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State/Territory Name: PENNSYLVANIA

State Plan Amendment (SPA) #: PA-13-027

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT # 091820134028

MAR 26 2014

Beverly Mackereth
Secretary of Public Welfare
Department of Public Welfare
Room 333, Health & Welfare Building
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Dear Ms. Mackereth:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Pennsylvania's State Plan Amendment (SPA) PA-13-027. We are pleased to inform you that SPA PA-13-027 has been approved. The effective date of SPA PA-13-027 is September 1, 2013.

This SPA was submitted to address CMS's issues raised in a February 22, 2013 Companion Letter. PA-13-027 amends Attachment 3.1A and 3.1B to set forth limits applicable to certain compensable services. Further, Attachment 4.19B was amended to reference inpatient consultation limits, identify the effective date for State's fee schedule for physicians and to identify the unit of service for inpatient consultations.

Enclosed, please find the signed CMS 179 form, and the approved SPA pages.

If you have any questions concerning this letter, please contact Mary McKeon at (215) 861-4181.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13-027

2. STATE: Pennsylvania

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR §430.10 and §447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $0
b. FFY 2014 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 2aa of Attachment 3.1A
Page 2l of Attachment 3.1B
Page 1 of Attachment 4.19B
Page 4b of Attachment 4.19B

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Page 2aa of Attachment 3.1A
Page 2l of Attachment 3.1B
Page 1 of Attachment 4.19B
Page 4b of Attachment 4.19B

10. SUBJECT OF AMENDMENT:
Identify the effective date of the Department's fee schedule for physicians
Identify the unit of service for inpatient consultations

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Review and approval authority has been delegated to the Department of Public Welfare

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Beverly D. Mackereth

14. TITLE:
Secretary of Public Welfare

15. DATE SUBMITTED: SEP 13 2013

16. RETURN TO:
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Policy, Analysis and Planning
P.O. Box 8046
Harrisburg, Pa.17105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 01 2013

18. DATE APPROVED: MAR 26 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME:

22. TITLE:

23. REMARKS:

SERVICE	LIMITATIONS
4.c. Family Planning Services and Supplies	Limitations- Service must be under the supervision of a physician. (1) Any medical services, procedures, or pharmaceuticals related to treating infertility are not covered.
5.a. Physician's Services Furnished in office, patient's home, hospital, skilled nursing intermediate care facility, hospital emergency room birth center, renal dialysis facility (M.D. & D. O.)	Limitations – The following limits apply to compensable services: 1. [RESERVED] 2. [RESERVED] 3. [RESERVED] 4. [RESERVED] 5. [RESERVED] 6. Vision examinations are limited to four per year. 7. [RESERVED] 8. [RESERVED]

SERVICE	LIMITATIONS
5.a. Physician's Services (Continued)	1. [RESERVED] 2. [RESERVED] 3. [RESERVED] 4. [RESERVED] 5. [RESERVED] 6. Vision examinations are limited to four per year. 7. [RESERVED] 8. [RESERVED] 9. [RESERVED]

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

SERVICE	LIMITATIONS
1. Individual Practitioners, i.e., Physicians, Dentists, Chiropractors, Optometrists, Podiatrists	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician, dentist, chiropractor, optometrist, and podiatrist services. The agency's fee schedule rate was set as of June 24, 2013 and is effective for services provided on or after that date. All rates are published on the Department of Public Welfare's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm.
2. Prescribed Drugs	Usual and customary charge to the general public The pharmacy's lowest net charge a medical assistance recipient would pay for a prescription as a non-medicaid patient at the time of dispensing for the same quantity and strength of a particular drug or product, including all applicable discounts, such as special rates to nursing home residents, senior citizens, or other such discounts extended to particular group of patients, including generic drug discounts and savings programs. This lowest net price shall not apply to special in-store rates or discounts extended to charitable organizations, religious groups, store employees and their families, nonprofit organizations, members of the medical profession, or other similar non-medicaid groups. Method of Payment (a) The Department will pay a pharmacy for a compensable legend and nonlegend drug by deducting the copayment amount, if applicable, from the lowest of the following amounts: (1) The estimated acquisition cost (EAC) for the drug, multiplied by the number of units dispensed, plus the current dispensing fee. (2) The State MAC for the drug, multiplied by the number of units dispensed, plus the current dispensing fee. (3) The provider's usual and customary charge to the general public. (b) For purposes of medical assistance payment to pharmacies, the prescription dispensing fee is $2.00. (c) The Department will pay a pharmacy for a compensable compound prescription at the lower of the cost of all ingredients plus a $3.00 dispensing fee or the provider's usual and customary charge to the general public. A compound prescription, for the purposes of medical assistance payment, is one which is prepared in the pharmacy by combining two or more ingredients and involves the weighing of a least one solid ingredient which shall be a compensable item or a legend drug in a therapeutic amount. (d) For medical assistance recipients with a pharmacy benefit resource which is a primary third party payer to medical assistance, the Department will pay a $0.50 prescription dispensing fee.

LIMITATIONS- PHYSICIANS, DENTISTS, AND PODIATRISTS

1. The maximum allowable payment to a physician, dentists or podiatrists per hospitalization per recipient is $1,250.00 unless a procedure provided during the hospitalization has a fee which exceeds $1,250.00, in which case that fee is the maximum reimbursement for the period of hospitalization.

2. The maximum allowable payment to a physician, dentist, or podiatrist for outpatient services per recipient per day is $500.00 unless the outpatient procedure has a fee which exceeds $500.00, in which case that fee is the maximum reimbursement on a daily basis, for that day only.

3. Payment will not be made for services provided to more than two (2) persons during a visit to a recipient's home no matter how many others are seen.

4. Payment for two or more surgical, obstetrical or anesthesia services performed by the same physician, dentist or podiatrist is limited to 100% of the allowable fee for the highest paying procedures and 25% of the second highest paying procedure. No payment is made for any additional procedures.

5. Payment for surgical, obstetrical and anesthesia services includes the inpatient preoperative and antepartum care as well as all postoperative and postpartum care in the hospital and outpatient visits during the number of postoperative or postpartum days specified for each procedure in the Medical Assistance Program Fee Schedule. Additional payment will be made for visits for treatment of medical or surgical conditions if the diagnosis is different and unrelated to the surgery.

6. Payment is limited to one (1) visit (e.g. office, home, hospital emergency room, clinic, inpatient care, nursing facility or Early Periodic Screening, Diagnosis, and Treatment (EPSDT) per recipient per day per individual provider.

7. Payment is made to only one podiatrist for a particular service or procedure and all services must be billed in the name of the podiatrist providing the service.

8. Payment for an office visit includes payment for any injection of medication or local anesthesia.

9. Payment for inpatient consultation procedure codes 99251 through 99255, or their successor procedure codes, is limited to 2 units per period of hospitalization. One inpatient consultation equals one unit of service.