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State/Territory Name: **Pennsylvania**

State Plan Amendment (SPA) #: **20-0017**

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

May 15, 2023

Teresa D. Miller, Secretary
Department of Human Services
P.O. Box 2675
Harrisburg, PA 17105-2675

Re: Pennsylvania State Plan Amendment (SPA) 20-0017

Dear Secretary Miller:

Enclosed please find a corrected approval package for your Pennsylvania State Plan Amendment (SPA) submitted under transmittal number (TN) 20-0017. This SPA, which the state submitted to continue certain benefits changes beyond the end of the COVID-19 Public Health Emergency (PHE), was originally approved on May 24, 2021. At the time of approval, the end date of the PHE was not known. Now that the date is known, the CMS-179 form and SPA pages are updated to reflect an effective date of May 12, 2023.

The enclosed package contains the corrected CMS-179, and the corrected SPA pages.

If you have any questions, please contact Dan Belnap at 215-861-4273 or via email at Dan.Belnap@cms.hhs.gov.

Sincerely,

James G. Scott, Director
Division of Program Operations

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER
20-0017

2. STATE
Pennsylvania

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~Day after COVID-19 PHE ends~~ May 12, 2023

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
Social Security Act, Section 1902(a)

7. FEDERAL BUDGET IMPACT
a. FFY ~~2019~~ 2021 $0
b. FFY ~~2020~~ 2022 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1A/3.1B, pages 3d, 3e, 3f, 3fa, 3g
Attachment 3.1A/3.1B, page 5a
Attachment 3.1A/3.1B, Supplement 2, pages 1-2
Attachment 4.19C, pages 1-2

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 3.1A/3.1B, pages 3d, 3e, 3f, 3fa, 3g
Attachment 3.1A/3.1B, page 5a
Attachment 3.1A/3.1B, Supplement 2, pages 1-2
Attachment 4.19C, pages 1-2

10. SUBJECT OF AMENDMENT

Continuation of certain flexibilities beyond the end of the COVID-19 public health emergency.

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

13. TYPED NAME
Teresa D. Miller

14. TITLE
Secretary of Human Services

15. DATE SUBMITTED
~~October 5, 2020~~ October 6, 2020

16. RETURN TO
Commonwealth of Pennsylvania
Department of Human Services
Office of Medical Assistance Programs
Bureau of Policy, Analysis and Planning
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
October 6, 2020

18. DATE APPROVED
May 24, 2021

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
May 12, 2023

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
James G. Scott

22. TITLE
James G. Scott, Director, Division of Program Operations

23. REMARKS

Pen & ink change made with state's permission to change federal fiscal years in Box 7 to 2021 and 2022, and to change date submitted in Box 15 to October 6, 2020. (db)
Change made to box 4 to correct the effective date of this SPA, which is May 12, 2023.

SERVICES

7. Home Health Services (42 CFR 440.70)

7a. Nursing service, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency or, if there is no agency in the area, a registered nurse when prescribed by Physicians, Physician Assistants, and Certified Registered Nurse Practitioners within their scope of practice authorized under State law (42 CFR 440.70(b)(1)).

Limitations

1. For beneficiaries 21 years of age or older, there are no limits for home health nursing visits for the first twenty-eight (28) days. After the first twenty-eight (28) days, beneficiaries 21 years of age or older are limited to fifteen (15) days of home health nursing visits, home health aide visits, therapy visits, and speech pathology and audiology visits.

2. 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.

7. Home Health Services (42 CFR 440.70)

7b. Home health aide services provided by a licensed home health agency when prescribed by Physicians, Physician Assistants, and Certified Registered Nurse Practitioners within their scope of practice authorized under State law (42 CFR 440.70(b)(2)).

Limitations

1. For beneficiaries 21 years of age or older, there are no limits for home health aide services for the first twenty-eight (28) days. After the first twenty-eight (28) days, beneficiaries 21 years of age or older are limited to fifteen (15) days of home health aide visits, home health nursing visits, therapy visits and speech pathology and audiology visits.

2. 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.

7. Home Health Services (42 CFR 440.70)

7c. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place as defined at 42 CFR 440.70(c)(1) when prescribed by Physicians, Physician Assistants, Certified Registered Nurse Practitioners, and Podiatrists within their scope of practice authorized under State law (42 CFR 440.70(b)(3)).

Wheelchair lifts, stair glides, ceiling lifts and metal accessibility ramps and other items that are used by a beneficiary with a mobility impairment to enter and exit the home or to support activities of daily living; and are removeable or reusable without damage to the item. Coverage includes installation.

1. Installation of the medical equipment and appliances includes, but is not limited to:
    a. Parts or supplies provided or recommended by the manufacturer for attaching or mounting the item to the surface at the home or residence
    b. Labor to attach or mount the item to a surface per the manufacturer's installation guide
    c. Required permits
    d. Installing an electrical outlet or connection to an existing electrical source
    e. Pouring a concrete foundation (slab) according to the manufacturer's instructions (which may include leveling the ground under the concrete foundation)
    f. External supports, such as bracing a wall
    g. Removing a portion of an existing railing or bannister only as needed to accommodate the equipment.

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 dollars ($600). The Department also requires prior authorization for the purchase of some appliances or equipment that cost less than six hundred dollars ($600).

4. Home modifications are not covered. Home modifications include:
    a. Modifications to the home or place of residence
    b. Repairs of the home, including repairs caused by the installation, use, or removal of the medical equipment or appliance
    c. Changes to the internal or external infrastructure of the home or residence including:
        i. Adding internal supports such that the support requires access to the area behind a wall or ceiling or underneath the floor
        ii. Constructing retaining walls or footers for a retaining wall
        iii. Installation of or modification of a deck
        iv. Installation of a driveway or sidewalk
        v. Upgrading the electrical system
        vi. Plumbing
        vii. Ventilation or HVAC work
        viii. Widening a doorway
        ix. Drywall

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

7c. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place as defined at 42 CFR 440.70(c)(1) when prescribed by Physicians, Physician Assistants, Certified Registered Nurse Practitioners, and Podiatrists within their scope of practice authorized under State law (42 CFR 440.70(b)(3)). (continued)

x. Painting
xi. Installation of flooring
xii. Tile work
xiii. Demolition of existing property or structure.

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)

7d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a licensed home health agency. The services may be prescribed by Physicians, Physician Assistants, and Certified Registered Nurse Practitioners within their scope of authorized under State law (42 CFR 440.70(b)(4)).

Limitations

1. For beneficiaries 21 years of age or older, there are no limits for physical therapy, occupational therapy, or speech pathology and audiology services for the first twenty-eight (28) days. After the first twenty-eight (28) days, beneficiaries 21 years of age or older are limited to fifteen (15) days of therapy visits, speech pathology and audiology services, home health nursing visits, and home health aide visits.

2. 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.

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 up to a 90-day supply or 100 units, whichever is greater. Exception to the 90-day supply is systemic contraceptives.

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 individuals with intellectual disabilities 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 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 not approved by the FDA.

   e. Drugs not approved by the FDA.

   f. Placebos.

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 CFR 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 any 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 annually 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, services 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 annually 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 442.18(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;

The Pennsylvania Department of Human Services recognizes reserved bed days as an allowable cost when an MA resident is absent from a nursing facility for a continuous 24-hour period for the purpose of hospitalization or for therapeutic leave.

A. Hospitalization

1. A resident receiving nursing facility services is eligible for a maximum of 15 consecutive reserved bed days per hospitalization. The Department will pay a nursing facility at a rate of one-third of the facility's current per diem rate on file with the Department for a hospital reserved bed day if the nursing facility meets the overall occupancy requirements as set forth below.

   a. During the rate year 2009-2010, the nursing facility's overall occupancy rate for the rate quarter in which the hospital reserved bed day occurs shall equal or exceed 75%.

   b. Beginning with rate year 2010-2011 and thereafter, the nursing facility's overall occupancy rate for the rate quarter in which the hospital reserved bed day occurs shall equal or exceed 85%.

   c. The Department will calculate a nursing facility's overall occupancy rate for a rate quarter as follows:

      (i) The Department will identify the picture date for the rate quarter (July 1 rate quarter – February 1 picture date; October 1 rate quarter – May 1 picture date; January 1 rate quarter – August 1 picture date; and April 1 rate quarter – November 1 picture date) and the two picture dates immediately preceding this picture date.

      (ii) The Department will calculate the nursing facility's occupancy rate for each of The picture dates identified in (i) above, by dividing the total number of assessments listed in the facility's CMI report for that picture date by the number of the facility's certified beds on file with the Department on the picture date and multiplying the result by 100%. The Department will assign the highest of the three picture date occupancy rates as the nursing facility's overall occupancy rate for the rate quarter.

      (iii) The Department will only use information contained on a valid CMI report to Calculate a nursing facility's overall occupancy rate. If a nursing facility did not submit a valid CMI report for a picture date identified in (i) above, the Department will calculate the nursing facility's overall occupancy rate based upon the valid CMI reports that are available for the identified picture dates. If no valid CMI reports are available for the picture dates identified in (i) above, the nursing facility is not eligible to receive payment for hospital reserve bed days in the rate quarter.

d. A new nursing facility is exempt from the applicable occupancy requirements set forth in 1.a. and 1.b. above, until a CMI Report for each of the three picture dates used to calculate overall occupancy as set forth in 1.c.(i) above is available for the rate quarter.

2. If the resident's hospital stay exceeds the Department's 15 reserved bed day payment limitation, the nursing facility shall readmit the resident to the nursing facility upon the first availability of a bed in the nursing facility if, at the time of readmission, the resident requires the services provided by the nursing facility.

3. If a bed is reserved for a hospitalized resident, it must be available to the resident upon the resident's return to the nursing facility. The bed need not remain empty pending the resident's return; however, it must be recorded as a resident day on the nursing facility's daily census and on the invoice if it is temporarily occupied by another resident. A bed reserved for a hospitalized resident is not counted as a resident if the bed remains empty.

B. Therapeutic Leave

A resident receiving nursing facility services is eligible for a maximum of 30 days per calendar year of therapeutic leave outside the nursing facility providing the leave is included in the individual's plan of care and is ordered by the attending physician.

Therapeutic leave day extension. In addition to per diem payment for 30 therapeutic leave days per calendar year, a nursing facility will be eligible to receive payment for additional therapeutic leave days subject to the following:

(i) The nursing facility contacts the Department to request a therapeutic leave day extension.

(ii) The Department approves the therapeutic leave day extension.

(iii) The day has not been reimbursed from other sources, including the U.S. Department of Health and Human Services, the Medicare Program or Medicare Advantage Plans.

(iv) Payment for additional therapeutic leave days will be made at the facility's per diem rate on File with the Department for a therapeutic leave day.

Therapeutic Leave Day Extensions will be evaluated on a case-by-case basis and approved at the discretion of the State.

The Department will pay a nursing facility its current per diem rate on file with the Department for therapeutic leave days.

Each bed reserved for therapeutic leave must remain unoccupied pending the resident's return to the facility. The bed must be recorded as a resident day on the facility's daily census and on the invoice.