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State/Territory Name: Pennsylvania

State Plan Amendment (SPA) #:PA-13-005A

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

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

SWIFT #052920134036

JUN 25 2014

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

Dear Secretary Mackereth:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Pennsylvania's (PA) State Plan Amendment (SPA) PA-13-005A relating to home health, transportation, dental, rural health clinic, federally qualified health center and Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

However, during the SPA review process, CMS performed an analysis of the reimbursement pages 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.

This SPA is approved with an effective date of April 1, 2013. Enclosed are:

1. The CMS Summary Page (CMS-179 form); and
2. The approved State Plan pages for PA-13-005A.

If you have any questions, please contact Mary McKeon at 215-861-4181.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

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

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

Dear Secretary Mackereth:

This letter is being sent as a companion to our approval of PA's State Plan Amendment (SPA) 13-005A. PA-13-005A corrected issues, in part, noted in a previous companion letter dated November 9, 2012 associated with SPA PA-12-028 – Dental Services. While we are proceeding with approval of SPA PA-13-005A, 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 coverage 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

Exhibit 1

Targeted Service Management (TCM) for Persons with MR:

Given that the subject state plan coverage pages were most recently approved in January 1990, CMS is sharing the attached outline (See attached Supplement 1 to Attachment 3.1-A) that reflects updated regulatory requirements around the provision of targeted case management within the Medicaid program. The State may use the outline as a guide to identify the necessary components of TCM benefit that must be described on all TCM coverage pages.

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

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.]

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ **[insert a number; not to exceed 180]** 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):
___ 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.
___ 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;

  [Specify and justify the frequency of assessments.]

- 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;
  - 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

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

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

- 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. **[Specify the type of monitoring and justify the frequency of monitoring.]**

___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)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

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: ___

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [**Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

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).

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

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

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

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))

[Specify any additional limitations.]

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: 13-005A

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
April 1, 2013

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 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $0.00
b. FFY 2014 $0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment A3.1-A: 3b, 3c and 9a
Attachment A3.1-B: 3d and 8a
Attachment 4.19B: 2bb, 2bbb, 2bbbbb, 2c, 2cc and 3

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

Attachment A3.1-A: 3b, 3c and 9a
Attachment A3.1-B: 3d and 8a
Attachment 4.19-B: 2c and 3

10. SUBJECT OF AMENDMENT:
Home Health Services, Transportation, Dental Services, Rural Health Clinic Services, Early and Periodic Screening Diagnosis, and Treatment Program (EPSDT) and Federally Qualified Health Center Services

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:
Beverly D. Mackereth

14. TITLE:
Secretary of Public Welfare

15. DATE SUBMITTED: JUN 17 2014

16. RETURN TO:
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Policy, Budget and Planning
P.O. Box 2675
Harrisburg, Pennsylvania 17110

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JUN 25 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
APR 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
FRANCIS McCULLOUGH

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR

23. REMARKS:

FORM HCFA-179 (07-92)

SERVICE	LIMITATION
7. Home Health Services	
7.a. Intermittent or part-time nursing service provided by a licensed home health agency or by a registered nurse when no home health agency exists	Limitations – The following limits apply: 1. 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 60 days. 2. [Reserved] 3. [Reserved] 4. [Reserved] 5. 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.b. Home health aide services provided by a licensed home health agency.	Limitations – The following limits apply: Subject to the same limitations and provider qualifications as listed in item 7a.

	SERVICE	LIMITATION
7.	Home Health Services (continued)	
7.c.	Medical supplies, equipment and appliance suitable for use in the home.	Limitations – The following limits apply: 1. [Reserved] 2. [Reserved] 3. Prior authorization is required for rental of all medical appliances or equipment for periods exceeding six months. The Department also requires prior authorization for the rental of some medical appliances or equipment at the initial month's rental or after a period of less than six months. The Department announces prior authorization requirements by notice in the Pennsylvania Bulletin and in Medical Assistance Bulletins. In addition, the MA Program Fee Schedule provides a complete listing of the medical appliances and equipment that require prior authorization. 4. 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 specific appliances or equipment that cost less than six hundred dollars ($600). The MA Program Fee Schedule provides a complete listing of the medical appliances and equipment that require prior authorization. 5. 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. The prescriber must still complete and submit the prior authorization request for Department review. This request will be reviewed in the same manner as a prospective request for prior authorization. If the beneficiary's circumstances did not constitute an emergency situation and the authorization request is denied, the provider will not be paid for the service or item provided.
7.d.	Physical therapy, occupational therapy, or speech pathology and audiology services provided by a licensed home health agency.	Limitations – The following limits apply: 1. Subject to the same limitations listed on item 7a. 2. The service must be performed by a physical therapist, occupational therapist, speech pathologist or audiologist who is currently licensed to practice in the Commonwealth and comply with 42 CFR 440.110.
8.	Private duty nursing services	Limitations – The service is limited to individuals under 21 years of age for treatment of physical or mental problems identified during EPSDT screenings and requires prior authorization.

Service	Limitation
24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.	
a. Transportation 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 patient'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 patient'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.

SERVICE	LIMITATIONS
7. Home Health Services	
7.a. Intermittent or part-time nursing service provided by a licensed home health agency or by a registered nurse when no home health agency exists	Limitations – The following limits apply: 1. 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 60 days. 2. [Reserved] 3. [Reserved] 4. [Reserved] 5. 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.b. Home health aide services provided by a licensed home health agency.	Limitations – The following limits apply: Subject to the same limitations and provider qualifications as listed in item 7a.
7.c. Medical supplies, equipment and appliance suitable for use in the home.	Limitations – The following limits apply: 1. [Reserved] 2. [Reserved] 3. Prior authorization is required for rental of all medical appliances or equipment for periods exceeding six months. The Department also requires prior authorization for the rental of some medical appliances or equipment at the initial month's rental or after a period of less than six months. The Department announces prior authorization requirements by notice in the Pennsylvania Bulletin and in Medical Assistance Bulletins. In addition, the MA Program Fee Schedule provides a complete listing of the medical appliances and equipment that require prior authorization. 4. Prior authorization is required for the purchase of all appliances or equipment that cost more than six hundred dollars ($600). Prior authorization is also required for the purchase of some appliances or equipment that cost less than six hundred dollars ($600). The MA Program Fee Schedule provides a complete listing of the medical appliances and equipment that require prior authorization.
7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a licensed home health agency.	Limitations – The following limits apply: 1. Subject to the same limitations listed on item 7a. 2. The service must be performed by a physical therapist, occupational therapist, speech pathologist, or audiologist who is currently licensed to practice in the Commonwealth and comply with 42 CFR 440.110.

Service	Limitation
22. Respiratory care services (in accordance with Section 1902(e)(9)(A) through (C) of the Act).	Limitations – This service is limited to individuals under 21 years of age for treatment of physical or mental problems identified during EPSDT screenings and requires prior authorization.

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

a. Transportation

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 patient'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 patient'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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS RATES-OTHER TYPES OF CARE

SERVICE	LIMITATIONS
4. Dental Services	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services. The agency's fee schedule (rate) was last updated on September 30, 2011, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm

METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS RATES-OTHER TYPES OF CARE

SERVICE	LIMITATIONS
5. Home Health Services	Established fee per visit and mileage allowance. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home health services. The agency's fee schedule (rate) was last updated on July 1, 2008, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm. Payment Limitations (1) Only one fee will be paid per home health agency visit. Payment for a visit pertains to a separate service, by a separate caregiver, to a recipient. More than one visit can be billed for the same recipient on the same day but only for separate care. (2) Payment for a postpartum visit includes payment for care provided to the newborn child. (3) Payment for hypodermic or intramuscular therapy provided during a home visit is included in the visit fee. (4) Home health agencies are limited to payment for medical/surgical supplies listed in the fee schedule. (5) Home health agencies are not reimbursed for supplies routinely needed as part of furnishing home health care. Provider qualifications are located in Attachments 3.1-A, page 3b and 3.1-B, page 3d.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS RATES-OTHER TYPES OF CARE

SERVICE	LIMITATIONS
7. Rural Health Clinic Services	Payment is made on the basis of an all-inclusive visit fee established by the Department. See page 2c for descriptions of the prospective payment system (PPS) and supplemental payments under managed care.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS RATES-OTHER TYPES OF CARE

SERVICE	LIMITATIONS
8. Federally Qualified Health Center Services	For core services, payment is made on the basis of an all-inclusive visit fee established by the Department. See below for descriptions of the PPS and supplemental payments for managed care enrollees.

Prospective Payment System

a. For the period January 1, 2001, through September 30, 2001, the Department will pay FQHCs/RHCs, on a per visit basis, 100% of the average of their audited reasonable costs related to the provision of Medicaid covered services during Fiscal Years 1999 and 2000, adjusted to account for any increase or decrease in the scope of services furnished by the FQHC/RHC during Fiscal Year 2001.

b. Beginning October 1, 2001, and for each fiscal year thereafter, the Department will pay FQHCs/RHCs, on a per visit basis, the amount paid for the preceding fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care services for the current fiscal year, adjusted to take into account any increase or decrease in the scope of such services furnished by the FQHC,RHC during that fiscal year.

c. For FQHCs/RHCs newly qualified after the fiscal year 2000, the Department will pay for the initial year, on a per visit basis, 100% of the reasonable costs related to provision of Medicaid-covered services of other centers/clinics located in the same or adjacent areas with similar caseloads. In the absence of such other centers/clinics, the Department will use the FQHC's/RHC's cost report to set the rate. For the next fiscal year, the Department will pay, on a per visit basis, the amount paid for the initial year, adjusted to reflect the actual audited reasonable costs of the FQHC/RHC, increased by the percentage increase in the MEI applicable to primary care services for the current fiscal year and adjusted to take into account any increase or decrease in the scope of such services furnished by the FQHC/RHC during that fiscal year. For subsequent fiscal years, the Department will use the payment methodology set forth in (b) above.

Supplemental Payments

The Department will pay FQHCs and RHCs directly, on a quarterly basis, an amount which represents the difference, if any, between the amounts paid by managed care organizations (MCOs) to FQHCs and RHCs for services provided to MCO enrolled medical assistance recipients and the payment to which the FQHC/RHC would be entitled for these services under the PPS payment method. The Department's contracts with MCOs require the MCO payments to FQHCs and RHCs be no less than the level and amount of payments the MCOs would make for such services if they were furnished by a provider other than an FQHC or and RHC.

The Department will use FQHC's and RHC's audited cost report to reconcile the amount of these supplemental payments, and for FQHCs only, to reconcile the amount paid for dental services.

Case Management Fees

The Department will pay case management fees during the first year of an FQHC's or RHC's participation in a primary care case management (PCCM) system. Thereafter, the Department will use the FQHC's/RHC's audited cost report to adjust the payment, on a per visit basis, to take into account the FQHC's/RHC's costs for participation in the PCCM system. Any PCCM fees paid after the initial year will offset the FQHC's/RHC's overall costs.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENTS RATES-OTHER TYPES OF CARE

SERVICE	LIMITATIONS
9. Early and Periodic Screening Diagnosis, and Treatment Program (EPSDT)	Payment for non-state plan services for treatment of physical or mental problems identified during EPSDT screenings will require prior authorization and will be reimbursed on an established fee for service basis. The prior approval process does not pertain to drug, medical supplies, durable medical equipment, prosthetics or orthotics which have been extended to medically needy individuals under the age of twenty-one as a result of OBRA '89.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—OTHER TYPES OF CARE

CARE OR SERVICE	POLICY/METHODS USED TO ESTABLISH PAYMENT RATES
10. Prosthesis, Appliances, Medical Equipment and Supplies	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of prosthesis, appliances, medical equipment and supplies. The agency's fee schedule (rate) was last updated on December 10, 2012, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm. State Agency Fee Schedule Based on Established Criteria.* 1. One (1) month's rental fee will be applied to the purchase price of durable medical equipment. 2. Home health agencies are not reimbursed for supplies routinely needed as part of furnishing home health care.
11. Laboratory and X-ray Services	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of laboratory and x-ray services. The agency's fee schedule (rate) was last updated on December 10, 2012, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm. State Agency Fee Schedule Based on Established Criteria.*
12. Public and Private Skilled Nursing Facility Services	See Attachment 4.19-D.
13. Public and Private Intermediate Care	See Attachment 4.19-D.
14. ICF/MR (Intermediate Care Facility Services for the Intellectually Disabled)	See Attachment 4.19-D.
15. Screening Services	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of screening services. The agency's fee schedule (rate) was last updated on June 14, 2010, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm. State Agency Fee Schedule Based on Established Criteria.*
16. Outpatient Hospital Services	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule (rate) was last updated on June 5, 2012, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm. State Agency Fee Schedule Based on Established Criteria.* Hospitals that qualify for disproportionate share payments as per attachment 4.19A, Part III.
17. Inpatient Psychiatric Services	See Attachment 4.19-A.
18. Birth Center Services	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of birth center services. The agency's fee schedule (rate) was last updated on March 1, 2006, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm State Agency Fee Schedule Based on Established Criteria.*
19. Targeted service management for persons with intellectual disabilities	See Attachment 4.19B Page 8