Table of Contents

State/Territory Name: Pennsylvania

State Plan Amendment (SPA) #: PA-15-0011

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: 051320154013

NOV 13 2015

Theodore Dallas, Secretary
Department of Human Services
Room 333 Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Secretary Dallas:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Pennsylvania's State Plan Amendment (SPA) PA-15-0011, "Alignment of Categorically Needy and Medically Needy Benefits." This SPA was approved on November 13, 2015 with an effective date of January 1, 2015.

PA-15-0011amends existing Attachments 3.1A and 3.1B of the Pennsylvania Medicaid State Plan. PA-15-0011aligns the Medicaid services covered for the State's Categorically Needy and Medically Needy populations effective January 1, 2015.

However, during the SPA review process, CMS performed an analysis of the reimbursement page and related coverage pages, and as a result, our analysis revealed compliance issues that will need to be addressed through a corrective action plan. Under separate cover, CMS will release a companion letter detailing those issues, and providing guidance on time frames for correction.

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 215-861-4481.

Sincerely,

/s/

Francis McCullough
Associate Regional Administrator

Enclosures

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

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

SWIFT: 051320154013

NOV 13 2015

Theodore Dallas, Secretary
Department of Human Services
Room 333 Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Acting Secretary Dallas:

This letter is being sent as a companion to our approval of PA's State Plan Amendment (SPA) 15-0011, "Alignment of Categorically Needy and Medically Needs Benefits." While we are proceeding with approval of SPA PA-15-0011, 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 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, please contact Mary McKeon at 215-861-4181.

Sincerely,

/s/

Francis McCullough
Associate Regional Administrator

Cc: De Earhart, CMS

Exhibit 1 – PA 15-0011 Companion Reimbursement Letter Review

1. OP Psych or Partial Hospitalization is listed on Attachment 3.1A/3.1B page 1c, Section 2.a.(2) of the SPA. CMS was unable to find the reimbursement (Attachment 4.19-B) section related to these services. Attachment 4.19-B, page 11 discusses Mental Health Rehabilitation Services. Does this section tie to the OP Psych or partial hospitalization services? If not, where is the reimbursement section related to these services?

2. Ambulatory Services offered by a Health Center are listed on pages I and I, of the SPA under Section 2d. Are ambulatory services in a "health center" different than provided and reimbursed per the Ambulatory Surgical Centers listed in Attachment 4.19-B, p5a? ASC payment pages have not been updated since 1991. Please confirm that the description outlined on page 5a is still current or does PA now use APG as the payment unit? This section needs to be updated to reflect current regulations as outlined per 42 CFR Section 416.2.

3. See Family Planning Services per page i and 2 of the SPA under sections 4 and 4c. Where are family planning reimbursement provisions outlined in the State Plan? Family planning is discussed in Attachment 3.1A/3.1B, page 2. This is tied to SPA 13-027 which included a change to 4.19-B, page 1. Is Family Planning included under physician fees?

4. See Tobacco Cessation Counseling per pages i, section 4d. Where are Tobacco Cessation Counseling reimbursement provisions outlined per the Attachment 4.19-B?

5. Are renal dialysis services paid through the drug/pharmacy section of Attachment 4.19-B.

6. Are dentures and glasses as outlined in the SPA page ii paid under the drug or DME provisions of Attachment 4.19-B?

7. Rehab services are included in the SPA on pages ii and 6a-6h. Are PT, OT and speech therapy included anywhere in Attachment 4.19-B? CMS was unable to find a reimbursement method identified and these services are allowed for the population under 21. Mental Health Rehab is discussed in Attachment 4.19-B, pages 4 and 11.

8. Hospice Services are identified in the State Plan on page ii and 7c. Please update the reimbursement section 4.19-B, page 5 to reflect the new payment structure per the new rules (42 CFR Part 418) - the RHC rates and the Service Intensity Add-on (SIA) payment policies.

9. Please see 4.19-B, page 11 related to Mental Health Rehabilitation Services and is included in PA 15-0011 on pages 6a through 6g. This page was last updated by SPA 5-029 on 2/22/2007, and needs to include effective date language.

10. TCM for Mental Illness is included in the SPA in page 6a-6g, 10a and ii. Reimbursement for this service is included in the State Plan in Attachment 4.19-B, page 9. This section needs to be updated for effective date language, reference to the services and providers that can provide service.

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: 15-0011

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
January 1, 2015

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:
Section 1905 of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $0
b. FFY 2016 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1A, Pages i – 1j Attachment 3.1A/3.1B, Pages i – 12;
Attachment 3.1A, Pages 2 – 4ff
Attachment 3.1A, Pages 4i - 5 Attachment 3.1A/3.1B,
Attachment 3.1A, Pages 5f – 9 Supplement 2;
Attachment 3.1A, Pages 9aaaaa – 11b
Attachment 3.1A, Supplement 2 Attachment 3.1B, Pages
Attachment 3.1B, Pages 1 – 9c 1-9c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1A, Pages 1 – 1d, 1e – 1j Attachment 3.1A, Pages i-11b;
Attachment 3.1A, Pages 2 – 3c, 4 – 4ff
Attachment 3.1A, Pages 4i, 5 Attachment 3.1A/3.1B;
Attachment 3.1A, Pages 5f – 5h, 6 – 7b, 8 – 8aa, 9 Supplement 2;
Attachment 3.1A, Pages 9aaaaa, 9b, 10 – 10b, 11b
Attachment 3.1A, Supplement 2
Attachment 3.1B, Pages 1 – 9c Attachment 3.1B, Pages 1-9c

10. SUBJECT OF AMENDMENT:
Alignment of Categorically Needy and Medically Needy benefits

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 Human Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME:
Theodore Dallas

14. TITLE:
Acting Secretary of Human Services

15. DATE SUBMITTED:
FEB 20 2015

16. RETURN TO:
Commonwealth of Pennsylvania
Department of Human Services
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:

18. DATE APPROVED
November 13, 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL.
January 1, 2015

20. SIGNATURE OF REGIONAL OFFICIAL
/s/

21. TYPED NAME: Francis McCullough

22. TITLE: Associate Regional Administrator

23. REMARKS:
Pen and ink changes to this CMS-179 authorized by The Pennsylvania Department of Human Services. Mary McKeon CMS Pennsylvania State Lead

FORM HCFA-179 (07-92)

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

1. Inpatient Hospital services other than those provided on an institution for mental diseases.
2a. Outpatient Hospital services
2b. Rural Health Clinic (RHC) services and other ambulatory services furnished by a RHC.
2c. Federally Qualified Health Center (FQHC) and other ambulatory services furnished by a FQHC
2d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.
3. Other Laboratory and X-ray services.
4. Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease), EPSDT, and family planning services and supplies.
4a. Nursing Facility services
4b. EPSDT services for individuals under age 21
4c. Family Planning services and supplies
4d. Tobacco Cessation Counseling Services for Pregnant Women
5. Physicians' services – Office, Home, Hospital, Skilled Nursing Facility or elsewhere
5a. Physician's services
5b. Medical and surgical services furnished by a dentist
6. Medical and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law
6a. Podiatrists' services
6b. Optometrists' services
6c. Chiropractors' services
6d. Other Practitioners' Services
7. Home Health services
7a. Intermittent or part-time nursing service provided by a licensed home health agency or by a registered nurse when no home health agency exists
7b. Home health aide services provided by a licensed home health agency
7c. Medical supplies, equipment and appliances suitable for use in the home
7d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a licensed home health agency
8. Private Duty Nursing services
9. Clinic services
9a. Independent Medical Clinic Services
9b. Psychiatric Clinic Services
9c. Drug and Alcohol and Methadone Maintenance Clinic Services
9d. Renal Dialysis Services
9e. Ambulatory Surgical Center (ASC) Services
10. Dental services
11. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
11a. Physical Therapy
11b. Occupational Therapy
11c. Services for individuals with speech, hearing, and language disorders.

12. Prescribed drugs, dentures, prosthetic devices, and eyeglasses
12a. Prescribed drugs
12b. Dentures
12c. Prosthetic devices
12d. Eyeglasses
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan
13a. Diagnostic services
13b. Screening services
13c. Preventive services
13d. Rehabilitative services
14. Inpatient hospital services, Nursing facility services, and Intermediate Care Facility (ICF) services for individuals age 65 or older in institutions for mental diseases.
14a. Nursing facility services for individuals age 65 or older in Institutions for Mental Disease
15a. Intermediate care facility services for individuals with intellectual disability (ICF/IID) and for other related conditions (ORC) (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.
15b. Including such services in a public institution (or distinct part thereof) for individuals with intellectual disability or persons with related conditions.
16. Inpatient psychiatric services for individuals under age 21
17. Nurse-midwife services
18. Hospice services
19. Case management services and Tuberculosis related services
20. Extended services for pregnant women
21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider
22. Respiratory care services
23. Nurse Practitioner services
24. Any other medical care or remedial care recognized under State law, specified by the Secretary
24a. Transportation
24b. Services provided in religious nonmedical health care institutions.
24c. Nursing facility services for beneficiaries under age 21
24d. Emergency hospital services
24e. Personal care services in a beneficiary's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse
25. Case management services
26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1A
27a. Licensed or Otherwise State-Approved Freestanding Birth Center Services
27b. Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

1. Limitations do not apply to those beneficiaries who are pregnant

2. The following medical services are not covered through the Medical Assistance Program:

   a. Any medical services, procedures, or pharmaceuticals related to treating infertility.
   b. Surgical, medical, diagnostic or therapeutic procedures performed solely for experimental, research, or educational purposes.
   c. Surgical procedures and medical care provided in connection with sex reassignment. This includes, but is not limited to, hormone therapy and release of vaginal adhesions.
   d. Acupuncture.
   e. Gastroplasty for morbid obesity, gastric stapling, or ileo-jejunal shunt- except when all other types of treatment of morbid obesity have failed.
   f. Cosmetic surgery- unless performed to improve the functioning of a malformed body member, to correct a visible disfigurement which would affect the ability of the person to obtain or hold employment, or as post mastectomy breast reconstruction.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

1. Inpatient hospital services other than those provided on an institution for mental diseases.

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

2a. Outpatient hospital services.

☒ Provided: ☐No limitations ☒ With limitations
☐ Not provided

2b. Rural Health Clinic (RHC) services and other ambulatory services furnished by a RHC.

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

2c. Federally Qualified Health Center (FQHC) and other ambulatory services furnished by a FQHC.

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

2d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

3. Other Laboratory and X-ray services.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

4a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

4b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

SERVICES

1. Inpatient Hospital Services (42 CFR 440.10)

Limitations

(a) Coverage for beneficiaries 21 years of age and older for inpatient hospitalization in a psychiatric unit is limited to thirty (30) days per calendar year (CY), during which the beneficiary with a psychiatric diagnosis is a beneficiary in an approved unit. An exception will be made to this requirement in an emergency situation, in which case coverage will be for a maximum of two (2) days of inpatient psychiatric care in an area other than the psychiatric unit.

(b) Coverage for beneficiaries 21 years of age and older for inpatient rehab hospital admissions is limited to one (1) per CY.

(c) Each beneficiary is limited to two (2) periods of therapeutic leave per calendar month. Neither of these periods of therapeutic leave may exceed twelve (12) hours in a calendar day.

Exception: Beneficiaries receiving care in an acute care general hospital's extended acute care psychiatric unit approved by the Department are limited to seven (7), twelve (12) hour periods of therapeutic leave per month which may be used consecutively.

(d) The Department determines beneficiary eligibility for compensable transplant procedures in accordance with written standards, which are applied uniformly to similarly situated beneficiaries.

General Considerations for Organ Transplantation

1. Services are available to beneficiaries under the age of 21 as required by the Omnibus Budget Reconciliation Act of 1989 (OBRA-89).
2. Organ transplantation will be covered if the Department agrees the procedure is medically necessary and no alternative medical treatment is available.
3. The organ transplantation must be utilized for the management of end stage disease as a recognized standard of treatment in the medical community AND must not be of an investigational or experimental nature.
4. All organ transplants must be prior authorized before evaluation occurs OR if the beneficiary is new to MA and already on the United Network for Organ Sharing (UNOS) transplantation list.
5. All organ transplants must be done in facilities that are a CMS Medicare approved program for the particular organ. If a combination transplant is performed, that facility must be Medicare-approved for all types of organs being transplanted (42 CFR 482.1 – 482.57).

SERVICES

1. Inpatient Hospital Services (42 CFR 440.10) (continued)

Limitations - continued

(d) continued

General medical indications for specific organ transplants are as follows:

Kidney - Kidney transplantation is determined to be medically necessary when there is medical documentation of chronic end stage renal disease and no absolute contraindication to kidney transplantation.

Heart - Based on the medical necessity guidelines from the American College of Cardiology/American Heart Association (ACC/AHA).

Heart/Lung - Based on the joint medical necessity guidelines from the American Thoracic Society, American Society for Transplant Physicians and the International Society for Heart and Lung Transplantation (ISHLT).

Lung - Based on the medical necessity guidelines from the International Society for Heart and Lung Transplantation (ISHLT).

Liver - Based on the medical necessity guidelines from the Clinical Practice Committee of the American Society of Transplantation and the United Network for Organ Sharing (UNOS).

Pancreas - Based on the medical necessity guidelines from the American Diabetes Association and the American Society for Transplant Physicians.

Pancreas/Kidney - Pancreatic/kidney transplantation is primarily performed on diabetics with end stage renal disease. Based on the medical necessity guidelines from the American Diabetes Association and the American Society of Transplantation.

Intestinal - Based on the medical necessity guidelines from The American Society of Transplantation, the American Gastroenterological Association and the Centers for Medicare and Medicaid Services.

Corneal - Corneal transplantation of autologous or donor limbal stem cells is determined to be medically necessary when there is documentation in the medical record of limbal stem cell deficiency which is refractory to conventional treatments.

Hematopoietic Stem Cell Transplantation from Bone Marrow or Peripheral Stem Cells -

Hematopoietic stem cell transplantation (HSCT) is defined as the administration of hematopoietic stem cells from sources such as bone marrow, peripheral blood, or umbilical cord blood. Autologous HSCT (auto-HSCT) uses hematopoietic progenitor cells derived from the individual with the disorder while allogeneic HSCT (allo-HSCT) uses hematopoietic stem cells from someone other than the individual receiving the transplant. Based on the medical necessity guidelines from The American Society for Blood and Marrow Transplantation, certain conditions can be treated with either autologous HSCT or allogeneic HSCT. For specific conditions medically necessary treatment may be with only autologous HSCT or only allogeneic HSCT.

SERVICES

2.a. (1) Outpatient Hospital Services (42 CFR 440.20(a)(3))

(2) Psychiatric Partial Hospitalization (42 CFR 440.20(a)(3))

Psychiatric Partial Hospitalization is an active outpatient psychiatric day or evening treatment session. The services are provided by an approved Psychiatric Partial Hospitalization provider. The following is a description of the service components and professional qualifications. These service components are provided to the individual, if necessary, in accordance with their individualized care plan:

- **Individual, Group, and Family psychotherapy**

  - Individual Therapy: Psychotherapy provided to one person with a diagnosed mental disorder
  - Group Therapy: Psychotherapy provided to no less than two and no more than ten persons with diagnosed mental disorders
  - Family Therapy: Psychotherapy provided to two or more members of a family. At least one family member shall have a diagnosed mental disorder

  Psychotherapy can be provided by any of the following professionals:

  a) Psychiatrist: A physician who has completed a 3 year residency in psychiatry and is licensed to practice in the state

  b) Psychologist: A person licensed to practice psychology in the state

  c) Outpatient Mental Health Professional: A person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology, nursing or rehabilitation or activity therapies; who has a graduate degree and one year of mental health clinical experience.

- **Health Education:** Include basic physical and mental health information; nutrition information and assistance in purchasing and preparing food, personal hygiene instruction, basic health care information, child care information and family planning information and referral and information on prescribed medications. Health Education can be provided by any of the following professionals:

  a) Psychiatrist

  b) Psychologist

  c) Outpatient Mental Health Professional

  d) Mental Health Worker: A person who does not have a graduate degree in a clinical discipline but who by training and experience has achieved recognition as a mental health worker, or a person with a graduate degree in a clinical discipline

  e) Registered Nurse: An individual licensed by the State Board of Nursing to practice professional nursing

  f) Licensed Practical Nurse: A person who is a graduate of a school approved by the State Board of Nursing.

SERVICES

2.a. (2) Psychiatric Partial Hospitalization (42 CFR 440.20(a)(3)) (continued)

- **Instruction in basic care of the home or residence for daily living**: This includes guidance that helps the individual to care for their home and perform regular household chores to maintain a healthy and safe living environment. This can be provided by any of the following professionals - Psychiatrist, Psychologist, Outpatient Mental Health Professional, Mental Health Worker, Registered Nurse, or Licensed Practical Nurse.

- **Instruction in basic personal financial management for daily living:** This includes basic instruction on budgeting, money management and related areas to help the individual have the financial stability to achieve the goals identified in the care plan. This can be provided by any of the following professionals - Psychiatrist, Psychologist, Outpatient Mental Health Professional, Mental Health Worker, Registered Nurse, or Licensed Practical Nurse

- **Medication Management:** This involves administration of a drug and evaluation of the individual's physical and mental condition during the course of prescribed medication. This can be provided by any of the following professionals - Psychiatrist, Physician, Registered Nurse, or Licensed Practical Nurse.

- **Guidance on Social Skills**: This includes providing guidance to communicate and interact with other members of the society without undue conflict or disharmony. This can be provided by any of the following professionals - Psychiatrist, Psychologist, Outpatient Mental Health Professional, Mental Health Worker, Registered Nurse, or Licensed Practical Nurse.

- **Crisis Management:** This includes counseling and intervention to assist individuals in the management of the crises that they are experiencing due to psychiatric events or psychological issues. This can be provided by any of the following professionals - Psychiatrist, Psychologist, Outpatient Mental Health Professional, Mental Health Worker, Registered Nurse, or Licensed Practical Nurse.

- **Referral:** This includes activities that assist in linking the individual with medical, social and educational providers, or other programs and services that are capable of providing the needed services identified in the care plan. This can be provided by any of the following professionals - Psychiatrist, Psychologist, Outpatient Mental Health Professional, Mental Health Worker, Registered Nurse, or Licensed Practical Nurse.

Limitations

1. For beneficiaries 21 years of age and older, treatment sessions may not be less than three (3) hours and no more than six (6) hours per twenty-four (24) hour period. Services are limited to one hundred eighty (180) three (3) hour sessions (540 total hours) per CY per beneficiary.

2. Coverage for medically necessary clozapine support services are limited to one per week, regardless of the frequency or intensity of monitoring activities provided during each calendar week. If a beneficiary is discontinued from clozapine therapy, the beneficiary remains eligible for clozapine support services on an outpatient Basis for not less than four weeks or more than eight weeks after the drug therapy is stopped.

SERVICES

2a. (3) Short Procedure Unit (SPU) Services (42 CFR 416.2)

Prior authorization is required for an admission for same day surgical services.

SERVICES

RESERVED

SERVICES

RESERVED

SERVICES

RESERVED

SERVICES

RESERVED

SERVICES

2.b. Rural Health Clinic Services (42 CFR 440.20(b))

Rural Health Clinic (RHC) services are defined in section 1905(a)(2)(B) of the Social Security Act. RHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, and visiting nursing and other ambulatory services included in the state plan. RHC services also include services and supplies that are furnished as incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife and, for visiting nurse care, related medical supplies other than drugs and biologicals.

Limitations

Limitations on other ambulatory services furnished in the RHC are the same as defined for those services in the state plan.

SERVICES

RESERVED

SERVICES

2c. Federally Qualified Health Center (FQHC) Services (42 CFR 405.2401(b))

Federally Qualified Health Centers (FQHC) services are defined in section 1905(a)(2)(B) of the Social Security Act. FQHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and visiting nursing and other ambulatory services included in the state plan. FQHC services also include services and supplied that are furnished as incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife and, for visiting nurse care, related medical supplies other than drugs and biologicals.

Limitations

Limitations on other ambulatory services furnished in the FQHC are the same as defined for those services in the state plan.

SERVICES

3. Other Laboratory and X-Ray Services (42 CFR 440.30)

Provider Qualifications

1. The provider must have a current appropriate level of Clinical Laboratory Improvement Amendments (CLIA) certification for the laboratory tests performed at the physical address where the laboratory service is provided.

   Exemption: Not-for-profit or Federal, State or local government laboratories that engage in limited (not more than a combination of fifteen (15) moderately complex or waived tests per certificate) public health testing may have a single CLIA certification for multiple physical addresses where the laboratory service is provided.

SERVICES

4b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

All individuals under the age of 21 will receive all medically necessary services coverable under 1905(a), regardless of whether the service is otherwise covered under the state plan.

SERVICES

RESERVED

SERVICES

4.b.1 Services provided by School-Based Service Providers

Services are only provided to beneficiaries under 21 years of age.

Services provided by school-based service providers, known as the School-Based ACCESS Program (SBAP) in Pennsylvania, are provided or purchased by Local Education Agencies (LEAs) that are government units enrolled in the Medical Assistance (MA) Program to MA-eligible beneficiaries for whom the service is medically necessary and documented in the Individualized Education Program (IEP). LEAs that are government units include school districts, charter schools, intermediate units, vocational-technical schools and preschool early intervention programs. LEAs are enrolled in the MA Program as the qualified providers of service. Direct services must be delivered by qualified provider types, as identified below.

School-Based Rendering Providers Qualifications and Service Definitions

Assistive Technology Devices (42 CFR 440.70(b)(3))

Definition:

An assistive technology device (ATD) is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability and prescribed by a physician.

Qualified Provider Types:

ATDs are obtained by the LEA from a licensed medical supplier.

Nursing Services (42 CFR 440.60(a))

Definition:

Nursing services are professional services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and relevant to the medical needs of the beneficiary provided through direct interventions that are within the scope of the professional practice of a Registered Nurse (RN) or Licensed Practical Nurse (LPN) during a face-to-face encounter and on a one-to-one basis.

Limitation:

Nursing services provided must be documented in a service log.

Qualified Provider Types:

Nursing services are provided by a currently licensed RN, currently licensed LPN, or currently licensed Certified Registered Nurse Practitioner (CRNP).

SERVICES

Nurse Practitioner Services (42 CFR 440.166 and 440.60)

Definition:

Nurse practitioner services are services provided within their scope of practice.

Qualified Provider Types:

Nurse practitioner services are provided by a currently licensed CRNP.

Occupational Therapy Services (42 CFR 440.110(b))

Definition:

Occupational therapy services are services, including necessary supplies and equipment as well as direct assistance with the selection, acquisition, training, or use of an ATD, prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided in an individual or group setting by or under the supervision of a currently licensed occupational therapist within the scope of his or her professional practice.

Limitation:

Occupational therapy services provided must be documented in a service log.

Qualified Provider Types:

Occupational therapy services are provided by or under the supervision of a currently licensed occupational therapist.

The standards for supervision by a licensed occupational therapist are set forth in state law, currently codified at 49 Pa.Code § 42.22 (relating to supervision of occupational therapy assistants). Supervision is conducted and documented by the licensed occupational therapist.

Orientation, Mobility and Vision Services (42 CFR 440.130(d))

Definition:

Orientation, mobility and vision services are services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under law and provided by an Orientation and Mobility Specialist in an individual or group setting.

Limitation:

Orientation, mobility and vision services provided must be documented in a service log.

SERVICES

Qualified Provider Types:

Orientation, mobility and vision services are provided by an Orientation and Mobility Specialist certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) who possesses a Pennsylvania Department of Education teaching certification for the visually impaired.

Personal Care Services (42 CFR 440.167)

Definition:

Personal care services are prescribed by a physician in accordance with a plan of treatment or otherwise authorized for the individual in accordance with a service plan approved by the State and provided on a one-to-one basis to treat physical or mental impairments or conditions in accordance with the IEP.

Limitations:

Personal care services provided must be documented in a service log.

Qualified Provider Types:

Personal care services are provided by an individual who is not a legally responsible relative and who is 18 years of age or older and possesses a high school diploma or general equivalency diploma, a current certification in first aid, and a current certification in cardiopulmonary resuscitation (CPR).

Physical Therapy Services (42 CFR 440.110(a))

Definition:

Physical therapy services are services, including necessary supplies and equipment as well as direct assistance with the selection, acquisition, training, or use of an ATD, prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided in an individual or group setting by or under the supervision of a currently licensed physical therapist within the scope of his or her professional practice.

Limitation:

Physical therapy services provided must be documented in a daily service log.

Qualified Provider Types:

Physical therapy services are provided by or under the supervision of a currently licensed physical therapist.

The standards for supervision by a licensed physical therapy are set forth in state law, currently codified at 49 Pa.Code § 40.173 (Supervision of occupational therapy assistants). Supervision is conducted and documented by the licensed physical therapist.

SERVICES

Physician Services (42 CFR 440.50(a))

Definition:

Physician services are services provided within their scope of practice.

Qualified Provider Types:

Physician services are provided by a currently licensed doctor of medicine or currently licensed doctor of osteopathy.

Psychological, Counseling and Social Work Services (42 CFR 440.130(d))

Definition:

Psychological, Counseling and Social Work Services are services prescribed by a physician or other licensed practitioner of the healing arts within their scope of practice under State law and include assessment and evaluation, treatment planning, and individual and group therapy provided by a psychologist, counselor, therapist or social worker within the scope of their professional practice.

Assessment

Assessment consists of the diagnosis and evaluation, medical, social and developmental history of the child.

Planning

Planning is the development of treatment plans based on the assessment, which establish specific, attainable goals and which designate responsibility for activities proposed to achieve these goals. Planning also includes periodic evaluations of progress, reviews of activities, evaluating and updating the treatment plan and its goals.

Treatment

Treatment includes a multi-systemic approach to addressing the child's mental health needs. Such approaches include counseling and therapies.

Qualified Provider Types:

Assessment, planning and treatment are provided by:

- A currently licensed psychologist;
- A psychologist who is currently certified by the Pennsylvania Department of Education to practice school psychology;
- A currently licensed professional counselor;
- A currently licensed Marriage and Family Therapist; or
- A currently licensed social worker.

Limitation: Psychological, counseling and social work services provided must be documented in a service log.

SERVICES

Special Transportation Services (42 CFR 440.170(a))

Definition:

Special transportation services are services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and include:

1. Travel to and from school and between schools or school buildings on a day when a Medicaid service is on the IEP to be rendered on school premises and special transportation is included on the IEP as a separate service;
2. Travel and from off-site premises on a day when a Medicaid service is on the IEP to be rendered off-site and special transportation is included on the IEP as a separate service; and
3. Use of specialty adapted vehicle (such as a specially adapted bus or van).

Qualified Provider Types:

Special transportation services are provided by a school or other entity under contract with the LEA to provide the services.

Special transportation services must be provided in accordance with the Public School Code of 1949 (24 P.S. §§ 1-101—27-2702), the Vehicle code (75 Pa.C.S. §§ 101-9701), regulations at 22 Pa.Code Chapter 23 (relating to pupil transportation) and 67 Pa.Code Chapters 71 and 171 (relating to school bus drivers and school buses and school vehicles).

Limitations:

- Special transportation services must be provided on the same date of service that a Medicaid-covered service, required by the beneficiary's IEP, is received.
- Special transportation services must be provided on a specially adapted school vehicle or other vehicle to or from the location where the Medicaid service is received.
- Special transportation services must represent a one-way trip.
- Special transportation services provided must be documented in a transportation log.

Speech, Language and Hearing Services (42 CFR 440.110(c))

Definition:

Speech, language and hearing services are services, including necessary supplies and equipment as well as direct assistance with the selection, acquisition, training, or use of an ATD, prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided in an individual or group setting by or under the supervision of a speech pathologist, audiologist or teacher of the hearing impaired within the scope of his or her professional practice.

SERVICES

Limitation:

Speech, language and hearing services provided must be documented in a service log.

Qualified Provider Types:

Speech, language and hearing services are provided by:

- A speech pathologist who:
  - Has a Certificate of Clinical Competence (CCC) from the American Speech-Language-Hearing Association (ASHA); or
  - Has completed the equivalent educational requirements and work experience necessary for the CCC; or
  - Has completed the academic program and is acquiring supervised work experience to qualify for the CCC; or
  - Is currently licensed as a speech-language pathologist; or
- A currently licensed audiologist; or
- A teacher of the hearing-impaired who:
  - Has a current professional certificate issued by the Council on Education of the Deaf; or
  - Is currently licensed as a teacher of the hearing-impaired; or
  - Has a Master's degree, from an accredited college or university, with a major in teaching of the hearing impaired or in a related field with comparable course work and training.

Freedom of choice (42 CFR 431.51)

Consistent with section 1902(a)(23) of the Social Security Act, the Department assures that the provision of Medicaid services provided by school-based service providers will not restrict an individual's free choice of qualified providers for Medicaid services.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

4c. Family planning services and supplies for beneficiaries of child-bearing age.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

4d. Face-to-face tobacco cessation counseling services for pregnant women.

☒ Provided: ☒ No limitations ☐ With limitations+
☐ Not provided

+Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below.

5a. Physicians' services whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility or elsewhere.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

5b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a) (5) (B) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

SERVICES

4d. Tobacco Cessation Counseling Services for Pregnant Women

Face-to-Face Counseling Services provided:

1. By or under supervision of a physician;

2. By any other health care professional who is legally authorized to furnish such services under state law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or

3. Any other health care professional legally authorized to provide tobacco cessation services under state law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time.)

SERVICES

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

6a. Podiatrists' services

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

6b. Optometrists' Services.

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

6c. Chiropractors' Services.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

6d. Other Practitioners' Services.

☒ Provided: ☒ No limitations ☐ With limitations
☐Not provided

7. Home Health Services

7a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☐ No limitations ☒ With limitations

7b. Home health aide services provided by a home health agency.

☒ Provided: ☐ No limitations ☒ With limitations

7c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations

7d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency.

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

8. Private duty nursing services.

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

*Service is only provided to beneficiaries under 21 years of age.

SERVICES

6. Medical Care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law.

6.b. Optometrists' Services (42 CFR 440.60)

1. Beneficiaries 21 years of age and older are limited to two (2) visits/encounters per CY.

SERVICES

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SERVICES

6. Medical Care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law.

6.d. Other practitioners' services

Certified Registered Nurse Practitioner (CRNP) services (42 CFR 440.60)

CRNP services are those services provided by a CRNP, as licensed by the state who is certified by the State Board of Nursing and State Board of Medicine in a particular clinical specialty area who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in the state.

SERVICES

7. Home Health Services (42 CFR 440.70)

7a. Intermittent or part-time nursing service provided by a licensed home health agency or by a registered nurse when no home health agency exists (42 CFR 440.70(b)(1)).

Limitations

1. For beneficiaries 21 years of age or older, the first twenty-eight (28) days have no visit limit for home health nursing service visits combined with home health aide service visits and home health therapy service visits per beneficiary. After the first 28 days, beneficiaries 21 years of age or older are limited to fifteen (15) days of the above listed services per month.

2. The services are provided to a beneficiary on the orders of his or her physician as part of a written treatment plan of care that a physician reviews every sixty (60) days.

3. The services require prior authorization.

Provider Qualifications

Home health services are provided by home health agencies certified by Pennsylvania's Department of Health as meeting the requirements for participation in Medicare.

SERVICES

7. Home Health Services (42 CFR 440.70) (continued)

7b. Home health aide services provided by a licensed home health agency (42 CFR 440.70(b)(2)).

Limitations

1. For beneficiaries 21 years of age or older, the first twenty-eight (28) days have no visit limit for home health aide service visits combined with home health nursing service visits and home health therapy service visits per beneficiary. After the first 28 days, beneficiaries 21 years of age or older are limited to fifteen (15) days of the above listed services per month.

2. The services are provided to a beneficiary on the orders of his or her physician as part of a written treatment plan of care that a physician reviews every sixty (60) days.

3. The services require prior authorization.

Provider Qualifications

Home health services are provided by home health agencies certified by Pennsylvania's Department of Health as meeting the requirements for participation in Medicare.

SERVICES

7. Home Health Services (42 CFR 440.70) (continued)

7c. Medical supplies, equipment and appliances suitable for use in the home (42 CFR 440.70(b)(3)).

Limitations

1. Prior authorization is required for rental of all medical appliances or equipment for periods exceeding six (6) months. The Department also requires prior authorization for some rental of medical appliances or equipment for periods of less than six (6) months.

2. In the event that a beneficiary is in the immediate need of a service or an item requiring prior authorization, and the situation is an emergency, the prescriber may indicate that the prescription be filled by the provider before submitting the prior authorization form.

3. Prior authorization is required for the purchase of all appliances or equipment if the appliance or equipment costs more than six hundred ($600). The Department also requires prior authorization for the purchase of specific appliances or equipment that cost less than six hundred dollars ($600).

Limitations for oxygen and related equipment

1. Beneficiaries must have had a comprehensive cardiopulmonary evaluation that resulted in an established diagnosis of the cause of the respiratory disability.

2. Prior approval is required for initial prescriptions for oxygen and related equipment unless the physician has certified that the beneficiary is adequately prepared to use oxygen equipment and the physical surroundings in the home are suitable to its use. Prior authorization is not required after forty-five (45) days of continued use if prescribed by a physician.

3. The physician must recertify orders for oxygen at least every six (6) months.

SERVICES

7. Home Health Services (42 CFR 440.70) (continued)

7d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a licensed home health agency (42 CFR 440.70(b)(4)).

Limitations

1. For beneficiaries 21 years of age or older, the first twenty-eight (28) days have no visit limit for home health therapy service visits combined with home health aide service visits and home health nursing service visits per beneficiary. After the first 28 days, beneficiaries 21 years of age or older are limited to fifteen (15) days of the above listed services per month.

2. The services are provided to a beneficiary on the orders of his or her physician as part of a written treatment plan of care that a physician reviews every sixty (60) days.

3. The services require prior authorization.

Provider Qualifications

The service must be performed by a physical therapist, occupational therapist, speech pathologist or audiologist who are currently licensed to practice in the Commonwealth and comply with 42 CFR 440.110.

SERVICES

8. Private duty nursing services (42 CFR 440.80)

Service is not provided to beneficiaries 21 years of age or older.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALL NEEDY

9. Clinic services

9a. Independent Medical Clinic services

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

9b. Psychiatric Clinic Services

☒ Provided: ☐No limitations ☒ With limitations
☐ Not provided

9c. Drug and Alcohol and Methadone Maintenance Clinic Services

☒ Provided: ☐No limitations ☒ With limitations
☐ Not provided

9d. Renal Dialysis Services

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

9e. Ambulatory Surgical Center (ASC) services

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

10. Dental services

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

11. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

11a. Physical Therapy

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

11b. Occupational Therapy

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

11c. Services for individuals with speech, hearing, and language disorders

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

*Service is only provided to beneficiaries under 21 years of age

SERVICES

9. Clinic Services

9b. Psychiatric Clinic services (42 CFR 440.90)

Provider Qualifications

Psychiatric clinics must have a certificate of compliance from the Department, Office of Mental Health and Substance Abuse Services.

Limitations

1. Beneficiaries 21 years of age and older are limited to five (5) hours or ten (10) one-half hour sessions of psychotherapy per thirty (30) consecutive days.
2. Two (2) psychiatric evaluations per beneficiary per year.
3. One (1) comprehensive diagnostic psychological evaluation per beneficiary per year.
4. Psychiatric clinic clozapine monitoring and evaluation visits are limited to one (1) visit per week.
    a. Clozapine support services are limited to beneficiaries with a diagnosis of schizophrenia.
    b. Each order of clozapine support services may not exceed a six (6) calendar month period.
    c. Clozapine support services can be provided for not less than four (4) weeks or more than eight (8) weeks after the drug therapy has been discontinued.

9. Clinic Services (continued)

9c. Drug and Alcohol and Methadone Maintenance Clinic services (42 CFR 440.90)

Provider Qualifications

Drug and alcohol outpatient clinics must be fully or provisionally licensed by the Department of Drug and Alcohol Programs. A drug and alcohol clinic may provide methadone maintenance if approved to do so by the Department of Drug and Alcohol Programs.

Limitations

1. Three (3) chemotherapy/drug-free visits per thirty (30) days.
2. Forty-two (42) opiate detox visits per three hundred sixty-five (365) days.
3. Seven (7) methadone maintenance clinic visits per beneficiary per week, one (1) per day, for as long as required as determined by his physician and documented in the medical record.

SERVICES

9. Clinic Services (continued)

9d. Renal Dialysis services (42 CFR 405.2102)

Limitations

1. Initial training for home dialysis, provided in a renal dialysis clinic, is limited to twenty-four (24) sessions per beneficiary.

2. Dialysis procedures provided as back-up to home dialysis are limited to seventy-five (75) per calendar year.

SERVICES

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SERVICES

10. Dental Services (42 CFR 440.100)

The following applies to compensable services for beneficiaries under 21 years of age.

Prior authorization is required for orthodontia, complete and partial dentures, crowns, surgical extractions of impacted teeth, and periodontal services.

SERVICES

10. Dental Services (42 CFR 440.100) (continued)

Limitations – The following limits apply to compensable services for beneficiaries 21 years of age and older.

1. Oral examination is limited to one per 180 days per beneficiary.
2. Dental prophylaxis is limited to one per 180 days per beneficiary.
3. Panoramic-maxilla or mandible, single film is limited to one per five years.
4. Prior authorization is required for orthodontia, complete and partial dentures, crowns, surgical extractions of impacted teeth, and periodontal services.
5. A Benefit Limit Exception is required for oral examinations and prophylaxis more often than once per 180 days, for crowns and adjunctive crown services, and for periodontal and endodontic services.
6. A Benefit Limit Exception will be approved if one of the following criteria is met:
    a. The department determines the recipient has a serious chronic systemic illness or other serious health condition and the denial of the exception will jeopardize the life of the recipient;
    b. The department determines the recipient has a serious chronic systemic illness or other serious health condition and the denial of the exception will result in the rapid, serious deterioration of the health of the recipient;
    c. The department determines that granting a specific exception is a cost effective alternative for the Medical Assistance Program; or
    d. The department determines that granting an exception is necessary to comply with Federal law.

SERVICES

11. Physical Therapy and Related Services (42 CFR 440.110)

11a. Physical Therapy

Service is only provided to beneficiaries under 21 years of age.

Provider Qualifications

The service must be performed by a physical therapist that is currently licensed to practice in the Commonwealth and comply with 42 CFR 440.110.

SERVICES

11. Physical Therapy and Related Services (42 CFR 440.110) (continued)

11b. Occupational Therapy

Service is only provided to beneficiaries under 21 years of age.

Provider Qualifications

The service must be performed by an occupational therapist that is currently licensed to practice in the Commonwealth and comply with 42 CFR 440.110.

SERVICES

11. Physical Therapy and Related Services (42 CFR 440.110) (continued)

11c. Services for individuals with speech, hearing and language disorders

Service is only provided to beneficiaries under 21 years of age.

Provider Qualifications

The service must be performed by a speech pathologist and/or audiologist who is currently licensed to practice in the Commonwealth and comply with 42 CFR 440.110.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

12. Prescribed drugs, dentures and prosthetic devices; and, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12a. Prescribed drugs

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

12b. Dentures

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

12c. Prosthetic devices

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

12d. Eyeglasses

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in the plan.

13a. Diagnostic services

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

13b. Screening services

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

13c. Preventive services

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

*Service is only provided to beneficiaries under 21 years of age.

SERVICES

12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses

12a. Prescribed Drugs (42 CFR 440.120(a))

Limitations - The following limitations apply to payment for compensable services:

1. Payment is limited to a 34-day supply or 100 units, whichever is greater.

2. Payment to a pharmacy for all prescriptions dispensed to a beneficiary in either a skilled nursing facility, an intermediate care facility, or an intermediate care facility for the mentally retarded shall be limited to one dispensing fee for each drug dispensed within a 30 day period. A 5-day grace period will be allowed to accommodate prescriptions filled and delivered prior to the normal 30-day cycle. This limitation does not apply to:

    a. Antibiotics.

    b. Anti-Infectives.

    c. Schedule III analgesics.

    d. Topical and injectable preparations dispensed in the manufacturer's original package size unless evidence indicates that the quantity issued at each dispensing incident does not relate to the beneficiary's known monthly requirements for that specific medication.

    e. Ophthalmic and optic preparations dispensed in the manufacturer's original package size.

    f. Compensable compound prescription.

    g. Insulin.

    h. Schedule II drugs.

    i. Oral liquid anticonvulsants and oral liquid potassium supplements.

    j. Legend cough and cold oral liquid preparation.

3. Payment will not be made for the following services and items:

    a. Any pharmaceutical product marketed by a drug company which has not entered into a rebate agreement with the federal government as provided under Section 4401 of the Omnibus Budget Reconciliation Act of 1990.

    b. Legend and non-legend drugs whose prescribed use is not for a medically accepted indication.

    c. Pharmaceutical services provided to a hospitalized person.

    d. Drugs classified as experiments by the FDA.

    e. Drugs not approved by the FDA.

    f. Placebos.

SERVICES

12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses

12a. Prescribed Drugs (42 CFR 440.120(a)) (continued)

g. Compound prescriptions when:

i. The active ingredients are used in quantities insufficient to produce a therapeutic effect or response.

ii. The active ingredient or active ingredients used in a compound are noncompensable.

h. Non-legend drugs not specified in the excluded drug section of Attachment 3.1A/3.1B, Page 5cc and 5d.

i. The following items when prescribed for beneficiaries receiving skilled nursing and intermediate care facility services:

i. Intravenous solutions as a routine source of electrolytes, nutrition, and water for hydration except when used to prepare compound intravenous medications specifically ordered for and dispensed to a particular beneficiary. The payment for intravenous solutions is included in the nursing home per diem rate.

ii. Legend laxatives – Payment for all laxatives is included in the nursing home per diem rate.

j. Items prescribed or ordered by a prescriber who has been barred or suspended during an administrative action from participation in the Medical Assistance Program.

k. Prescriptions or orders filled by a pharmacy other than the one to which a beneficiary has been restricted because of misutilization or abuse.

l. Prescriptions for Erectile Dysfunction (ED) drugs unless used for FDA approved indications other than for the treatment of sexual or ED.

SERVICES

12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses

12a. Prescribed Drugs (42 CFR 440.120(a)) (continued)

4. Drug Rebate Agreements

   a. The Commonwealth is in compliance with section 1927 of the Social Security Act. The state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

   b. The Commonwealth will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the Commonwealth and a pharmaceutical manufacturer will be separate from the federal rebates.

   c. CMS authorized a rebate agreement between the Commonwealth and a drug manufacturer for drugs provided to Medicaid beneficiaries, "TOP^{sm}, The Optimal PDL Solution State Supplemental Rebate Agreement Among Participating Medicaid Programs Provider Synergies, L.L.C. and (Manufacturer)".

   d. The Commonwealth will continue state-specific supplemental rebates and will also participate in a multi-state pooling program that will negotiate supplemental rebates in addition to federal rebates provided for in Title XIX. This multi-state pooling program is known as The Optimal PDL Solution (TOP^{sm}). TOP^{sm} rebate agreements will be separate from the federal rebates. TOP^{sm} supplemental rebates received by the Commonwealth in excess of those required under the federal drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the federal rebate agreement.

   e. CMS has authorized the Commonwealth of Pennsylvania to enter into "The Optimal PDL Solution (TOP^{sm})." The TOP^{sm} supplemental rebate agreement is effective October 1, 2013 for the Commonwealth of Pennsylvania.

   f. Supplemental rebates received by the Commonwealth in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

   g. All drugs covered by the program, irrespective of a prior authorization requirement, will comply with provisions of the national drug rebate agreement.

SERVICES

12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses

12a. Prescribed Drugs (42 CFR 440.120(a)) (continued)

5. Preferred Drug List and Prior Authorization

    a. The state established a preferred drug list with prior authorization for drugs not included on the preferred drug list pursuant to 42 U.S.C. section 1396r-8. Prior authorization is required with a 24-hour turn-around from receipt of request and a 72-hour supply of drugs in emergency situations.

    b. Prior authorization is required for certain drug classes, particular drugs or medically accepted indication for uses and doses in compliance with Federal law.

    c. The state will appoint a Pharmaceutical and Therapeutic Committee or utilize the drug utilization review committee in accordance with Federal law.

    d. The Preferred Drug List is for Pennsylvania State Medicaid beneficiaries receiving pharmacy benefits through the Medicaid Fee-For-Service Program only.

6. Beneficiaries 21 years of age and older are limited to six prescriptions per calendar month for all legend and non-legend drugs

    a. A Benefit Limit Exception is required for additional prescriptions above the six prescriptions per calendar month limit.

    b. A Benefit Limit Exception will be approved if one of the following criteria is met:

        i. The Department determines the beneficiary has a serious chronic systemic illness or other serious health condition and the denial of the exception will jeopardize the life of the beneficiary;

        ii. The Department determines the beneficiary has a serious chronic systemic illness or other serious health condition and the denial of the exception will result in the rapid, serious deterioration of the health of the beneficiary;

        iii. The Department determines that granting a specific exception is a cost effective alternative for the Medical Assistance Program; or

        iv. The Department determines that granting an exception is necessary to comply with Federal law.

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY AND MEDICALLY NEEDY

SERVICES

Provision(s) (1935(d)(1))

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY AND MEDICALLY NEEDY

SERVICES

Provision(s) (1927(d)(2) and 1935(d)(2))

7. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

   The following drugs are covered:

   - ☐ (a) agents when used for anorexia, weight loss, weight gain
   - ☐ (b) agents when used to promote fertility
   - ☐ (c) agents when used for cosmetic purposes or hair growth
   - ☒ (d) agents when used for symptomatic relief of cough and colds, excluding mouthwashes, lozenges, troches, throat sprays, and rubs, when prescribed for beneficiaries under 21 years of age and residents of nursing homes and intermediate care facilities
   - ☒ (e) prescription vitamins and mineral products, including prenatal vitamins and fluoride
   - ☒ (f) nonprescription drugs
     - i. Payment for non-legend drugs is limited to the following:
       - A. Those drug products marketed by drug companies which have entered into rebate agreements with the federal government as provided under Section 4401 of the Omnibus Budget Reconciliation Act of 1990.
       - B. Non-legend drug products listed in the following categories when prescribed by a licensed prescriber within the scope of the prescriber's practice:
         - a. Analgesics: acetaminophen and combinations, aspirin and combinations, salicylates, and nonsteroidal anti-inflammatory drugs.
         - b. Antacids.
         - c. Antidiarrheals: kaolin-pectin combinations and loperamide.
         - d. Antiflatulents: simethicone and simethicone combined with an antacid.
         - e. Antinauseants: concentrated balanced solutions of sugar and orthophosphoric acid, cyclizine lactate, dimenhydrinate, and meclizine hydrochloride.
         - f. Bronchodilators.
         - g. Contraceptive Drugs.
         - h. Laxatives and stool softeners.
         - i. Nasal preparations: oxymetazoline, phenylephrine, xylometazoline, and naphazoline.
         - j. Ophthalmic preparations: phenylephrine, and sodium chloride in strengths of 2.0 percent or greater.

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY AND MEDICALLY NEEDY

SERVICES

Provision(s) (continued) (1927(d)(2) and 1935(d)(2))

k. Topical products containing one or more of the following ingredients:
   i. Anesthetics: benzocaine, cyclomethycaine, dibucaine, lidocaine, pramoxine, and tetracaine.
   ii. Antibacterials: bacitracin, neomycin, polymyxin, povidone-iodine and tetracycline.
   iii. Antifungal Agents: iodochlorhydroxyquin (clioquinol), miconazole nitrate, salicylanilide, salicylic acid, sodium caprylate, sodium propionate, triacetin (glyceryl triacetate), tolnaftate, undecylenic acid, esters, and salts, and clotrimazole.
   iv. Rectal Preparations: bismuth subgallate, yeast, and zine oxide.
   v. Tar Preparations, excluding soaps, shampoos; and cleansing agents.
   vi. Wet Dressings: aluminum acetate, aluminum sulfate, calcium sulfate, and zinc sulfate.
   vii. Scabicides: permethrin.
   viii. Corticosteroids: hydrocortisone.
   ix. Gel products containing benzoyl peroxide.
l. Quinine.

☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

☐ (h) DESI drugs and any identical, similar, or related products or combination of these products.

SERVICES

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SERVICES

12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses (continued)

12b. Dentures (42 CFR 440.120(b))

Limitations – The following limits apply to denture services:

Beneficiaries 21 years of age and older are limited to one (1) upper arch complete or partial denture, and one (1) lower arch complete or partial denture, per lifetime. Prior authorization is required for complete or partial dentures. Additional dentures require a Benefit Limit Exception. A Benefit Limit Exception will be approved if one of the following criteria is met:

1. The department determines the beneficiary has a serious chronic systemic illness or other serious health condition and the denial of the exception will jeopardize the life of the beneficiary.
2. The department determines the beneficiary has a serious chronic systemic illness or other serious health condition and the denial of the exception will result in the rapid, serious deterioration of the health of the beneficiary.
3. The department determines that granting a specific exception is a cost effective alternative for the Medical Assistance Program; or
4. The department determines that granting an exception is necessary to comply with Federal law.

Denture relines, either full or partial, are limited to one (1) arch, every two (2) years.

SERVICES

12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses (Continued)

12c. Prosthetic and Orthotic devices (42 CFR 440.120(c))

The clinical purpose of prosthetics is to provide replacement, corrective or supportive devices that help to improve health outcomes.

Limitations – The following limits apply to services for prosthetic and orthotic devices:

1. Prior authorization is required for all prescribed prosthetic and orthotic devices.
2. Beneficiaries 21 years of age and older are not eligible for orthopedic shoes.
3. Coverage for molded shoes is limited to molded shoes prescribed for severe foot and ankle conditions and deformities of such degree that the beneficiary is unable to wear ordinary sturdy shoes with or without corrections and modifications.
4. Coverage for modifications to orthopedic shoes and molded shoes is limited to only those modifications necessary for the application of a brace or splint.
5. Coverage for low vision aids and eye prostheses is limited to one (1) per beneficiary per two (2) years. An eye ocular is limited to one (1) per year.
6. Beneficiaries 21 years of age and older are not eligible for hearing aids.

SERVICES

12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses (Continued)

12d. Eyeglasses (42 CFR 440.120(d))

Limitations

1. Beneficiaries 21 years of age and older and diagnosed with aphakia are limited to:

   a. Four (4) eyeglass lenses per CY.

   b. Two (2) eyeglass frames per CY. Deluxe frames are not included.

   c. Four (4) contact lenses per CY.

SERVICES

13. Diagnostic, Screening, Preventive, and Rehabilitative Services

13a. Diagnostic Services (42 CFR 440.130(a))

Medicaid services not otherwise covered under the State Plan are limited to beneficiaries under 21 years of age.

SERVICES

13. Diagnostic, Screening, Preventive, and Rehabilitative Services

13b. Screening Services (42 CFR 440.130(b))

Medicaid services not otherwise covered under the State Plan are limited to beneficiaries under 21 years of age.

SERVICES

13. Diagnostic, Screening, Preventive, and Rehabilitative Services

13c. Preventive Services (42 CFR 440.130(c))

Medicaid services not otherwise covered under the State Plan are limited to beneficiaries under 21 years of age.

Limitations

1. Coverage for tobacco cessation counseling services to individuals 21 years of age and older is limited to seventy (70), fifteen (15) minute units per CY.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

13d. Rehabilitative Services.

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

14. Services for individuals age 65 or older in institutions for mental diseases.

14a. Inpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations

14b. Nursing facility services.

☒ Provided: ☒ No limitations ☐ With limitations

13. Diagnostic, Screening, Prevention and Rehabilitative Services (42 CFR 440.130)

13d. Rehabilitative Services

(i) Family-Based Mental Health Rehabilitative Services (42 CFR 440.130(d))

Family Based Mental Health Rehabilitative Services are a service array that is recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law, and includes assessment, planning and individual and family therapy provided primarily in the home of a child or adolescent with a mental illness or a serious behavior disorder which is intended to forestall child and adolescent psychiatric hospitalization and other out of the home placements. This service is licensed by the Department of Human Services. This service may also be provided in other community sites, such as the child's school. The following is a description of the service components and provider qualifications:

- **Assessment**

Assessment consists of using the following:

(1) Diagnosis and evaluation of the child or adolescent by a qualified provider of the healing arts. This can be provided by any of the following professionals:
   a. A psychiatrist who is licensed to practice psychiatry in the Commonwealth
   b. A physician who is licensed to practice medicine in the Commonwealth
   c. A psychologist who is licensed to practice psychology in the Commonwealth

(2) A medical history of the child or adolescent, including a copy of a current physical examination.

This history can be compiled by any of the following professionals:
   a. A psychiatrist
   b. A physician
   c. A CRNP who is licensed to practice in the Commonwealth
   d. A psychologist
   e. A certified Family Based Mental Health Professional who has achieved certification through the Office of Mental Health and Substance Abuse Services, Department of Human Services
   f. A certified Family Based Mental Health Worker who has achieved certification through the Office of Mental Health and Substance Abuse Services, Department of Human Services
   g. A certified Family Based Mental Health Supervisor who has achieved certification through the Office of Mental Health and Substance Abuse Services, Department of Human Services
   h. A Family Based Mental Health Professional who is currently enrolled in a Department approved Family Based training program. Family Based Mental Health Professionals are either licensed mental health professionals or an individual with a graduate degree in a human service field plus 2 years of experience in a Child Adolescent Service System Program (CASSP) system.
   i. A Family Based Mental Health Worker who is currently enrolled in a Department approved Family Based training program. A Family Based Mental Health worker has a bachelor's degree in a human service field or at least 12 college level semester hours in humanities or social services, plus one year of experience in a CASSP system.
   j. A Family Based Mental Health Supervisor who is currently enrolled in a Department approved Family Based training program. A Family Based Mental Health Supervisor is either a licensed mental health professional or an individual with a graduate degree in a human service field plus 3 years of direct care experience with children or adolescents in a CASSP system program including two years supervisory experience in any program of the CASSP system or has a supervisory certificate from the American Association of Marriage and Family Therapists.

13d. (i) Family-Based Mental Health Rehabilitative Services (42 CFR 440.130(d))(continued)

(3) A social and developmental history of the child or adolescent, including the roles of other members of the consumer family. This history can be compiled by any of the following:
   a. A psychiatrist
   b. A physician
   c. A CRNP
   d. A psychologist
   e. A certified Family Based Mental Health Professional
   f. A certified Family Based Mental Health Worker
   g. A certified Family Based Mental Health Supervisor
   h. A Family Based Mental Health Professional who is currently enrolled in a Department approved Family Based training program.
   i. A Family Based Mental Health Worker who is currently enrolled in a Department approved Family Based training program.
   j. A Family Based Mental Health Supervisor who is currently enrolled in a Department approved Family Based training program.

- **Planning:**

  The development of treatment plans based on the assessment, which establish specific, attainable goals and which designate responsibility for activities proposed to achieve these goals. Planning also includes periodic evaluations of progress, reviews of activities, evaluating and updating the treatment plan and its goals, and discharge planning. This planning will be provided, in collaboration with the family and youth, by any of the following professionals:

a. A certified Mental Health Professional
b. A certified Mental Health Worker
c. A certified Mental Health Supervisor
d. A Family Based Mental Health Professional who is currently enrolled in a Department approved Family Based training program.
e. A Family Based Mental Health Worker who is currently enrolled in a Department approved Family Based training program.
f. A Family Based Mental Health Supervisor who is currently enrolled in a Department approved Family Based training program.

- **Treatment**

  Individual and family therapy from an ecosystemic approach to family therapy as taught by the Department approved Family Based Training Program. Specific therapies are to be incorporated within this model in response to specific needs of the child, such as trauma focused therapy. This therapy can be provided by the following professionals:

a. A certified Mental Health Professional
b. A certified Mental Health Worker
c. A certified Mental Health Supervisor
d. A Family Based Mental Health Professional who is currently enrolled in a Department approved Family Based training program.
e. A Family Based Mental Health Worker who is currently enrolled in a Department approved Family Based training program.
f. A Family Based Mental Health Supervisor who is currently enrolled in a Department approved Family Based training program.

SERVICES

13d. Rehabilitative Services (continued)

(ii) Mental Health Crisis Intervention Services (42 CFR 440.130(d))

Mental Health Crisis Intervention (MHCI) Services are a service array that is recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law, and includes immediate, crisis oriented services provided to a beneficiary and their family, who exhibits an acute problem of disturbed thought, behavior, mood or social relationships. The services are accessible 24 hours a day to provide a rapid response to crisis situations which threaten the well-being of the individual or others. Agencies providing these services must be licensed by the Department as Mental Health Crisis Intervention Service providers. Mental Health Crisis Intervention includes *screening, assessment, intervention, counseling, and disposition services.* The following is a description of these service components and professional qualifications:

- **Screening:** A formal process to determine whether a mental health crisis or emergency may exist by gathering initial information on the current situation and individuals involved to formulate the level of response needed. The initial screening must address health and safety issues of everyone involved in the crisis. The purpose is to establish the need for further assessment by a crisis worker or to determine if other services would best address the individual's current circumstances.

- **Assessment:** The formal process to evaluate the individual's safety risk and dangerousness of the crisis situation. Information related to the presenting problem, sources of stress, environment, interpersonal relationships, mental health symptoms, strengths and vulnerabilities that maybe contributing to the current crisis situation are gathered to formulate the appropriate intervention process.

- **Intervention:** A short-term, intensive mental health service initiated during an identified crisis situation. The purpose is to help the individual cope with immediate stressors, provide a sense of safety and stabilize the acute situation.

- **Counseling:** A series of strategies to address the crisis situation and mitigate distress. Specific strategies may include establishing rapport, active listening, problem solving techniques, stress management, or psycho-education based upon the crisis assessment.

- **Disposition Services:** Assistance in connecting with appropriate resources including formal and informal support systems. This may include providing follow-up contact for ongoing support, facilitating referrals to community mental health services, providing information and referrals for community resources for basic needs, engaging informal support networks such as family, friends, faith-based resources based upon the crisis situation.

All service components described above can be provided by any of the following professionals:

a) A MHCI Mental Health Professional who meets one of the following criteria:
   - A master's degree in social work, psychology, rehabilitation, activity therapies, counseling, education or related fields and 3 years of mental health direct care experience
   - A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, counseling, education or a related field, or be a registered nurse, and 5 years of mental health direct care experience, 2 of which shall include supervisory experience
   - A bachelor's degree in nursing and 3 years of mental health direct care experience

13d. (ii) Mental Health Crisis Intervention Services (42 CFR 440.130(d))(continued)

- A registered nurse license, certified in psychology or psychiatry

b) Crisis workers who are not MHCI mental health professionals shall be supervised by a MHCI mental health professional and shall meet one of following:
   - Have a bachelor's degree with major course work in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, nursing, counseling, education or a related field.
   - Be a registered nurse
   - Have a high school diploma or equivalency and 12 semester credit hours in sociology, social welfare, psychology, gerontology or other social sciences and 2 years of experience in public or private human services with 1 year of mental health direct care experience
   - Have a high school diploma or equivalency and 3 years of mental health direct care experience in public or private human services with employment as a mental health staff person prior to January 1, 1992
   - Be a consumer or a family member who has 1 year of experience as an advocate or leader in a consumer or family group, and has a high school diploma or equivalency.

c) A MHCI Service Medical Professional who meets one of the following:
   - A psychiatrist
   - A physician with 1 year of mental health service experience in diagnosis, evaluation and treatment
   - A certified registered nurse practitioner authorized in accordance with 49 Pa. Code Section 21.291 (relating to institutional health care facility committee; committee determination of standard policies and procedures) to diagnose mental illness

13d. Rehabilitative Services (continued)

(iii) Mobile Mental Health Treatment (MMHT) (42 CFR 440.130(d))

MMHT is a service array that is recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law to reduce the disabling effects of an illness or disability and restore the beneficiary to the best possible functional level in the community. The purpose of MMHT is to provide therapeutic treatment to reduce the need for more intensive levels of service including crisis intervention or inpatient hospitalization.

MMHT includes: *evaluation; individual, group, and family therapy; and medication visits* in a beneficiary's residence or approved community site. MMHT may be provided by any licensed psychiatric outpatient clinic enrolled in the MA Program. The following is a description of these service components and professional qualifications:

- **Evaluation:** A face to face interview which shall include an assessment of the psychiatric, medical, psychological, social, vocational, and educational factors important to the beneficiary. This can be provided by any of the following professionals:

  a) Psychiatrist: A physician who has completed a 3 year residency in psychiatry and is licensed to practice in this Commonwealth

  b) Psychologist: A person licensed to practice psychology in this Commonwealth.

  c) MMHT Mental Health Professional: A person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology or nursing or rehabilitation or activity therapies that has a graduate degree and one year of mental health clinical experience.

- **Psychotherapy:** The treatment, by psychological means, of the problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the beneficiary with the object of removing, modifying or retarding existing symptoms, of mediating disturbed patterns of behavior, and of promoting positive personality growth and development. This includes:

  - **Individual Therapy:** Psychotherapy provided to one person with a diagnosed mental disorder
  - **Group Therapy:** Psychotherapy provided to no less than two and no more than ten persons with diagnosed mental disorders
  - **Family Therapy:** Psychotherapy provided to two or more members of a family. At least one family member shall have a diagnosed mental disorder

  Psychotherapy can be provided by any of the following professionals:

  d) Psychiatrist

  e) Psychologist

  f) MMHT mental health professional: A person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology or nursing or rehabilitation or activity therapies that has a graduate degree and one year of mental health clinical experience.

SERVICES

13d. (iii) Mobile Mental Health Treatment (MMHT) (42 CFR 440.130(d))(continued)

- **Medication Visits**: A minimum 15-minute visit only for administration of a drug and evaluation of a beneficiary's physical and mental condition during the course of prescribed medication. This visit is provided to an eligible beneficiary by any of the following professionals:
  - **a)** Psychiatrist
  - **b)** Physician: An individual licensed under the laws of this Commonwealth to practice medicine and surgery within the scope of the Medical Practice Act of July 20, 1974
  - **c)** Certified Registered Nurse Practitioner (CRNP): A registered nurse licensed in this Commonwealth who is certified by the State Board of Nursing and State Board of Medicine in a particular clinical specialty area who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in this Commonwealth
  - **d)** Registered Nurse: An individual licensed by the State Board of Nursing to practice professional nursing or
  - **e)** Licensed practical nurse who is a graduate of a school approved by the State Board of Nursing or who has successfully completed a course in the administration of medication approved by the State Board of Nursing.

SERVICES

13d. Rehabilitative Services (continued)

(iv) Peer Support Services (42 CFR 440.130(d))

Peer Support Services (PSS) are mental health rehabilitative services recommended by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to reduce the disabling effects of an illness or disability and restore the beneficiary to the best possible functional level in the community. Peer Support Services are person-centered and recovery focused. It is the purpose of Peer Support to inspire hope in beneficiaries that recovery from mental illness and co-occurring substance abuse is not only possible, but probable.

Peer Support Services providers must be licensed by the Office of Mental Health and Substance Abuse Services (OMHSAS) as a peer support services provider, an outpatient psychiatric clinic, partial hospitalization program, crisis intervention provider, resource coordination provider, intensive case management provider or, a psychiatric rehabilitation services provider; receive a letter of approval to provide peer support services from OMHSAS; comply with the licensing requirements that apply to the particular provider type in providing peer support services; and be enrolled in, and comply with all requirements that govern participation in, the MA Program.

Peer Support Services include: *mentoring, crisis support, development of community roles and natural supports, individual advocacy, self-help, self-improvement, and social network*. The following is a description of these service components and professional qualifications:

- **Mentoring:** To serve as a role model for a beneficiary in recovery; to coach and guide through shared experiences.
- **Crisis support:** Assisting the beneficiary to recognize the early signs of relapse and how to implement identified coping strategies.
- **Development of Community Roles and Natural Supports:** Assisting the beneficiary to gain information about school, job training, work, housing and how to become an active community member.
- **Individual Advocacy**: Assisting the beneficiary toward a proactive role in his or her own recovery.
- **Self Help:** Cultivating the beneficiary's ability to make informed, independent choices.
- **Self-improvement**: Planning and facilitating practical activities leading to increased self-worth and improved self-concepts.
- **Social Network:** Assisting the beneficiary to develop and maintain positive personal and social support networks.

All service components described above are provided by a Certified Peer Specialist (CPS) whose qualifications are listed below:

- A self-identified individual, as defined in the Department's bulletin OMH-94-04, who has received or is receiving behavioral health services:

SERVICES

13d. (iv) Peer Support Services (42 CFR 440.130(d))(continued)

- A person must meet the federal definition of serious mental illness; must have a diagnosis of schizophrenia, major mood disorder, psychotic disorder NOS or borderline personality disorder; and must meet at least one of the following criteria: Treatment History, Functioning Level or Coexisting Condition or Circumstance; or,
- Any individual who met the standards for involuntary treatment (as defined in Chapter 5100 Regulations – Mental Health Procedures) within the 12 months preceding the assessment.

- Peer specialists will complete a peer specialist certification training curriculum approved by the Department before providing peer support services.
- Peer specialists will complete 18 hours of continuing education training per year with 12 hours specifically focused on peer support or Recovery practices, or both, in order to maintain peer specialist certification.

Supervision: A PSS mental health professional maintains clinical oversight of peer support services, which includes ensuring that services and supervision are provided consistent with the service requirements. An individual qualifies as a PSS mental health profession if they meet **either** (a) or (b) below:

a) A Mental Health Professional who meets one of the following criteria:
   - A master's degree in social work, psychology, rehabilitation, activity therapies, counseling, education or related fields and 3 years of mental health direct care experience
   - A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, counseling, education or a related field, or be a registered nurse, and 5 years of mental health direct care experience, 2 of which shall include supervisory experience
   - A bachelor's degree in nursing and 3 years of mental health direct care experience
   - A registered nurse license, certified in psychology or psychiatry

b) A Mental Health Professional who is trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology or nursing or rehabilitation or activity therapies who has a graduate degree and one year of mental health clinical experience.

Care Coordination: The provider will ensure the initial and all subsequent Individual Service Plans will specify: measurable goals and objectives written in individualized and outcome-oriented language; the services to be provided, including the expected frequency and duration; the location where the services will be provided; and the peer specialist's role in relating to the beneficiary and involved other persons.

Limitations

1. Beneficiaries 21 years of age and older are limited to four (4) hours per day. Services are limited to nine hundred (900) hours per CY.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

15a. Intermediate care facility services for individuals with intellectual disability (ICF/IID) and for other related conditions (ORC) (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided*

15b. Including such services in a public institution (or distinct part thereof) for individuals with intellectual disability or persons with related conditions.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided*

16. Inpatient psychiatric facility services for individuals under 21 years of age.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

17. Nurse-midwife services.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided
☒ Provided in accordance with section 2302 of the Affordable Care Act

*Service is only provided to beneficiaries under 21 years of age.

SERVICES

RESERVED

SERVICES

RESERVED

SERVICES

18. Hospice Services (42 CFR 483.75)

Limitations

1. Coverage for inpatient respite care is limited to no more than five (5) consecutive days in a sixty (60) day certification period.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

19. Case management services and Tuberculosis related and services (42 CFR 440.169(b))

19a. Case management services as defined in, and to the group specified in, Enclosure A and Supplements 2-5 to ATTACHMENT 3.1A/3.1B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

19b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided

20. Extended services for pregnant women (42 CFR 440.210(a)(3))

20a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

_____ Additional coverage++

20b. Services for any other medical conditions that may complicate pregnancy.

_____ Additional coverage++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only (Supplement 1)

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by qualified provider (in accordance with section 1920 of the Act).

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act). (42 CFR 440.185(a))

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

23. Nurse Practitioners services (42 CFR 440.166(b) and (c))

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

*Service is only provided to beneficiaries under 21 years of age.

SERVICES

22. Respiratory Care Services, in accordance with section 1902(e)(9)(A)-(C) of the Act (42 CFR 440.185(a))

Service is not provided to beneficiaries 21 years of age or older.

SERVICES

RESERVED

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

24a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations

24b. Services provided in Religious Nonmedical Health Care Institutions

☐ Provided: ☐ No limitations ☐ With limitations
☒Not provided*

24c. Nursing facility services for beneficiaries under 21 years of age.

☒ Provided: ☒ No limitations ☐ With limitations
☐Not provided*

24d. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations

24e. Personal care services in beneficiaries home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☐ Provided: ☐ No limitations ☐ With limitations
☒Not provided*

*Service is only provided to beneficiaries under 21 years of age.

SERVICES

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (42 CFR 440 170)

24a. Transportation (42 CFR 440 170(a))

Transportation for beneficiaries is available in three modes: Ambulance (both emergency and non-emergency), Non-Emergency Non-Ambulance (non-brokered) and Non-Emergency Non-Ambulance (brokered).

i. A. Ambulance (emergency)

Limitations – The following limits apply to compensable emergency ambulance transportation:

1. Coverage of ambulance transportation is limited to eligible beneficiaries only when the beneficiary's condition precludes any other method of transportation.
2. Ambulance transportation must be made to or from an appropriate medical facility, pursuant to State agency regulatory standards.
3. [RESERVED]

B. Ambulance (non-emergency)

Limitations - The following limits apply to compensable non-emergency ambulance transportation:

1. Coverage of ambulance transportation is limited to eligible beneficiaries only when the beneficiary's condition precludes any other method of transportation.
2. Ambulance transportation must be made to or from an appropriate medical facility pursuant to State agency regulatory standards.
3. [RESERVED]

ii. Non-Ambulance (non-emergency, non-brokered)

Limitations – The following limits apply to compensable non-emergency non-ambulance transportation:

1. Transportation must be made to or from services which are covered under the Medical Assistance Program.
2. For dual eligibles, in addition to services covered by Medical Assistance, transportation to or from Medicare Part D pharmacy providers.

SERVICES

ii. Brokered Transportation

☒ Provided under section 1902(a)(70) for Philadelphia County only.

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provided transportation and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36(b)-(f).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(1):

☒ (1) statewideness (indicate areas of State that are covered)

☒ (10)(B) comparability (indicate participating beneficiary groups)

☒ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

☒ wheelchair van

☒ taxi

☐ stretcher car

☒ bus passes

☒ tickets

☐ secured transportation

☐ such other transportation as the Secretary determines appropriate (please describe)

(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).

SERVICES

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

- ☒ Low-income families with children (section 1931)
- ☒ Low-income pregnant women
- ☒ Low-income infants
- ☒ Low-income children 1 through 5
- ☒ Low-income children 6-19
- ☒ Qualified pregnant women
- ☒ Qualified children
- ☒ IV-E Federal foster care and adoption assistance children
- ☒ TMA beneficiaries (due to employment)
- ☒ TMA beneficiaries (due to child support)
- ☒ SSI beneficiaries
- ☒ Persons essential to beneficiaries under Title I, X, XIV, or XVI
- ☒ Individuals provided extended benefits under section 1925

SERVICES

(5) The broker contract will provide transportation to the following categorically needy optional populations:

- ☒ Optional low-income pregnant women
- ☒ Optional low-income infants
- ☒ Optional targeted low-income children
- ☒ Individuals under 21 who are under State adoption assistance agreements
- ☒ Individuals under age 21 who were in foster care on their 18th birthday
- ☒ Individuals who meet income and resource requirements of AFDC or SSI
- ☒ Individuals who would meet the income and resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
- ☐ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
- ☐ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
- ☐ Individuals infected with TB
- ☒ Individuals screened for breast or cervical cancer by CDC program
- ☒ Individuals receiving COBRA continuation benefits
- ☐ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
- ☒ Individuals receiving home and community based waiver services that would only be eligible under State plan if in a medical institution
- ☒ Individuals terminally ill if in a medical institution and will receive hospice care
- ☒ Individuals aged or disabled with income not above 100% FPL
- ☐ Individuals receiving only an optional State supplement in a 209(b) State
- ☐ Individuals working disabled who buy into Medicaid (BBA working disabled group)
- ☒ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
- ☐ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids)
- ☒ Employed individuals with a medically improved disability (as defined in section V)
- ☒ Individuals described in section 1902(aa)
- ☒ Individuals screened for breast or cervical cancer by CDC program
- ☒ Individuals receiving COBRA continuation benefits
- ☒ Individuals residing in Personal Care Homes

SERVICES

(6) The State will pay the contracted broker by the following method:

☒ (i) risk capitation

☐ (ii) non-risk capitation

☐ (iii) other (e.g., brokerage fee and direct payment to providers)

SERVICES

24. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary. (42 CFR 440 170) (continued)

24b. Services provided in religious Nonmedical Health Care Institutions (42 CFR 440 170(b))

Services are only provided to beneficiaries under 21 years of age.

SERVICES

24. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary (42 CFR 440 170) (continued)

24d. Emergency Hospital Services (42 CFR 440 170(e))

Services are necessary to prevent the death or serious impairment of the health of the beneficiary and because of the threat to the life or health of the beneficiary necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet:

(i) The condition of participation under Medicare; or
(ii) The definition of inpatient or outpatient hospital services under 42 CFR 440.10 and 442 CFR 440.20

SERVICES

24. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary. (42 CFR 440 170) (continued)

24e. Personal care services in beneficiary's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Services are only provided to beneficiaries under 21 years of age.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

25. Case Management Services

☐ Provided ☐ No limitations ☐ With limitations
☒ Not provided*

*Service is only provided to beneficiaries under 21 years of age.

SERVICES

25. Case Management Services (42 CFR 440.169(a))

Services are only provided to beneficiaries under 21 years of age.

SERVICES

RESERVED

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1A.

__X__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

_____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

SERVICES

RESERVED

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

Freestanding Birth Center Services

27a. Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☒No limitations ☐With limitations ☐None licensed or approved

Please describe any limitations:

None

27b. Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☒No limitations ☐With limitations
☐Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

None

Check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

State Plan under Title XIX of the Social Security Act
State/Territory: PA

TARGETED CASE MANAGEMENT SERVICES
Individuals with Severe Mental Illness

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
Medicaid eligible individuals with serious mental illness or serious emotional disturbance.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
X Entire State
___ Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - Taking client history;
  - Identifying the individual's needs and completing related documentation; and
  - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Initial comprehensive assessment will consider the beneficiary's strengths, needs, interests, and circumstances and will be used to prepare a care plan to meet the needs. Periodic reassessments will be completed at least once every six months in order to determine if the beneficiary's strengths, needs, interests, and circumstances have changed and to update the care plan, if appropriate.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

State Plan under Title XIX of the Social Security Act
State/Territory: PA

TARGETED CASE MANAGEMENT SERVICES
Individuals with Severe Mental Illness

- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual;

❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
- Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

❖ Monitoring and follow-up activities:
- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Periodic reviews of the care plan will be completed and documented every six months at a minimum. These activities shall be conducted in accordance with a written care plan, or as frequently as necessary based upon individual need to ensure care plan goals are accomplished.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Provider Agency Qualifications:
a. Provide case management as a separate and distinct service within the agency organization;
b. Establish referral agreements and linkages with essential social and health service agencies to coordinate access to needed resources;

State Plan under Title XIX of the Social Security Act
State/Territory: PA

TARGETED CASE MANAGEMENT SERVICES
Individuals with Severe Mental Illness

c. Demonstrate the ability to provide comprehensive full time case management services;
d. Administrative capacity to document and maintain individual case management records in accordance with state and federal requirements;
e. Ability to meet state and federal requirements for documentation, billing and audits.
f. Hold a current certificate of compliance from the State to provide case management services to individuals with serious mental illness.

Case management is provided by a staff person who meets one of the following requirements:

a. A Bachelor's degree; or,

b. Registered nurse; or

c. A high school diploma and 12 semester credit hours in sociology, social welfare, psychology, gerontology, or other social science and two years of experience in direct contact with mental health consumers; or

d. A high school diploma and five years of mental health direct care experience in public or private human services with employment as a case management staff person prior to April 1, 1989.

Mental health direct care experience is working directly with mental health service consumers (adults, children or adolescents) providing services involving casework or case management, individual or group therapy, crisis intervention, early intervention, vocational training, residential care, or social rehabilitation in a mental health facility or in a facility or program that is publicly funded to provide services to mental health consumers, or in a nursing home, a juvenile justice agency, or a children and adolescent service agency.

Case management staff who were employed as case managers prior to September 1, 1993 under federal standards that existed prior to April 1, 1993 are exempt from the qualifications standards listed above.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

State Plan under Title XIX of the Social Security Act
State/Territory: PA

TARGETED CASE MANAGEMENT SERVICES
Individuals with Severe Mental Illness

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
X Target group consists of eligible individuals with serious mental illness or serious emotional disturbance. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with serious mental illness receive needed services. Agencies providing case management services will need a certificate of compliance from the state. This certificate of compliance ensures the provider is appropriately qualified to serve individuals with serious mental illness.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

State Plan under Title XIX of the Social Security Act
State/Territory: PA

TARGETED CASE MANAGEMENT SERVICES
Individuals with Severe Mental Illness

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

State Plan under Title XIX of the Social Security Act
State/Territory: PA

TARGETED CASE MANAGEMENT SERVICES
Individuals with Severe Mental Illness

RESERVED

State Plan under Title XIX of the Social Security Act
State/Territory: PA

TARGETED CASE MANAGEMENT SERVICES
Individuals with Severe Mental Illness

RESERVED

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

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