Table of Contents

State/Territory Name: PENNSYLVANIA

State Plan Amendment (SPA) #: PA-13-038

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 # 121820134060

JUN 10 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-13-038. We are pleased to inform you that SPA PA-13-038 has been approved. The effective date of SPA PA-13-038 is July 1, 2013.

SPA PA-13-038 proposes to continue paying emergency department and outpatient access payments previously authorized to implement the State's Hospital Assessment Program (Program). SPA PA-13-038 proposed to reauthorize the Program for an additional three years, subject to approval of CMS.

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: 13-038

2. STATE: Pennsylvania

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

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

4. PROPOSED EFFECTIVE DATE
July 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 447 Subpart F

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $0.00
b. FFY 2014 ~~$92,757,478~~ 160,904,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B, Page 4a, Page 4aa (new)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B, Page 4a

10. SUBJECT OF AMENDMENT:
Philadelphia Hospital Tax Assessment FY 2013 and Forward

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:
/s/

13. TYPED NAME:
Beverly D. Mackereth

14. TITLE:
Secretary of Public Welfare

15. DATE SUBMITTED: SEP 27 2013

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 30 2013

18. DATE APPROVED: JUN 10 2014

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: FRANCIS McCULLOUGH

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR

23. REMARKS:

FORM HCFA-179 (07-92)

EMERGENCY DEPARTMENT AND OUTPATIENT ACCESS PAYMENTS

The Department will make additional outpatient payments to hospitals that meet all of the following criteria:

(a) is an acute care general hospital that operates an emergency department.
(b) is located in Philadelphia.
(c) Provides at least 1,000 emergency department services to Pennsylvania (PA) Medical Assistance (MA) patients per year.
(d) is not eligible for a disproportionate share payment for enhanced access to multiple types of medical care in economically distressed areas of PA as specified on page 21a of Attachment 4.19A of the current state plan.
(e) Does not furnish acute care inpatient services to patients who are predominantly under the age of 18.

Payments will be made on a quarterly basis. The total payment amount that each qualified hospital receives in a fiscal year will be determined as follows utilizing hospital data from State fiscal year 2009-2010 unless otherwise specified:

(a) The Department will authorize payment to a qualified hospital in the lowest of the following amounts:

    (1) The ratio of the hospital's PA MA fee-for-service outpatient revenue to the total PA MA fee-for-service outpatient revenue for all qualified hospitals multiplied by the amount of funds allocated by the Department for emergency department and outpatient access payments.
    (2) The amount permitted under the hospital's OBRA 93 hospital specific limit.
    (3) 2.91% of the hospital's net patient revenue.

(b) If, after calculating the payments in (a), funds remain from the total funds allocated in the fiscal year for these payments, and subject to (c), the Department will increase the payment amount of a qualified hospital for which payment was authorized under (a)(1) by an amount equal to the ratio of the hospital's PA MA fee-for-service outpatient revenue to the total PA MA fee-for-service outpatient revenue of all qualified hospitals for which payment was authorized under (a)(1) multiplied by the funds remaining from the total funds allocated in the fiscal year for emergency department and outpatient access payments.

(c) The total payments made to a qualified hospital pursuant to (a) and (b) shall not exceed the lower of:

    (1) The payment amount permitted by the hospital's OBRA 93 hospital specific limit.
    (2) 2.91% of the hospital's net patient revenue.

The Department will allocate an annualized total amount of $160.904 million for these supplemental payments. The Department will allocate for FY 2013/2014 the total amount of $160.904 million for these supplemental payments. The Medicaid base and supplemental outpatient hospital payments in total may not exceed the UPL defined on page 4aa.

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

DESCRIPTION OF THE OUTPATIENT UPPER PAYMENT LIMIT CALCULATION

1. A Medicare payment to charge ratio is calculated for each hospital using the hospitals' most recently available Medicare cost reports at the time of the calculation. The following fields are used in establishing the Medicare payment to charge ratio.

Charges Used: For the payment to charge ratios, the following program charges are used:
Worksheet D Part V, Col 2, Row 200 - PPS Reimbursed Services
Worksheet D, Part V, Col 3, Row 200 - Cost Reimbursed Services Subject to Ded. & Coins.
Worksheet D, Part V, Col 4, Row 200 - Cost Reimbursed Services Not Subject to Ded. & Coins.

Payments Used: For the payment to charge ratios, the following payments are used:
Worksheet E, Part B, Line 40 - Subtotal of Payments
Worksheet E, Part B, Line 25 - Deductibles and coinsurance
Worksheet E, Part B, Line 26 - Deductibles and coinsurance related to amount on line 24

2. The Medicare payment to charge ratio for each hospital as established in step 1 is multiplied by the hospital's total outpatient charges for Medicaid hospital outpatient non-crossover paid claims from the Department's MMIS claims data for the same fiscal year as the Medicare cost report data year for services provided to Medicaid eligible individuals for that fiscal year. This calculation results in Medicare equivalent payments for the non-crossover Medicaid claims. For hospitals with no Medicare cost report data, the state wide average Medicare payment to charge ratio is used to establish the hospital's Medicare equivalent payment.

Medicaid Charges Used:

3. Medicaid FFS charges are derived from the State MMIS for paid claims from the dates of service described in section 2 above.

Medicaid Revenue Used:

4. Medicaid FFS payments are derived from the State MMIS for paid claims from the dates of service described in section 2 above.

   The payments include all FFS base and supplemental payments paid to Medicaid participating hospitals.

5. The initial UPL room is determined by subtracting the Medicaid FFS payments as determined in section 4 from the Medicare equivalent payment as determined in section 2. This UPL room is inflated to the demonstration year using the enrollment and eligibility growth data for the Medicaid program.

6. The overall remaining UPL room is determined by subtracting hospitals' outpatient supplemental payments to be paid to the hospitals for the fiscal year from the calculated UPL room in 5 to determine the remaining UPL for the fiscal year.