

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Philadelphia Regional Office  
105 S. Independence Mall, West  
Suite 216, The Public Ledger Building  
Philadelphia, PA 19106-3499



**REGION III/DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS**

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SWIFT: 082220124015

**NOV 09 2012**

Gary D. Alexander, Secretary  
Office of the Secretary  
P.O. Box 2675  
Harrisburg, PA 17105

Dear Mr. Alexander:

This letter is being sent as a companion to our approval of PA's State Plan Amendment (SPA) 12-028 Dental Services. This SPA corrected issues noted in a previous companion letter associated with PA SPA 11-022. While we are proceeding with approval of PA SPA 12-028, this letter follows up on matters noted which were not in compliance with current Federal regulation, so that we can work with you to resolve the issues listed below.

Section 1902(a) of the Social Security Act (the Act) requires that States have a State Plan for medical assistance that meets certain Federal requirements that set out a framework for the State program. Implementing regulations at 42 CFR 430.10 require that the State Plan be a comprehensive written statement describing the nature and scope of the State's Medicaid Program and that it contain all information necessary for the Centers for Medicare & Medicaid Services (CMS) to determine whether the plan can be approved to serve as the basis for Federal financial participation (FFP) in the State program. During our review of the SPA, CMS performed an analysis of the coverage and reimbursement pages related to this SPA, and found that additional clarification is necessary.

In reviewing the State Plan pages, CMS found companion page issues related to coverage and reimbursement which are outlined per Exhibit 1. Please revise the State Plan pages to include the required detailed information. Please respond to this letter within 90 days from your receipt of this letter with a corrective action plan describing how you will resolve the issues identified above. During the 90-day period, we are happy to provide any technical assistance that you need. A State Plan that is not in compliance with requirements at 42 CFR 430.10 and 42 CFR 440.167 is grounds for initiating a formal compliance process.

If you have any questions regarding this letter, please contact Rosemary Feild at (215) 861-4278. We look forward to working with you on these issues.

Sincerely,

A handwritten signature in black ink, appearing to read "Francis McCullough", is written over a circular stamp or watermark.

Francis McCullough  
Associate Regional Administrator

Enclosure: Exhibit 1

COMPANION LETTER PA 12-028 DENTAL  
TRANSPORTATION, HOME HEALTH, OUTPATIENT CLINIC SERVICES  
EXHIBIT 1

**Outpatient Clinic Services**

**Attachment 4.19-B, Page 2b, #3**

42 CFR 430.10 and 447.252 require that the State plan contain a comprehensive description of the rate methodologies for Medicaid services. The Plan doesn't include a comprehensive description of how rates are set for outpatient clinic services. Are outpatient clinic services hospital based clinics? Please include in the State Plan a description of the rate methodology, the unit of service, a description of how the upper payment limit is calculated, a description of any payment limitations, a reference to where providers are identified, etc. If a cost report is used to identify the outpatient clinic costs, please describe in the Plan how costs are identified. If the States uses a fee-for-service schedule, please include the following language:

"The Agency's fee schedule rate was set as of (date here) and is effective for services provided on or after that date. All rates are published on the Agency's website at [insert website address]. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners."

**Home Health Services**

**Attachment 4.19-B, Page 2b, #5**

Please include in the State Plan a description of the rate methodology, the unit of service, a reference to a description of the provider qualifications, and any payment limitations. For example, can a provider bill for more than 24 hours per day. If a fee schedule is used, please add the following language to the plan:

"The Agency's fee schedule rate was set as of (date here) and is effective for services provided on or after that date. All rates are published on the Agency's website at [insert website address]. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners."

**Attachments 3.1-A and 3.1-B**

**Page 3b; 7.a.1**

- 1) In order to comport with CFR 440.70, please include language in the State Plan that home health services are provided to a recipient on the orders of his or her physician as part of a written plan of care that a physician reviews every 60 days.

**Page 3b; 7.a.2**

- 2) Please remove the homebound requirement from the State Plan, as this is a Medicare requirement and does not apply to Medicaid's home health benefit.

**Page 3b; 7.a.3**

- 3) It appears that the limitations applied to 7.a (nursing services) are combined with 7.b (home health aide services) and 7.d (physical therapy, occupational therapy, or speech pathology and audiology services). Combining limits across independent home health components is not allowed. Please remove these combined limitations where they exist.

**Home Health Services: Attachments 3.1-A and 3.1-B**

**Page 3b; 7.a.3**

- 4) Per CFR 440.230 a service must be sufficient in amount, duration and scope in order to reasonably achieve its purpose. The home health limitation in 7.a.3 limits payment to 15 visits per month per treatment plan regardless of the caregiver (after 28 days of unlimited visits). Please indicate support for this scope of services through clinical literature or evidence-based practice guidelines, or describe your consultation with your provider community that resulted in assurance that this scope of services has clinical merit to achieve its intended clinical purpose.

**Page 3b; 7.a.4**

- 5) Per CFR 440.230 a service must be sufficient in amount, duration and scope in order to reasonably achieve its purpose. The prenatal care limitation found in 7.a.4 limits prenatal care to one visit per month. Please indicate support for this scope of services through clinical literature or evidence-based practice guidelines, or describe your consultation with your provider community that resulted in assurance that this scope of services has clinical merit to achieve its intended clinical purpose.

**Page 3c; 7.c.3**

- 6) Please describe in greater detail the prior approval process for the \$100 limitation on medical supplies. Can a recipient receive medical supplies, equipment and/or appliances and receive retrospective approval for that device?

**Page 3c; 7.d**

- 7) Please include in the State Plan the provider qualifications for therapy services, or include a statement that, "therapy services and provider qualifications comport with 42 CFR 440.110."

**Transportation**

**Attachment 4.19-B, Page 2b, #6 and Attachments 3.1-A, 3.1-B, and 3.1-D**

It is our understanding that school-based transportation and non-emergency brokered transportation services in Philadelphia County are claimed as **medical** costs under 440.170(a)(4), and all other transportation is claimed as an administrative expense. Therefore, a complete description of the service and reimbursement methodology should be outlined in the PA State Plan in *Attachments 3.1-A, 3.1-B, 3.1-D and 4.19B (MATP only)*. Note that ambulance services (emergency and non-emergency) are described in *Attachment 3.1-D Page 1, Attachment 3.1-A p. 9 and 9a 9 (transportation limits), Attachment 3.1-B p 7a, and Attachment 4.19-B, page 2b*.

***Attachment 4.19B, page 2b, #6.1 – Emergency and Non-Emergency Ambulance***

The Plan language states that ambulance services are paid based on a flat rate per trip plus a mileage fee when over 20 miles. Based on this description and discussion with the State, CMS is uncertain what rate is actually being paid for this service. Please include in Attachment 4.19-B a discussion of the rate methodology, who is a qualified provider or a reference to where the Plan identifies the provider, any payment limitations, and the unit of service. Also, please explain emergency ambulance services are paid any differently than non-emergency ambulance.

**Attachment 4.19B, page 2b, #6.II Transportation – Non-Emergency Medical Transportation (NEMT):**

- a. **Contractual Agreements:** (Also see Attachment 3.1-D, page 1) All counties in Pennsylvania other than Philadelphia County are reimbursed for non-emergency medical transportation (NEMT) services as an administrative cost. The State recently submitted a cost allocation plan (CAP) for NEMT. The 66 counties other than Philadelphia use a request for proposal (RFP) process and then negotiate rates for that particular provider, or a public rate (as in a shared ride program administered by PennDOT), or a mileage rate reimbursement up to 12 cents per mile. At the beginning of each year, counties are given advances equal to 25 percent of their total projected costs for the year. One hundred percent of the advance is funded by the State. Federal funds aren't drawn down until expenditures are actually incurred. The counties submit an expenditure report quarterly. The shared ride program is not just a Medicaid transportation service but a service provided to seniors. Seniors pay 15 percent of the cost and the Pennsylvania Lottery Fund, which funds programs for seniors, pays the other 85 percent of the cost. The State does not pay for no-load rides. However, the county and private contractors include the no-load cost in the rate. Mileage reimbursement trips are reimbursed from the recipient's house to the appointment and back to the home.

The counties submit a quarterly cost report. Costs included in the report are not allowable Medicaid costs. No step-down is performed and cost related to other programs aren't identified or excluded from total costs. Non allowable costs are also being included on the report, including no-show costs. Only a CMS approved cost report should be used to determine Medicaid allowable costs. The State allows the counties to come up with their own way of allocating costs to Medicaid. Some counties do use time studies. The State only checks for reasonableness. If the counties do not receive direct funding from HHS, then there should be a signed contract between the Medicaid Agency and the counties outlining how costs are identified, the service being performed, and a narrative of how costs are reimbursed. This information must be included in the Medicaid cost allocation plan and in Attachment 3.1-D of the Pennsylvania State Plan. The counties' cost reports and time studies must be approved by CMS prior to implementation.

CMS confirmed that the State does not have an approved Department of Health and Human Services (DHHS) CAP. The CAP must be amended and approved by the Division of Cost Allocation (DCA) within DHHS before FFP is available for administrative claims in the Medicaid program. [Subpart E of 45 CFR Part 95 and 42 CFR 433.34] (The State submitted a draft plan on July 26, 2012.) Per the Office of Management and Budget Circular A-87, Attachment D, 2: "The effective date of the plan or plan amendment will be the first day of the quarter following the submission of the plan or amendment". [45 CFR 95.515]

- b. **Non-contractual Services:** (Also see Attachment 3.1-D, pages 1 and 2) If the counties use non-contract services for non-ambulance transportation, then services are paid by the County Assistance Offices. It is unclear how payment is made to the County Assistance Offices. Page 2 of Attachment 3.1-D states that public transportation is used or, if that is not available, then the 12 cents a mile is paid. CMS is unable to ascertain how the County's Assistance Office is reimbursed for Medicaid services. The Medicaid Agency must update its cost allocation plan for these services. A cost report and time study may be required. Again, the payment of these services must be outlined in the same manner as noted for contractual services above.

To correct the outstanding issues associated with non-emergency services, the State should be mindful of the following rules:

- i. Pennsylvania must have an approved DHHS CAP. The CAP must be amended and approved by the DCA within DHHS before Federal financial participation (FFP) is available for administrative claims in the Medicaid program. *[Subpart E of 45 CFR Part 95 and 42 CFR Part 433.34]* The State submitted a draft plan on July 26, 2012, but that plan isn't effective until September 1 2012. Per OMB Circular A-87, Attachment D; 2: "The effective date of the plan or plan amendment will be the first day of the quarter following the submission of the plan or amendment". *[45 CFR Part 95.515]*
- ii. Medicaid costs must be authorized or not prohibited under Federal, State or local laws or regulations. CMS noted a number of claimed expenses by Delaware County that are not allowable Medicaid costs because they are not necessary and reasonable for proper and efficient performance and administration of the Medicaid program. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The question of reasonableness is particularly important when governmental units or components are predominately federally-funded. The State included costs associated with no-shows and escorts, which are not Medicaid reimbursable. Although CMS has only reviewed Delaware County cost methodology, we believe similar methodologies are being applied in other Pennsylvania localities. An allowable administrative cost may not include the operating costs of an agency whose primary purpose is other than operation of the Medicaid program. Pennsylvania includes indirect costs of 12.34 percent, as calculated by Delaware County, and 12.4 percent by the County's subcontractor in the total computable cost reimbursed by Medicaid. These indirect costs include salaries, rent/lease of space, materials/supplies, data processing, professional fees, and depreciation. None of these costs are allowable based on the provisions of OMB 87. Where a local government only receives funds as a sub-recipient, the primary recipient, i.e., the Medicaid Agency, is responsible for negotiating the indirect cost rates and/or monitoring the sub-recipient's plan. *[OMB Circular A-87, Attachment C, Subpart D, Item 3]* All departments or agencies of the governmental unit desiring to claim indirect costs under Federal awards must prepare an indirect cost rate proposal and related documentation to support those costs. All indirect cost should be captured through the indirect cost rate. No additional pools of indirect cost permitted (generally).
- iii. Salary costs reported by the counties for MATP are based on estimates using historical past time usage and there is no reconciliation of estimates to actual. Professional fees reported quarterly are also based on estimated cost, which in this instance does get reconciled to actual costs at year end. Estimated costs are not considered allowable costs to be reported on the CMS-64 expenditure report. The counties will need to develop a time study and cost report to appropriately allocate salaries and other direct costs to the various benefiting programs.
- iv. An allowable administrative cost may not include funding for a portion of general public health initiatives that are made available to all. CMS noted that Medicaid is billed for the full fare for seniors that are on Medicaid even though seniors that are not on Medicaid get subsidized by Pennsylvania Lottery fund for 85 percent of the fare.

Medicaid eligible seniors should also only be charged that portion of the ride that is not subsidized by other programs or funding.

- c. **Brokerage Program:** Philadelphia County uses a brokerage system that is claimed at the medical rate. Broker services are outlined at *Attachment 3.1-A, page 9aa, 9aaa, 9aaaa and 9aaaaa and Attachment 3.1-B, page 8a through 8aaa*. Although described in Attachments 3.1-A and 3.1-B, please also specify in detail in Attachment 3.1-D the nature of brokered transportation in Philadelphia County.
- d. **School-based Transportation Services:** (See Attachment 3.1-D, page 2) School-based services are reimbursed as a medical service, using a certified public expenditure (CPE) funding mechanism. A Financial Management Review found that Pennsylvania is performing CPEs without State Plan authority. CMS advised the State to submit a revised State Plan Amendment (SPA) establishing school-based services using an approved CMS cost report. However, the State does not properly certify or reconcile costs. CMS found that the State pays one rate which does not differ for a single one-way trip or for a round trip. The State must establish a one-way rate which is reimbursed only when a recipient has a medical procedure performed on that specific day. (See *Attachment 3.1-D*, and limitations are described at *Attachment 3.1-A, page 9 and 9a*.) There appear to be no provisions in the Medicaid cost allocation plan for payment of these services. (The State submitted a SPA in September 2012 that is under CMS review.)

#### **Attachment 3.1-D**

All transportation-related services – emergency and non-emergency, medical and administrative services, and school-based transportation services – should be described in Attachment 3.1-D, with references to other parts of the State Plan and CAP as appropriate. Please describe here how the brokerage operates and is paid and how NEMT is provided in the rest of the State as an administrative service.

1. The description in Attachment 3.1D of how the State assures non-emergency transportation provided is incomplete. It should fully describe how the NEMT program operates, including county responsibilities. For example: it's unclear how the ambulance (emergency and non-emergency) services are provided, who makes the decision to allow the cost? The description provided for the contracted and non-contracting non-emergency, non-ambulance services are also incomplete. What service is performed by the County Assistance Offices? How do they track the services? What documentation is required? How do they get reimbursed?
2. A complete description of the responsibilities of the counties for contracted and non-contracted services needs to be included.
3. An escort must be medically necessary for the cost of the escort's transportation to be reimbursed for accompanying the beneficiary. Please verify that, if the cost of the ride is not per person (for example, bus ride or shared van ride), then no additional cost should be incurred for the escort, and that the cost of transporting the escort to and from the beneficiary is not being reimbursed by the Medicaid program.

4. Contracted services: Are beneficiaries or counties given a three-month advance payment for non-emergency transportation? If so, please explain how this operates.
5. Non-contract services: Payment is made for public transportation in accordance with the rates established for the general public. For recurring transportation needs, categorically needy recipients may receive either a County Assistance Office disbursement or have an allowance for public transportation included in their regular grant. Medically needy recipients may receive County Assistance Office funds. What are the authorization provisions for such an advance? This statement indicates that the State is providing advances to the beneficiary as part of a welfare payment. Please explain how this prospective payment is directly related to a medical service that was actually received and how the amounts are reconciled retrospectively. Also confirm that State-only funds are used for these advances and that the State is not claiming FFP until the transportation is actually verified as being provided.

**Attachment 3.1-A, Page 9a**

Emergency and non-emergency ambulance should be described in the State plan in separate sections. Does the State reimburse only for the farthest ride in an emergency if more than one person is in the ambulance? Does the State reimburse emergency versus non-emergency transportation services differently? If so, how? Is there any type of prior approval for non-emergency ambulance services?

**Attachment 3.1-A, page 9aaaaa and Attachment 3.1-B, page 8aaa**

Please add an assurance stating: "The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial arrangement as described at 42 CFR 440.170(4)(ii)."

**Attachment 3.1B**

The language on page 7a is somewhat duplicative of page 8a, but the differences are not included in Attachment 3.1A, with no apparent reason. Please revise the language so that Attachments 3.1A and 3.1B are consistent and that any differences are clear.