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State/Territory Name: Pennsylvania

State Plan Amendment (SPA) #: PA-11-022

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

SWIFT #121420114045

MAY 14 2012

Gary D. Alexander, Secretary
Department of Public Welfare
Commonwealth of Pennsylvania
Room 333 Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Alexander:

The Centers for Medicare & Medicaid Services (CMS) has finalized its review of Pennsylvania's State Plan Amendment (SPA) 11-022, which proposes to implement changes to dental benefits for adults 21 and older. Following our review, CMS finds the SPA approvable. Enclosed is a copy of the approved SPA and signed CMS-179 form. The effective date is September 30, 2011.

Please note that accompanying this approval, there is an enclosed companion letter addressing unrelated issues that arose in review of this SPA.

If you have any questions regarding this letter, please contact Gilson DaSilva at (215) 861-4181 or by e-mail at gilson.dasilva@cms.hhs.gov.

Sincerely,

/s/

Francis McCullough
Associate Regional Administrator

Enclosures

cc: Leesa Allen, OMAP
Jason Frandson, CMCS
De Earhart, CMS

Do you know someone who has been denied medical insurance because of a pre-existing condition? If so, they may be eligible for the new Pre-Existing Condition Insurance Plan. Call toll free 1-866-717-5826 (TTY 1-866-561-1604) or visit www.pcip.gov and click on "Find Your State" to learn more

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MAY 14 2012

Gary D. Alexander, Secretary
Department of Public Welfare
Commonwealth of Pennsylvania
Room 333 Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Alexander:

This letter is being sent as a companion to our approval of Pennsylvania's State Plan Amendment (SPA) 11-022 (Dental Benefit Changes). This SPA limits dental services to adults 21 and older. While we are proceeding with approval of PA SPA 11-022, 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 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 requires that the State Plan be a comprehensive written statement describing the nature and scope of the State's Medicaid Program and that it contains 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 (attached). Please revise the respective State Plan page to include the required detailed information.

Please respond to this letter within 90 days from the date noted above with a corrective action plan describing how you will resolve the issues identified above. During the 90-day period, we are available to provide any technical assistance you may need. State Plans that are not in compliance with requirements at 42 CFR 430.10 and 42 CFR 440.167 are grounds for initiating a formal compliance process.

If you have any questions regarding this letter, please contact Harry Mirach at (215) 861-4284. We look forward to working with you on these issues.

Sincerely,

/s/

Francis McCullough
Associate Regional Administrator

Enclosures

cc: Leesa Allen, OMAP
Jason Frandson, CMCS
De Earhart, CMS

EXHIBIT 1
Companion Letter Issues Related to PA SPA 11-022

REIMBURSEMENT ISSUES

Attachment 4.19-B, page 2:

Dental services are paid based on a "State Agency Fee Schedule Based on Established Criteria*." Please define the methodology or criteria used to base individual practitioner rates. Describe all factors in the rate setting process.

If the plan does not include this information because the State does not know how the rates were established, CMS requires that the following language be added:

> "Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of *(e.g., case management for persons with chronic mental illness)*. The agency's fee schedule rate was set as of *(insert date here)* and is effective for services provided on or after that date. All rates are published on the agency's website at *(e.g., on the agency's website)*."

Once the State specifies the factor used to update rates, no other adjustments may be made to the fee schedule without a SPA. The effective date language ensures that a State submits a State Plan Amendment when rates are adjusted and issues a public notice in accordance with 42 CFR 447.205.

The above language is not needed when:

- A state sets rates at a percentage of the Medicare fee schedule and follows the Medicare updates published by CMS, and language in the State Plan outlines the methodology;
- A state sets rates at a percentage of the Medicare fee schedule for a certain year (e.g., 2005) and trends those rates using an inflation factor identified in the Plan. The State Plan must identify that the rates are set as a percentage of the Medicare fee, and the year and inflation factors used to trend the data forward;
- A state includes a complete, comprehensive, and self-contained description of how the fee schedule was determined. The description must have enough information to determine the actual rate.

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: 11-022

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
September 30, 2011

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 USC 1396d(*l*)(1), (2); 42 CFR 440.100,

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 $ 0
b. FFY 2012 ($31,606,392)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pg. 1, 1i, 4h, and 5f, Attachment 3.1A
Pg. 2 and 2i, Attachment 3.1B

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Pg. 1, 1i, 4h, and 5f, Attachment 3.1A
Pg. 2 and 2i, Attachment 3.1B

10. SUBJECT OF AMENDMENT:
Dental Benefit Changes for Recipients 21 Years of Age and Older

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME:
Gary D. Alexander

14. TITLE:
Secretary of Public Welfare

15. DATE SUBMITTED: SEP 30 2011

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: Feb. 14, 2012

18. DATE APPROVED: MAY 14 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 9/30/2011

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Francis McCullough

Associate Regional Administrator/DMCHO

23. REMARKS:

FORM HCFA-179 (07-92)

	SERVICE		LIMITATIONS
2.A. (6)	Short Procedure Unit (SPU) Services (continued)	(9)	Diagnostic tests and procedures performed in a clinic or practitioner's office and diagnostic tests and procedures not related to the diagnosis.
		(10)	Services and items for which full payment is available through Medicare, other financial resources or other health insurance programs.
		(11)	Services and items not ordinarily provided to the general public.
		(12)	Diagnostic or therapeutic procedure solely for experimental, research or educational purposes.
		(13)	Services that are not listed under the Medical Assistance Fee Schedule.
		(14)	Services that are not medically necessary.
		(15)	Services provided in conjunction with an admission that is not certified under the Department's utilization review process for same day surgical services.
		(16)	Any medical services, procedures, or pharmaceuticals related to treating infertility.
2.b.	Rural Health Clinic Services	Limitations - The following limits apply to dental services:	
		(1)	Recipients 21 years of age and older are limited to one upper arch complete or partial denture, and one lower arch complete or partial denture, per lifetime. Additional dentures require a Benefit Limit Exception.
		(2)	Oral examination is limited to one per 180 days per recipient.
		(3)	Dental prophylaxis is limited to one per 180 days per recipient.
		(4)	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 for recipients 21 years of age and older.
		(5)	Benefit Limit Exception criteria are set forth in Attachment 3.1A, Section 10, Dental Services.
2.c.	Federally Qualified Health Center (FQHC) Services	Limitations - The following limits apply to dental services:	
		(1)	Recipients 21 years of age and older are limited to one upper arch complete or partial denture, and one lower arch complete or partial denture, per lifetime. Additional dentures require a Benefit Limit Exception.
		(2)	Oral examination is limited to one per 180 days per recipient.
		(3)	Dental prophylaxis is limited to one per 180 days per recipient.
		(4)	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 for recipients 21 years of age and older.
		(5)	Benefit Limit Exception criteria are set forth in Attachment 3.1A, Section 10, Dental Services.
3.	Other Laboratory and X-Ray Services	Limitations - Specific limits are set forth in the Medical Assistance Program Fee Schedule.	
		(1)	Payment will not be made for procedures relating to treating infertility.
4.a.	Hospital-Based Skilled Nursing Services	Limitations – All hospital-based nursing units must meet requirements as follows:	
	Please refer to Attachment 4.19 D For Reimbursement	(1)	The nursing unit must be composed of former acute care hospital beds that have converted to and certified for skilled nursing or intermediate care.
		(2)	The need for the beds must have been approved by the local health planning agency.

SERVICE	LIMITATIONS
10. Dental Services	Limitations- The following limits apply to compensable services for recipients 21 years of age and older: (1) Oral examination is limited to one per 180 days per recipient. (2) Dental prophylaxis is limited to one per 180 days per recipient. (3) [RESERVED] (4) [RESERVED] (5) [RESERVED] (6) Panoramic-maxilla or mandible, single film is limited to one per five years. (7) Prior authorization is required for all surgical extractions. (8) [RESERVED] (9) [RESERVED] (10) [RESERVED] (11) 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. (12) 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.

SERVICE	LIMITATIONS
Prescribed Drugs, Dentures, and Prosthetic Devices and Eyeglasses (Continued)	
12.b. Dentures	Limitations - The following limits apply to denture services: One (1) pair of complete and partial dentures per recipient per five (5) year period for recipients under 21 years of age. Limits are waived when medical necessity is documented for recipients under 21 years of age. Recipients 21 years of age and older are limited to one upper arch complete or partial denture, and one lower arch complete or partial denture, per lifetime. Prior authorization is required for complete or partial dentures. Additional dentures require a Benefit Limit Exception. Benefit Limit Criteria are set forth in Attachment 3.1A, Section 10, Dental Services. Denture relines, either full or partial, are limited to one arch, every two years.
12.c. Prosthetic and Orthotic devices	Limitations on payment- The following limits apply to services for prosthetic and orthotic devices: 1. Prior authorization is required for all prescribed prosthetic and orthotic devices. 2. Only recipients under 21 years of age are eligible for orthopedic shoes. 3. Orthopedic shoes and orthopedic devices are subject to the following limitations: (i) Four pairs of orthopedic shoes, either with or without, an attached leg brace per year. (ii) One pair of orthotic devices every three years for those eligible recipients 16 years of age or older. These are not compensable, however, if the recipient has received orthopedic shoes in the 365 days prior to provision of the orthotic device. (iii) Four pairs of orthotic devices every three years for those eligible recipients under 16 years of age. These are not compensable, however, if the recipient has received orthopedic shoes in the 365 days prior to provision of the orthotic device. (iv) Limits are waived when medical necessity is documented for recipients under 21 years of age.

SERVICE		LIMITATIONS	
2.A. (6)	Short Procedure Unit (SPU) Services (continued)	(8)	Dental cases involving oral rehabilitation or restorative services, except for procedures performed for treatment of a secondary diagnosis, unless: (i) The nature of the surgery or the condition of the patient precludes the procedure in the dentist's office. (ii) A physician or dentist has documented in the patient's medical record the medical justification for performing the procedure in a same day surgery setting.
		(9)	Diagnostic tests and procedures that can be performed in a clinic or practitioner's office and diagnostic tests and procedures not related to the diagnosis.
		(10)	Services and items for which full payment is available through Medicare, other financial resources or other health insurance programs.
		(11)	Services and items not ordinarily provided to the general public.
		(12)	Diagnostic or therapeutic procedures solely for experimental, research or educational purposes.
		(13)	Services that are not listed under the Medical Assistance Fee Schedule.
		(14)	Services that are not medically necessary.
		(15)	Services provided in conjunction with an admission that is not certified under the Department's utilization review process for same day surgical services.
		(16)	Any medical services, procedures, or pharmaceuticals related to treating infertility.
2.b.	Rural Health Clinic Services	Limitations - The following limits apply to dental services:	
		(1)	Recipients 21 years of age and older are limited to one upper arch complete or partial denture, and one lower arch complete or partial denture, per lifetime. Additional dentures require a Benefit Limit Exception.
		(2)	Oral examination is limited to one per 180 days per recipient.
		(3)	Dental prophylaxis is limited to one per 180 days per recipient.
		(4)	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 for recipients 21 years of age and older.
		(5)	Benefit Limit Exception criteria are set forth in Attachment 3.1A, Section 10, Dental Services.
2.c.	Federally Qualified Health Center (FQHC) Services	Limitations - The following limits apply to dental services:	
		(1)	Recipients 21 years of age and older are limited to one upper arch complete or partial denture, and one lower arch complete or partial denture, per lifetime. Additional dentures require a Benefit Limit Exception.
		(2)	Oral examination is limited to one per 180 days per recipient.
		(3)	Dental prophylaxis is limited to one per 180 days per recipient.
		(4)	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 for recipients 21 years of age and older.
		(5)	Benefit Limit Exception criteria are set forth in Attachment 3.1A, Section 10, Dental Services.