for 1 year plus 6 months of transitional case management services. The DPW CommCare Waiver will meet the long-term needs of clients who require maintenance services. The Department has appropriated funds to DPW to be used to transfer Medicaid-eligible HIP rehabilitation clients to the CommCare program. Any funds appropriated to DPW for the CommCare Waiver which are not used will revert back to the Fund to be used for HIP services.

Comment

The proposed HIP regulations should not go into effect until the previously referenced waiver program is in place.

Response

The Department disagrees. Although the Department and DPW are both confident that the waiver program will go into effect, the Department's ability to administer HIP should not under any circumstances be held hostage to the success of an initiative on the part of another Commonwealth agency.

Comment

A bill, H.B. 1467, which would create a HIP in the Office of Social Programs of DPW, was introduced in the House of Representatives and referred to the House Health and Human Services Committee. This bill, coupled with the previously-mentioned application for waiver by DPW indicate that the Commonwealth is moving in the direction of transferring responsibility for HIP from the Department to DPW. The timing of the final-form regulations is therefore inopportune.

Response

The Department disagrees. The possibility that there will be a change in policy exists in every aspect of government. That a possibility exists does not mean that those who are responsible for administering programs should "wait and see" which way the wind will blow. The Department is currently responsible for administering HIP, and will be responsible to do that for the foreseeable future. A need for these regulations was perceived, and the Department responded.

Comment

If HIP is transferred to DPW, the proposed regulations will be obsolete. Promulgation of the final-form regulations should therefore be precluded.

Response

The Department disagrees. It would be inappropriate to delay the implementation of necessary final-form regulations for an indefinite period of time pending the outcome of uncertain events. The Department is responsible for the Program, and must continue to administer it until an actual transfer of authority takes place. The administration of HIP will be simpler, as well as fairer to head injured individuals who are still waiting to receive rehabilitation services through HIP, if the final-form regulations are implemented.

Comment

One of the factors to be considered by IRRC in approving or disapproving a regulation is whether the regulation "represents a policy decision of such a substantial nature that it requires legislative review." See 71 P. S. § 745.5a(i)(4). Transfer of HIP from the Department to DPW does present a substantial policy decision that deserves legislative review. In fact, that legislative review has begun through the introduction of H.B. 1467 and its referral to the House Health and Human Services Committee. The publication of the final-form regulations at this time ignores that overriding policy issue.

Response

The Department disagrees. The Regulatory Review Act requires IRRC to review regulations and to consider certain factors in determining whether the regulations are in the public interest. Among these factors, as stated by the commentator, is "[w]hether the final-form or final-omitted regulation represents a policy decision of such a substantial nature that it requires legislative review." However, the commentator then goes on to state that it is the transfer of HIP from the Department to DPW that presents the substantial policy decision which deserves legislative review. That transfer is not before the IRRC; these regulations are. The final-form regulations do not have as their subject matter the contemplated transfer of HIP to DPW. Their sole focus is the Department's administration of moneys from the Fund, which responsibility has been placed upon the Department by statute. The final-form regulations provide that the Department will use Fund money to provide rehabilitation and case management services to persons who have incurred a TBI, set parameters for participation in the Program and establish a system of administration for the Program. These are matters that are appropriately addressed through the promulgation of regulations. The final-form regulations do not present a policy decision of a nature that legislative review is required, other than that which is provided through the rulemaking process. IRRC's determination as to these regulations should be made based upon their content, and not upon its consideration of proposed legislation.

Comment

The Department lacks the statutory authority to promulgate the regulations. Section 14(e) of the act gives the Department only the ability to decide which class or type of injury to fund, in order of priority. The Department does not have the authority to develop detailed administrative regulations relating to the operation of HIP.

Response

The Department disagrees that it lacks the statutory authority to promulgate these regulations. The Department has the statutory power and duty to promulgate rules and regulations to facilitate its administration of the Fund under section 2102(g) of The Administrative Code of 1929 (71 P. S. § 532(g)). Section 14(e) of the act allocates money to the Fund, which is under the authority of the Department. The Fund, under the act, can be used to pay for all traumatic injuries. Clearly, however, there is not enough money to fund every person. Section 14(e) of the act, therefore, allows the Department to decide which traumatic injuries to fund by category, as opposed to on an individual basis.

The Department already has the statutory authority, under section 2102(g) of The Administrative Code of 1929, to promulgate rules and regulations for any program administered by it, including HIP. Nothing in the act indicates that the General Assembly intended to remove this general authority when it gave the Department the specific authority to, “. . . by regulation, prioritize the distribution of funds by classification of traumatic injury.” Finally, reading the language of the act so as to prevent the Department from making any administrative decisions with regard to the Fund, other than deciding what types of injuries the money may be used for, leads to an absurd result. The reading would effectively tie the Department’s hands with regard to proper and effective administration of the Fund. The General Assembly could not logically have intended to give the Department the authority to decide to whom a significant amount of Fund money would be given, without also giving it the authority to ensure that the Fund is utilized properly and efficiently.

Comment

It is a matter for concern that HIP has not accepted any new applicants for services in over 1 year.

Response

The final-form regulations restrict the type of services a client will receive through HIP, the cost of services per enrollment period for which HIP will pay and the length of time that each enrollment period may last. These provisions are designed to open HIP up to a greater number of qualified people. A main purpose of the final-form regulations is to make HIP resources available to a greater number of persons across this Commonwealth who have suffered TBIs. The HIP waiting list demonstrates that there are many individuals who would like to participate in HIP. The Department believes that a number of these people have not been able to secure rehabilitation services, and will not be able to do so except through HIP. The limitations on client participation in the final-form regulations are aimed at ensuring that individuals with TBIs have an opportunity to receive rehabilitation services for at least 1 year. If 1 year of services does not enable a client to function as fully as before the TBI was sustained, it is likely to at least prepare that individual to be able to utilize other services and programs appropriately.

Fiscal Impact

Implementation of the final-form regulations will entail administrative costs associated with contract development, data analysis, fiscal monitoring and other program activities. HIP currently has similar administrative costs from current program operations. Additional costs may be incurred due to the review and administrative appeal process, depending upon the frequency of appeals. The final-form regulations are intended to channel the bulk of funding into rehabilitation services for clients who are able to progress as a result of those services.

Paperwork Requirements

The Department will experience some increase in paperwork related to Program review of rehabilitation service plans and plan modifications, as well as the quarterly patient reports required from providers. Providers will have to provide quarterly patient status reports. Rehabilitation service plans and modifications are a part of rehabilitation treatment; the necessity for them does not arise from the final-form regulations. Persons applying to HIP must complete an application and provide verifying documentation.

Effective Date/Sunset Date

The final-form regulations will become effective August 27, 2001. A sunset date has not been established. The Department will continue to monitor these regulations on an ongoing basis, and they will be subject to revision as it becomes necessary.

Statutory Authority

Section 14(e) of the act authorizes the Department to promulgate regulations prioritizing distribution of moneys in the Fund by classification of traumatic injury. The Department has the statutory power and duty to promulgate its rules and regulations under section 2102(g) of The Administrative Code of 1929.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on May 22, 1999, the Department submitted a copy of the notice of proposed rulemaking, published at 29 Pa.B. 2671, to IRRC and the Chairpersons of the House Health and Human Service Committee and the Senate Public Health and Welfare Committee for review and comment.

Under section 5(c) of the Regulatory Review Act, the Department also provided IRRC and the Committees with copies of all comments received, as well as other documentation. In preparing these final-form regulations, the Department has considered all comments received from IRRC, the Committees and the public. In compliance with section 5.1(a) of the Regulatory Review Act (71 P. S. § 745.5a(a)), the Department submitted a copy of the final-form regulations to IRRC and the Committees on May 3, 2001. In addition, the Department provided IRRC and the Committees with information pertaining to commentators and a copy of a detailed Regulatory Analysis Form prepared by the Department in compliance with Executive Order 1996-1, ‘Regulatory Review and Promulgation.’ A copy of this material is available to the public upon request.

On May 22, 2001, the Department requested that the regulations be tolled in accordance with section 5.1(g)(1) of the Regulatory Review Act to consider revisions recommended by IRRC. IRRC did not object to tolling. The Department submitted the revised regulations to the Committees and to IRRC for their review on May 24, 2001.

Under authority of section 5.1(d) of the Regulatory Review Act (71 P. S. § 745.5a(d)), on June 4, 2001, these final-form regulations were deemed approved by the House and Senate Committees. Under section 5.1(e) of the Regulatory Review Act, IRRC met on June 7, 2001, and approved the final-form regulations. The Attorney General approved the regulations on July 10, 2001.

Contact Person

Questions regarding the final-form regulations may be submitted to Elaine Terrell, Head Injury Program, Department of Health, P. O. Box 90, Harrisburg, PA 17108-0090, (717) 783-5436. Persons with disabilities may submit questions in alternative formats (such as audio tape or Braille) by using V/TT: (717) 783-6514 or the Pennsylvania AT&T Relay Service at (800) 654-5984 (TT).

Persons with disabilities who would like to obtain this document in an alternative format (that is, large print, audiotape or Braille) should contact Elaine Terrell to make the necessary arrangements.

Findings

The Department finds that: (1) Public notice of intention to adopt the final-form regulations adopted by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202), and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2. (2) A public comment period was provided as required by law and all comments were considered. (3) The adoption of final-form regulations in the manner provided by this order is necessary and appropriate for the administration of the authorizing statute.

Order

The Department, acting under the authorizing statutes, orders that: (a) The regulations of the Department, 28 Pa. Code, are amended by adding §§ 4.1—4.15 and Appendix A to read as set forth in Annex A. (b) The Secretary of Health shall submit this order and Annex A to the Office of General Counsel and the Office of Attorney General for approval as required by law. (c) The Secretary of Health shall submit this order, Annex A and a Regulatory Analysis Form to IRRC, the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare for their review and action as required by law. (d) The Secretary of Health shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law. (e) This order shall take effect August 27, 2001.

ROBERT S. ZIMMERMAN, Jr.,
Secretary

(Editor’s Note: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 31 Pa.B. 3370 (June 23, 2000).)

Fiscal Note: 10-129. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 28. HEALTH AND SAFETY

PART I. GENERAL HEALTH

CHAPTER 4. HEAD INJURY PROGRAM

Sec.

- 4.1. Scope and purpose.
- 4.2. Definitions.
- 4.3. Services eligible for payment.
- 4.4. Requirements for provider participation.
- 4.5. Application for enrollment as a HIP client.
- 4.6. Assessment.
- 4.7. Enrollment.
- 4.8. Rehabilitation service plan.
- 4.9. Rehabilitation period.
- 4.10. Transition period.
- 4.11. Case management services.
- 4.12. Funding limits.
- 4.13. Payment for HIP services.
- 4.14. Peer review.
- 4.15. Administrative review.

§ 4.1. Scope and purpose.

(a) This chapter establishes standards for the Department to administer the Fund.

(b) The Department will use the Fund to administer a head injury program, as set forth in this chapter, to pay for medical, rehabilitation and attendant care services for persons with traumatic brain injury.

§ 4.2. Definitions.

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

Agency head - The Secretary or a deputy secretary designated by the Secretary.

Alternative financial resources –

(i) All income subject to tax under section 61 of the Internal Revenue Code (26 U.S.C.A. § 61).

(ii) Funds which are available to the applicant or client by virtue of experiencing a TBI. These include, but are not limited to, court awards, insurance settlements and other financial settlements made as a result of the TBI and received by any person on behalf of or for the use of the applicant or client.

(iii) Funds which are available to the applicant or client through other State or Federal programs including, but not limited to, Medicaid, Medicare, Social Security Disability Insurance (Title II), Supplemental Security Income (Title XVI), veterans' benefits, workers' compensation insurance and unemployment compensation insurance.

Applicant—An individual for whom a completed application for enrollment in HIP has been submitted to the Department.

Authorized representative—An individual who is authorized by law to make a decision for, or enter into an agreement on behalf of, an applicant or client. The term does not include an employee of the provider unless the employee is appointed by a court to serve as the legal guardian of the applicant or client.

Case management services—Services to be offered by the provider to a client during the enrollment period.

Case manager—An individual who delivers case management services to a client through a provider.

Client—An individual enrolled in HIP.

Day services—Nonresidential services intended to improve the physical, cognitive, behavioral or functional abilities of the client through therapeutic intervention and supervised activities which are provided on an outpatient basis at a facility belonging to a provider.

Department—The Department of Health of the Commonwealth.

Division—The Division of Child and Adult Health Services.

Enrollment period—The period of time, comprised of the rehabilitation period and the transition period, during which a client is enrolled in HIP.

Fund—The Catastrophic Medical and Rehabilitation Fund.

HIP— Head Injury Program—The traumatic brain injury program of the Department.

HIP Peer Review Committee—A committee, composed of professionals and representatives of organizations offering rehabilitation services in this Commonwealth to persons with traumatic brain injury, whose members are appointed by the Department to review rehabilitation plans and services offered to clients and to recommend actions to improve services.

HIP services—Rehabilitation and case management services for which the Department authorizes payment through HIP.

Home facilitation—A formal rehabilitation program which provides a community reentry specialist in the client's home to continue therapy learned by the client and to assist the client in the practice of techniques and strategies for living independently.

Immediate family—A parent, spouse, child, brother, sister, grandparent or grandchild and, when living in the family household (or under a common roof), all other individuals related by blood or marriage.

Peer review—A review of services and rehabilitation service plans for clients conducted by the HIP Peer Review Committee for the purpose of advising the Department on best practices to be followed in offering services to clients.

Provider—An individual, organization or facility that delivers rehabilitation and case management services to clients under a contractual agreement with the Department.

Rehabilitation period—The period of time that a client receives rehabilitation services through HIP.

Rehabilitation service plan—The written plan developed by the provider, which states specific goals to be achieved and expected time frames for achievement of each goal.

Rehabilitation services—Services provided to assist the client to recover from TBI, improve the client's health and welfare, and realize the client's maximum physical, social, cognitive, psychological and vocational potential for useful and productive activity. These services include neuropsychological evaluation, physical therapy, occupational therapy, speech or language therapy, behavior management, home facilitation, therapeutic recreation, prevocational services, case management services and psychological services which may include cognitive remediation.

Secretary - The Secretary of the Department.

TBI— traumatic brain injury—An insult to the brain, not of a degenerative or congenital nature, caused by an external physical force that may produce a diminished or altered state of consciousness, which results in impairment of cognitive abilities or physical functioning or in the disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment.

Transition period—The period of time following the rehabilitation period during which a client receives case management services through HIP to guide and assist the client to make the transition out of HIP.

§ 4.3. Services eligible for payment.

HIP will pay for the following:

- (1) Assessments of applicants by providers.

- (2) Development of rehabilitation service plans by providers.
- (3) Rehabilitation services.
- (4) Case management services.

§ 4.4. Requirements for provider participation.

- (a) Providers of residential, outpatient, day and home-based rehabilitation services shall be accredited by a National accrediting body as approved by the Department. From time to time, the Department will publish a list of approved National accrediting bodies in the *Pennsylvania Bulletin*.
- (b) Providers shall provide rehabilitation services in accordance with their contractual agreements with the Department.
- (c) Providers shall use forms and procedures as prescribed by the Division in the provision of rehabilitation services.

§ 4.5. Application for enrollment as a HIP client.

(a) *Initial contact.* An individual who is interested in enrolling in HIP or in arranging for another individual to be enrolled in HIP shall contact the Eligibility Specialist of the Division by writing to: Eligibility Specialist, Department of Health, Division of Child and Adult Health Services, Post Office Box 90, Room 724, Health And Welfare Building, Harrisburg, Pennsylvania 17108. Contact may also be made by facsimile or electronic mail.

(b) *Funding.* The Division will accept an application for enrollment in HIP only if the funds designated to HIP from the Catastrophic Medical and Rehabilitation Appropriation exceed projected expenditures in providing HIP services to current clients.

(c) *Waiting list.* If the funds designated to HIP from the Catastrophic Medical and Rehabilitation Appropriation are not adequate to enable the Division to accept an application for an individual for whom enrollment in HIP is sought, the Division will place the individual on a waiting list if the individual so elects. The individual on the waiting list or the authorized representative shall immediately notify the Division of any change in mailing address. The Division will request an individual on the waiting list, or the authorized representative, to submit an application for enrollment as funding becomes available. Except as otherwise provided in this chapter, the Division will request individuals on the waiting list, or their authorized representatives, to submit applications in the order that the requests to be placed on the waiting list were received by the Division. Individuals who are receiving case management services through HIP as of August 27, 2001, but who have never received rehabilitation services through HIP, will be given first priority on the waiting list.

(d) *Application.* When an individual qualifies to receive an application for enrollment in HIP, the Division will send to that individual or the person who sought to enroll that individual in HIP, at the mailing address provided to the Division, information on HIP and application materials. If the individual is on a waiting list, the Division will also request that the individual notify the Division in writing whether the individual is still seeking enrollment in HIP. The notification shall be timely only if it is postmarked within 21 days after the date the materials were sent by the Division. If the Division receives a timely notification that enrollment in HIP is desired, the Division will proceed with the application process. If the Division is apprised that enrollment in HIP is no longer desired, or if the Division does not receive timely notification of continued interest in enrollment, the Division will remove the individual from the waiting list, contact the next person on the waiting list and repeat the process.

(e) *Request and application for reenrollment.* A request for reenrollment may be filed for an individual who was previously enrolled in HIP. If there is a waiting list, the Division will not accept an application for reenrollment. Instead, it will place the individual on the waiting list. The Division will give priority to individuals on the waiting list who have not previously received rehabilitation services from HIP. The Division will request individuals who have previously received rehabilitation services from HIP who are on the waiting list, or their authorized representatives, to submit applications for reenrollment. The Division's requests for these applications will be made in the order that the requests for reenrollment were received. Except as provided in subsection (c), the Division will only accept a request or application for reenrollment for an individual who is not a client at the time the request or application is made.

(f) *Acceptance of application.* The Division will accept an application for enrollment only from the individual for whom enrollment is sought or from an authorized representative.

§ 4.6. Assessment.

(a) *Eligibility for assessment.* The Division will review an application for enrollment in HIP to determine whether the applicant is eligible for an assessment, as follows:

(1) *General criteria.* An applicant shall be eligible for an assessment only if all of the following requirements are met:

- (i) The applicant sustained a TBI after July 2, 1985.
- (ii) The applicant is a citizen of the United States and was domiciled in this Commonwealth at the time of the injury and at the time of application for enrollment in HIP.
- (iii) The applicant is 21 years of age or older.
- (iv) The application is completed and is accompanied by the documentation that is requested to verify the applicant's satisfaction of the eligibility criteria in this subsection.
- (v) The applicant's alternative financial resources are at or below 300% of the Federal Poverty Income Guidelines.

(A) The applicant's income will be assessed using the applicant's most recent Federal Income Tax form, which the applicant shall provide. If that form is unavailable, the Division may request other documentation of income. If the most recent Federal Income Tax form is not representative of the applicant's income at the time of application, the applicant may submit documents to that effect in support of the application.

(B) The applicant shall provide, on forms provided by the Division, information about any court award or financial settlement made or pending as a result of the TBI, and any other funds which are available to the applicant. If all or part of the award, settlement or other funds is unavailable to the applicant to use for HIP services, the applicant may submit documents to that effect in support of the application.

(2) *Condition criteria.* An applicant shall be eligible for an assessment only if the applicant's impairment is not the result of one or more of the following conditions:

- (i) Cognitive or motor dysfunction related to congenital or hereditary birth defects.
- (ii) Putative birth trauma or asphyxia neonatorum (hypoxic-ischemic-encephalopathy).
- (iii) Hypoxic encephalopathy unrelated to TBI.
- (iv) Significant preexisting psychiatric, organic or degenerative brain disorder.
- (v) Stroke.
- (vi) Spinal cord injury in the absence of TBI.

(3) *Symptom criteria.* An applicant shall be eligible for an assessment only if the applicant does not manifest any symptom, such as a comatose condition, which would prevent the applicant from participating in the assessment in a meaningful way or prevent the provider from doing a full and complete assessment.

(4) *Assignment agreement.* An applicant shall be eligible for an assessment only if the applicant or authorized representative completes an assignment agreement which, conditioned upon the applicant's receipt of HIP services, would assign to the Department rights in future court awards, insurance settlements or any other proceeds which have accrued or will accrue to the applicant as a result or by virtue of the applicant's TBI, up to the amount expended for HIP services on behalf of that individual.

(b) *Assessment process.* The Division will refer an applicant who is eligible for an assessment to a provider. The provider shall assess the applicant for the following:

- (1) To corroborate the Division's determination that the applicant satisfies the condition and symptom criteria in subsection (a)(2) and (3).
- (2) To determine that the applicant has the physical, social, cognitive, psychological and vocational potential for useful and productive activity which can be nurtured by rehabilitation services available through HIP so as to enable the applicant to progress toward a higher level of functioning and transition to a less restrictive environment.
- (3) To determine that the applicant has needs that can be addressed by HIP services, that will not be addressed by any other services to which the applicant is entitled.
- (4) To determine that the applicant does not manifest suicidal or homicidal ideation, or potentially harmful aggressive behavior, to such a degree that HIP cannot provide the appropriate services through its providers to sufficiently address these ideations or behaviors.

(c) *Forms and procedure.* The provider shall complete the assessment on forms provided by the Division. A provider conducting an assessment shall:

- (1) Review the applicant's medical records.
- (2) Review all pertinent documentation submitted by physicians on behalf of the applicant.
- (3) Evaluate the applicant's ability to benefit from rehabilitation services, performed in accordance with standards prevailing in the field.

(d) *Development of rehabilitation service plan.* If the provider corroborates the Division's initial determination under subsection (a)(2) and (3), and determines that the applicant meets the criteria in subsection (b)(2)—(4), the provider shall develop a rehabilitation service plan for the applicant as specified in § 4.8 (relating to rehabilitation service plan).

(e) *Assessment period.* The provider shall complete its assessment and give written notification of its determination to the Division and the applicant or authorized representative within 14 days after the provider begins to conduct an assessment of the applicant. If the provider determines that the applicant is eligible for enrollment in HIP, the provider shall also complete a rehabilitation service plan for the applicant within that 14-day period.

(f) *Reapplication.* If the Division determines that an individual is not eligible for an assessment or that an applicant is not eligible for enrollment in HIP after an assessment has been completed, the individual may repeat the process for seeking enrollment in HIP when the individual or authorized representative believes that the factors which rendered the individual ineligible for enrollment in HIP have been eliminated.

§ 4.7. Enrollment.

(a) *Notification of decision.* The Division will notify an applicant or authorized representative in writing of its decision regarding an application for enrollment within 16 days after receiving from the provider the completed assessment and, if applicable, its decision regarding the rehabilitation service plan. If the Division determines that the applicant is ineligible, the notice will include the reason for that determination and will advise of appeal rights.

(b) *Provider determination that applicant is not eligible for enrollment.* If, after assessing the applicant the provider determines that the applicant does not satisfy the condition and symptom criteria in § 4.6(a)(2) and (3) (relating to assessment), lacks the potential to benefit or the need described in § 4.6(b)(2) and (3) or manifests ideation or behavior which would render the applicant unfit to participate in HIP under § 4.6(b)(4), the provider shall share its findings with the Division and the applicant or authorized representative. The Division will provide the applicant or authorized representative the opportunity to rebut the provider's findings, and then will make a determination as to whether the applicant is eligible for enrollment in HIP.

(c) *Overturning provider determinations.* If the Division determines that an applicant is eligible for enrollment in HIP despite the provider's determination to the contrary, or that a rehabilitation service plan is unacceptable, the Division will direct the provider, or another provider at the Division's discretion, to develop a rehabilitation service plan for the applicant within 14 days of receiving the Division's decision. The Division will act on the revised rehabilitation service plan within 16 days after receipt.

(d) *Commencement of enrollment.* A client's enrollment begins on the first day that a client receives rehabilitation services from a provider after the Division issues its written notification granting enrollment in HIP.

(e) *Duration of enrollment.* The enrollment period of a client shall be specified in the client's rehabilitation service plan. It may not exceed 18 consecutive months, comprised of a maximum rehabilitation period of 12 consecutive months followed by a maximum transition period of 6 consecutive months. A client's enrollment shall end prior to the time designated in the client's rehabilitation service plan when one of the following occurs:

- (1) The Division determines that the continuation of HIP services will not enable the client to progress to a higher level of functioning and transition to a less restrictive environment.
- (2) The client fails to cooperate or exhibits unmanageable behavior so that HIP cannot provide the appropriate services to meet the client's needs under § 4.6(b)(4).
- (3) The maximum funds available for allocation to the client under § 4.12 (relating to funding limits) are exhausted.
- (4) The client becomes eligible for other services offered as a result of the TBI, which services will meet the client's needs or duplicate HIP services so that HIP services are rendered unnecessary.

(f) *Notification of discharge from HIP.* The Division will notify a client or authorized representative in writing of its decision to terminate the client's participation in HIP. The notice will include the reason for the decision and will advise of appeal rights.

(g) *Grandfather clause.* Clients who are receiving rehabilitation services as of August 27, 2001 are eligible for the maximum enrollment period, beginning on August 27, 2001. Clients who are receiving only case management services as of August 27, 2001 are eligible for the maximum transition period.

§ 4.8. Rehabilitation service plan.

(a) *Development of rehabilitation service plan.* The provider shall collaborate with the applicant or authorized representative, and may collaborate with other individuals identified by the applicant, to develop a rehabilitation service plan for the applicant.

(b) *Goal.* The primary goal of the rehabilitation service plan shall be to enable the client to progress to a higher level of functioning, which will, in turn, enable the client to transition to a less restrictive environment.

(c) *Requirements.* The initial rehabilitation service plan shall contain the following:

- (1) A description of desirable goals and the anticipated outcomes in objective and measurable terms, including the expected time frames for the achievement of each goal and outcome, for the entire enrollment period.
- (2) A specification of the HIP services necessary to attain the agreed-upon goals.
- (3) A specification of any other services to which the applicant is entitled and a description of the impact of those services upon the attainment of the agreed-upon goals.
- (4) Beginning and ending dates of each HIP service.
- (5) The terms and conditions for HIP service delivery.
- (6) The specific responsibilities of the applicant and service provider relative to implementation of each HIP service.
- (7) The extent of financial responsibility of the applicant, HIP and any third party.

(d) *Quarterly review.* The rehabilitation service plan shall include a procedure and schedule for quarterly review and evaluation of progress towards the specified goals. These written reviews shall be submitted to the Division.

(e) *Modifications.* The provider shall make modifications to the rehabilitation service plan as often as necessary, and in accordance with subsections (a)—(d). Modifications shall indicate whether previously set goals were met. When goals were not met, modifications shall address the reasons why, and modify or change goals appropriately.

§ 4.9. Rehabilitation period.

(a) *Provision of rehabilitation services.* During the rehabilitation period a provider shall coordinate the provision of rehabilitation services to a client to ensure achievement of goals consistent with the rehabilitation service plan, and as appropriate to the needs of the client to improve the client's health, welfare and the realization of the client's maximum physical, social, cognitive, psychological and vocational potential for useful and productive activity.

(b) *Supervision.* Rehabilitation services shall be provided or their provision shall be supervised by a physician or other appropriate health professional qualified by training or experience to provide or supervise these services.

(c) *Purpose.* If authorized under the rehabilitation service plan, rehabilitation services may be provided for the following purposes:

- (1) Helping a client develop behaviors that enable the client to take responsibility for the client's own actions.
- (2) Facilitating a client's successful community integration.
- (3) Assisting a client to accomplish functional outcomes at home and in the community.
- (4) Teaching a client skills to live independently.
- (5) Supervising a client living in a home setting through the following:
 - (i) Home facilitation.
 - (ii) Physical rehabilitation.
 - (iii) Cognitive remediation.
 - (iv) Life-skills coaching.
 - (v) Assisting the client in maintaining independence.
- (6) Providing transitional living services to assist a client with community reentry skills.
- (7) Maximizing a client's physical potential.

§ 4.10. Transition period.

(a) *Provision of case management services.* Following the rehabilitation period, HIP will provide case management services to assist the client in making the transition out of HIP.

(b) *Commencement of transition period.* The transition period will commence immediately following the end of the rehabilitation period.

(c) *Duration of transition period.* The transition period may not exceed 6 consecutive months, and shall end when the maximum funds available for allocation to the client are exhausted under § 4.12 (relating to funding limits).

§ 4.11. Case management services.

Case management services shall be provided by a case manager who has a minimum of 1 year of experience in TBI case management, and shall include the following activities by the case manager:

- (1) Monitoring the client's progress with respect to the rehabilitation service plan and collaborating with the client or authorized representative, the client's significant others and the rest of the treatment team in the development and modification of the rehabilitation service plan.
- (2) Assisting the client in gaining access to services from which the client may benefit and for which the client may be eligible.
- (3) Monitoring and evaluating the client's progress in transitioning to living in a home or community setting and ensuring that any necessary supports are in place, or facilitating placement of the client in a long-term care facility.
- (4) Determining that the client has fully transitioned to the home or community or has been referred to the appropriate long-term care facility.

§ 4.12. Funding limits.

(a) HIP will provide no more than \$100,000 for case management and rehabilitation services for a client during a rehabilitation period. This amount will be reduced by any client share of costs under § 4.13(b) (relating to payment for HIP services).

(b) HIP will provide no more than \$1,000 for case management services for a client during a transition period. This amount will be reduced by any client share of costs under § 4.13(b).

(c) The Division will notify an applicant of these maximum funding limits when it accepts the applicant as a client.

§ 4.13. Payment for HIP services.

(a) *Written authorization.* The Division will provide written authorization, to the client and to the provider, as to HIP services for which the client is eligible and the maximum available funding and time limits for those services.

(b) *Client responsibility for payment.* If the Division determines that a client is responsible to pay for any part of HIP services, the client will be informed of that fact, and of the amount for which the client is responsible, as follows:

- (1) The client shall be assessed a share of the cost of HIP based upon alternative financial resources between 185% and 300% of the Federal Poverty Income Guidelines. The patient's share of the cost shall be determined using the Patient Share of Cost Table in Appendix A, as periodically updated and published in the *Pennsylvania Bulletin*.
- (2) The client will be responsible to pay for HIP services up to the amount of alternative financial resources which exceed 300% of the Federal Poverty Income Guidelines.

(c) *Notification of discontinuance of HIP funding.* The Division will notify a client in writing of any discontinuance of funding. The notice will include the reason for the discontinuance and advise of appeal rights.

(d) *Duty to update financial information.* A client shall immediately report to the Division all changes in availability of alternative financial resources.

(e) *Preexisting conditions.* HIP will not pay for services to address conditions existing prior to the TBI.

(f) *Services funded through other benefit programs.* HIP will not pay for services available through other publicly funded programs. The provider will coordinate HIP with other public and private programs to assist clients to access benefits for which they may be eligible.

(g) *Reimbursement.* The Department may seek reimbursement for payments made with HIP funds on behalf of a client from an insurer that provides coverage to the client or from the proceeds of any litigation arising out of the injury which led to eligibility for enrollment in HIP.

§ 4.14. Peer review.

(a) *Purpose.* The Department will appoint a peer review committee to conduct a review of services and rehabilitation service plans for clients. The HIP Peer Review Committee (Committee) shall advise the Department on best practices to be followed in offering services to clients.

(b) *Procedures.*

- (1) The Committee shall meet quarterly and review selected client charts, including charts for at least one client from each provider providing services at the time of the quarterly meeting, to evaluate the appropriateness of provision of services and client progress.
- (2) Within 30 days after it completes its review, the Committee shall provide to the Department, in writing, recommendations regarding the provision of services by each provider.
- (3) A member of the Committee may not participate in a review conducted by the Committee that presents a conflict of interest for that member. Examples of conflicts include, but are not limited to, participating in a review conducted by the Committee for one of the following:
 - (i) A service provided to a client of that member, that member's employer or that member's immediate family.
 - (ii) A service provided by a person who is in the immediate family of the member.
- (4) The Division will notify the Committee of any actions taken on the recommendations of the Committee.

§ 4.15. Administrative review.

(a) *Reconsideration by Division.*

- (1) An applicant, client or authorized representative may file with the Division a request for it to reconsider any of the following decisions made by the Division:
 - (i) An applicant is not eligible for an assessment.
 - (ii) An assessed applicant is not eligible for enrollment.
 - (iii) A disapproval or revision of a rehabilitation service plan.
 - (iv) A client is to be discharged from HIP prior to the date specified in the client's rehabilitation service plan.
 - (v) Alternative financial resources are available so that the client must pay for HIP services.
- (2) At the time a decision is made, the Division will notify the applicant, client or authorized representative in writing of the right to seek administrative review. The letter will advise the recipient to seek assistance from legal counsel, family and others who may serve in an advisory role, and include contact information for a HIP representative to answer questions.
- (3) An applicant, client or authorized representative shall file a request for reconsideration within 15 calendar days after the mailing date of the Division's determination. The request shall meet the following standards:
 - (i) State the specific legal and factual reasons for disagreement with the decision.
 - (ii) Identify the relief that is being sought for the applicant or client.
 - (iii) Include supporting documentation, if any, to support the factual averments made.
- (4) The Division will notify the applicant, client or authorized representative in writing of its decision within 30 days after receiving the request for reconsideration.

(b) *Administrative appeal.*

- (1) An applicant, client or authorized representative may file an administrative appeal to the Agency Head within 30 days after the mailing date of the Division's decision on the request for reconsideration. An applicant, client, or authorized representative may not file an administrative appeal unless reconsideration has been sought and the requested relief has been denied.
- (2) A hearing will be held only if a material issue of fact is in dispute.

(c) *General rules.* The General Rules of Administrative Practice and Procedure, 1 Pa. Code Part II, apply except when inconsistent with this section.

(d) *Status of clients and applicants.* A client shall continue to receive HIP services until the client's right to administrative review has been exhausted, and until the maximum funds available to a client under § 4.12 (relating to funding limits) are exhausted, or the maximum duration for enrollment under § 4.7(e) (relating to enrollment) has expired. An applicant, including one who has completed the assessment period, will not receive HIP services pending the disposition of the administrative review.

Appendix A
BUREAU OF FAMILY HEALTH
DIVISION CHILD AND ADULT HEALTH SERVICES
PATIENT SHARE of COST (PSC) TABLE

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