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 #030820134019

FEB 22 2013

Beverly Mackereth, Acting Secretary
Pennsylvania Department of Public Welfare
Room 333, Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Ms. Mackereth:

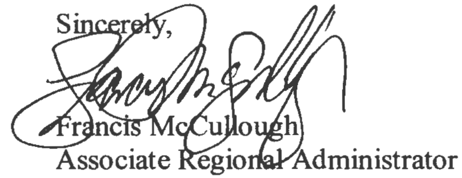
This letter is being sent as a companion to our approval of Pennsylvania's State Plan Amendment (SPA) 12-023. This amendment proposes to change the definition of usual and customary, decrease the dispensing fee from $4 to $2 for non-compounded drugs and from $5 to $3 for compounded drugs. This amendment also proposes to introduce a $0.50 dispensing fee for prescriptions when Medicaid is the secondary payer. While we are proceeding with approval of PA SPA 12-023, 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 Attachment 4.19-B, page 1, and found that additional clarification is necessary as outlined per Exhibit 1. Related to the analysis of the Attachment 4.19-B, CMS also performed an analysis of "limits on physician services" as provided in Attachment 3.1-A, page 2aa, item 5a and Attachment 3.1B, page 21, item 5a and found that additional clarification is necessary as outlined per Exhibit 2. Please revise the State Plan page/pages to include the required detailed information.

Please respond to this letter within 90 days from February 22, 2013 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. 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.

I trust that our request is clear. If you have any questions regarding this letter, please contact Mary McKeon of my staff at (215) 861-4181. We look forward to working with you on these issues.

Sincerely,



Francis McCullough
Associate Regional Administrator

Attachment: Exhibit 1 and Exhibit 2

cc: Daniel Sorge, DPW, Bureau of Policy, Analysis and Planning
De Earhart, CMS RO
Mark Ross, CMCS

EXHIBIT 1
PA Companion Letter Issues Related to PA SPA 12-023

REIMBURSEMENT ISSUES

Attachment 4.19-B, page 1:

See paragraph 1: Individual Practitioners, i.e. Physicians [limitations are discussed at Attachment 4.19-B, page 4b], Dentists [also referenced at Attachment 4.19-B, page 2b and limitations at 4b], Chiropractors, Optometrists, Podiatrists [limitations at page 4b]:

42 CFR 430.10 and 447.252 require that the State Plan contain a comprehensive description of the rate methodologies for Medicaid services. In review of Attachment 4.19-B, page 1 related to the review of PA 12-023 Pharmacy, CMS was unable to determine the payment methodology associated with physicians, dentists, chiropractors, optometrists, and podiatrists.

1. The following options are available to States to meet the requirements of 430.10 and 447.252 when reimbursing the aforementioned providers as related to a fee-for-service basis:

    - States can include the actual rates paid to providers in the State Plan. This option requires States to update the plan whenever changes are made.

    - States can include the precise formula in the State Plan for how rates are set, assure that all providers are paid the same, and reference the published location of the rates. The rate-setting formula must refer to a recognized standard for rate-setting (such as Medicare Resource-Based Relative Value Scale (RBRVS)) or a base rate (i.e. $20 per 15 minute unit as of July 1, 2012) and an inflation factor (the exact percentage, or a nationally recognized factor) used to update rates on a regular basis (i.e. annually, on January 1). Most States' rates are adjusted based on a legislative appropriation but that is not a comprehensive description of a payment methodology.

    - A State may identify in the plan the "effective date" (see below) of a fee schedule. The language requires States to include the date that rates were initially set in the plan. States must submit plans to change the date as subsequent rate adjustments occur. The language also identifies the published location of the fee schedule. Most States adjust rates annually or quarterly, which would require that a State merely change the "effective" date for the fee schedules. For States that have multiple rate changes for a service in a quarter, we have developed language that considers all rate changes made within the quarter.

    "Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of *(ex. 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 *(ex. on the agency's website)*."

2. The limitations outlined per Attachment 4.19-B, page 4b should be referenced in the rate methodology.
3. The State Plan language must also identify the unit of service.

EXHIBIT 2
PA Companion Letter Issues Related to PA SPA12-023

COVERAGE ISSUES

There is a limit of 2 inpatient physician consultations per hospitalization. How does a *payment* or compensable services limit differ from a *coverage* limit; are they different? Please help us to better understand how this limit works and if it can be exceeded based on medical necessity:

1. When you refer to consultations are you referring to services separate from the attending physician? Does this limit to no more than two (2) consults apply to each *specialist*? For example, a dermatologist cannot be paid multiple consults per admission? Or, does the limit apply across different specialists such as only one dermatologist and one gastroenterologist consult which could preclude a third consult by a cardiologist? Would this limit primarily affect people who have complex conditions including comorbid conditions? If so, how does this limit not violate regulations at 42 CFR 440.230(c)? When a patient is admitted for treatment, how is this limit implemented and what affect does this limit have on the beneficiary's quality of care, if a third consultation is medically necessary but not authorized? If the attending physician requests a third consultation, is a third consult never reimbursed or can it be authorized if certain medical necessity criteria is met, presumably this would occur with prior or post approval based on medical necessity criteria? Or, is a third consultation never considered medical necessary? What are the circumstances for potentially exceeding this limit of 2 consults per admission?

2. How did the state determine the two consult limit, what model did you use? How do you know that if this limit is sufficient to meet the needs of the majority of the patients as required by 42 CFR 440.230(b), especially those that are elderly or disabled or who have comorbid health conditions? If this limit not to reimburse for more than two consultations cannot be exceeded based on medical necessity, do you have any recent Medicaid Management Information System (MMIS) data that would specifically demonstrate that 90% of the Supplemental Security Income (SSI) Aged, Blind, and Disabled eligibility group are being fully served by this limit? Such data should separate out the comorbid population in the analysis. If available, specific eligibility data for pregnant women, adults and caretaker relative should also be included.

3. If a third (presumably medically necessary) consult is provided but not authorized, can this non-payment/coverage policy potentially influence the way a provider furnishes medically necessary services; will the attending physician be less likely to receive a third consultation knowing that coverage/payment will not be made for that third consultation? How will the consulting practitioner know that this is the attending physician's third consultation? What happens when complications arise, or the patient's condition deteriorates and needs more additional consults after already using two, or where the individual is admitted and is already very ill? Who makes these decisions or is the third consult routinely denied and is the third consult charged as charity care? Do all hospitals follow the same procedures? Is this done prospectively? It appears potential denial of reimbursement means denial of coverage in that the third consult is not provided—is that correct? If the third consultation is furnished but not reimbursed, does the consulting provider absorb the cost or can the beneficiary be billed for the third non-covered, non-reimbursed consultation? Are hospitals instructing staff not to provide needed inpatient care by a physician because payment is not available for such consultations? If that is occurring, the hospital may be jeopardizing its own certification and right to payment.

4. However, if this consultation limit of two per hospitalization *can* be exceeded and is being implemented based on medical necessity criteria and utilization control procedures authorized in Federal regulations at 42 CFR 440.230(d), then the State should indicate in the State Plan pages in item 5a that more than two consultations per hospitalization may be provided and reimbursed (with prior/post authorization) based on medical necessity criteria established by the state in provider manuals, regulations or policy. That medical necessary criteria should not be reflected in the State Plan pages as this authority is delegated to the State Medicaid Agency and is not criteria that CMS generally approves.

5. Depending on the State's responses to the foregoing, CMS may have additional follow-up questions.