Table of Contents

State/Territory Name: Pennsylvania

State Plan Amendment (SPA) #: 25-0022

This file contains the following documents in the order listed:

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

February 24, 2026

Valerie A. Arkoosh, MD, MPH
Secretary, Department of Human Services
P.O. Box 2675
Harrisburg, PA 17105-2675

Re: Pennsylvania State Plan Amendment (SPA) – 25-0022

Dear Secretary Arkoosh:

The Centers for Medicare & Medicaid Services (CMS) has reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0022. This amendment updates the Third-Party Liability language in the Pennsylvania Medicaid State Plan.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter informs you that Pennsylvania's Medicaid SPA TN 25-0022 was approved on February 24, 2026, with an effective date of October 1, 2025.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Pennsylvania State Plan.

If you have any questions, please contact Margaret Kosherzenko at (215) 861-4288 or via email at Margaret.Kosherzenko@cms.hhs.gov.

Sincerely,

[redacted]

Wendy E. Hill Petras, Acting Director
Division of Program Operations

Enclosures

cc: Eve Lickers

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0022

2. STATE: PA

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
Section 1902(a)(25)(A)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 0
b. FFY 2027 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.22-A, Page 3
Attachment 4.22-C, Pages 2-3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.22-A, Page 3
Attachment 4.22-C, Pages 2-3

9. SUBJECT OF AMENDMENT
Third Party Liability Updates

10. 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:

11. [redacted]Y OFFICIAL

12. TYPED NAME
Valerie A. Arkoosh, MD, MPH

13. TITLE
Secretary of Human Services

14. DATE SUBMITTED
December 2, 2025

15. 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 CMS USE ONLY

16. DATE RECEIVED
12/02/2025

17. DATE APPROVED
02/24/2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
10/01/2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Wendy E. Hill Petras

21. TITLE OF APPROVING OFFICIAL
Acting Director, Division of Program Operations

22. REMARKS

Instructions on Back

STATE REGULATION TO TRACK CLAIMS PAID WHEN A RECIPIENT IS INVOLVED IN AN ACCIDENT OR A TRAUMA RELATED INJURY

1902(a)(25) Effective January 1, 2009, the State's mechanized claims processing system PROMIS*e*™ began recognizing Supplementary Classification of External Causes of Injury and Poisoning (E Codes) when processing trauma claims and will begin to generate Trauma Code Tracking (TCT) questionnaires and increase accident recoveries. These E Codes are in addition to the trauma diagnosis codes 800 through 999 currently in use.

The State currently has a process in effect that monitors claims paid for certain diagnosis. This is to determine if the state may be able to seek payment from another party because of pending litigation or a primary insurance carrier liability. Section 1902(a)(25) of Title XIX of the Social Security Act (42 U.S.C. § 1396a(a)(25)) mandates the recovery of any funds paid by Medical Assistance (MA) when another resource is legally liable for those costs.

PROMIS*e*™ uses edits mandated by the federal government, hence, the TCT System. The Department reviews claims for trauma diagnosis codes based on most current diagnostic criteria coding system. The purpose of the edits is to review the claims, check for casualty accidents and other liable parties, and store TCT questionnaires to files.

In May 2007 the UB92 claim form was discontinued and replaced with the UB04. This revision included changes for institutional health care providers. The UB04 now recognizes the Supplementary Classifications of External Causes of Injury and Poisoning, otherwise known as E Codes.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

Calculation steps for Health Insurance Premium Payment Program (HIPP) Cost Effectiveness

1. Beneficiary information is retrieved from the Medical Assistance (MA) database and stored in HIPP operating system.
2. Benefit information, plan type, premium amount and premium frequency are entered by HIPP Operation Specialist (HOS) into the HIPP system.
3. The HOS calculates cost effectiveness of the case.
4. When calculating cost effectiveness, the HIPP system performs the following steps:
    a. Verifies that all required fields have been completed.
    b. Validates the information that has been entered.
    c. Calculates the MA beneficiary cost, for each beneficiary, by performing the following steps:
        i. Calculates the age group for the beneficiary using the beneficiary date of birth.
        ii. Determines which supplemental benefits (Dental, EPSDT, Prescription Drug, and Vision) the beneficiary is eligible for using the beneficiary sex, category and program status. This is also the point where the system will determine if the calculation for the beneficiary is to be skipped and the MA cost for beneficiary will not be factored into the calculation.
        iii. Calculates the MA cost for the beneficiary.
            1. The MA cost for each beneficiary is derived from the table of managed care rates. Based on the county that beneficiary lives in; the physical and behavioral health rates are retrieved. These amounts are added together and multiplied by 12 to obtain the MA cost. The rates are multiplied by 12 because the amounts stored in the HIPP system are monthly amounts.
            2. If the beneficiary is eligible for vision and the benefit plan does not offer vision, the managed care supplemental amount for vision is added to the HIPP costs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

3. If the beneficiary is eligible for dental and the benefit plan does not offer dental, the managed care supplemental amount for dental is added to the HIPP cost.
4. If the beneficiary is eligible for prescription drug and the benefit plan does not offer prescription drug, the managed care supplemental amount for prescription drug is added to the HIPP costs.
5. The managed care supplement amount for EPSDT is always added to the HIPP costs.
6. The supplemental rates are retrieved based on the beneficiary age.

d. All beneficiary MA costs are summed into the total MA cost.
e. The HIPP cost is calculated as follows:
   i. The premium amount is multiplied by the premium frequency: Monthly = 12, Bi-Weekly = 26, Weekly = 52, Semi-monthly = 24 and Quarterly = 4 to determine the annual premium amount.
   ii. For each benefit type on policy, the HIPP system calculates a deductible amount. All the deductible amounts are summed to determine the total deductible amount. If there is not a maximum deductible amount, the deductible amount is the number of eligible recipients multiplied by the minimum deductible. If there is a maximum deductible, then if the number of eligible beneficiaries multiplied by the minimum deductible is greater than the maximum deductible, then the maximum deductible is used, otherwise the lower amount used. This is added to the yearly premium amount.
   iii. The supplemental costs are added to HIPP cost.
f. The HIPP cost is compared to the total MA cost. If the HIPP cost is less than the total cost, the case is cost effective.