AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

1. Inpatient Hospital services other than those provided on an institution for mental diseases.
2a. Outpatient Hospital services
2b. Rural Health Clinic (RHC) services and other ambulatory services furnished by a RHC.
2c. Federally Qualified Health Center (FQHC) and other ambulatory services furnished by a FQHC
2d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.
3. Other Laboratory and X-ray services.
4. Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease), EPSDT, and family planning services and supplies.
4a. Nursing Facility services
4b. EPSDT services for individuals under age 21
4c. Family Planning services and supplies
4d. Tobacco Cessation Counseling Services for Pregnant Women
5. Physicians' services – Office, Home, Hospital, Skilled Nursing Facility or elsewhere
5a. Physician's services
5b. Medical and surgical services furnished by a dentist
6. Medical and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law
6a. Podiatrists' services
6b. Optometrists' services
6c. Chiropractors' services
6d. Other Practitioners' Services
7. Home Health services
7a. Intermittent or part-time nursing service provided by a licensed home health agency or by a registered nurse when no home health agency exists
7b. Home health aide services provided by a licensed home health agency
7c. Medical supplies, equipment and appliances suitable for use in the home
7d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a licensed home health agency
8. Private Duty Nursing services
9. Clinic services
9a. Independent Medical Clinic Services
9b. Psychiatric Clinic Services
9c. Drug and Alcohol and Methadone Maintenance Clinic Services
9d. Renal Dialysis Services
9e. Ambulatory Surgical Center (ASC) Services
10. Dental services
11. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
11a. Physical Therapy
11b. Occupational Therapy
11c. Services for individuals with speech, hearing, and language disorders.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

12. Prescribed drugs, dentures, prosthetic devices, and eyeglasses
12a. Prescribed drugs
12b. Dentures
12c. Prosthetic devices
12d. Eyeglasses
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan
13a. Diagnostic services
13b. Screening services
13c. Preventive services
13d. Rehabilitative services
14. Inpatient hospital services, Nursing facility services, and Intermediate Care Facility (ICF) services for individuals age 65 or older in institutions for mental diseases.
14a. Nursing facility services for individuals age 65 or older in Institutions for Mental Disease
15a. Intermediate care facility services for individuals with intellectual disability (ICF/IID) and for other related conditions (ORC) (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.
15b. Including such services in a public institution (or distinct part thereof) for individuals with intellectual disability or persons with related conditions.
16. Inpatient psychiatric services for individuals under age 21
17. Nurse-midwife services
18. Hospice services
19. Case management services and Tuberculosis related services
20. Extended services for pregnant women
21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider
22. Respiratory care services
23. Nurse Practitioner services
24. Any other medical care or remedial care recognized under State law, specified by the Secretary
24a. Transportation
24b. Services provided in religious nonmedical health care institutions.
24c. Nursing facility services for beneficiaries under age 21
24d. Emergency hospital services
24e. Personal care services in a beneficiary's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse
25. Case management services
26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1A
27a. Licensed or Otherwise State-Approved Freestanding Birth Center Services
27b. Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

1. Limitations do not apply to those beneficiaries who are pregnant

2. The following medical services are not covered through the Medical Assistance Program:

    a. Any medical services, procedures, or pharmaceuticals related to treating infertility.
    b. Surgical, medical, diagnostic or therapeutic procedures performed solely for experimental, research, or educational purposes.
    c. Acupuncture.
    e. Gastroplasty for morbid obesity, gastric stapling, or ileo-jejunal shunt- except when all other types of treatment of morbid obesity have failed.
    f. Cosmetic surgery- unless performed to improve the functioning of a malformed body member, to correct a visible disfigurement which would affect the ability of the person to obtain or hold employment, or as post mastectomy breast reconstruction.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

1. Inpatient hospital services other than those provided on an institution for mental diseases.

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

2a. Outpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

2b. Rural Health Clinic (RHC) services and other ambulatory services furnished by a RHC.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

2c. Federally Qualified Health Center (FQHC) and other ambulatory services furnished by a FQHC.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

2d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

3. Other Laboratory and X-ray services.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

4a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

4b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

SERVICES

1. Inpatient Hospital Services (42 CFR 440.10)

Limitations

(a) Each beneficiary is limited to two (2) periods of therapeutic leave per calendar month. Neither of these periods of therapeutic leave may exceed twelve (12) hours in a calendar day.

Exception: Beneficiaries receiving care in an acute care general hospital's extended acute care psychiatric unit approved by the Department are limited to seven (7), twelve (12) hour periods of therapeutic leave per month which may be used consecutively.

(b) Prior Authorization is required for elective admissions to determine medical necessity. Automated Utilization Review is completed for emergency and urgent inpatient admissions.

(c) The Department determines beneficiary eligibility for compensable transplant procedures in accordance with written standards, which are applied uniformly to similarly situated beneficiaries.

General Considerations for Organ Transplantation

1. Services are available to beneficiaries under the age of 21 as required by the Omnibus Budget Reconciliation Act of 1989 (OBRA-89).
2. Organ transplantation will be covered if the Department agrees the procedure is medically necessary and no alternative medical treatment is available.
3. The organ transplantation must be utilized for the management of end stage disease as a recognized standard of treatment in the medical community AND must not be of an investigational or experimental nature.
4. All organ transplants must be prior authorized before evaluation occurs OR if the beneficiary is new to MA and already on the United Network for Organ Sharing (UNOS) transplantation list.
5. All organ transplants must be done in facilities that are a CMS Medicare approved program for the particular organ. If a combination transplant is performed, that facility must be Medicare approved for all types of organs being transplanted (42 CFR 482.1 – 482.57).

SERVICES

1. Inpatient Hospital Services (42 CFR 440.10) (continued)

Limitations - continued

(d) continued

General medical indications for specific organ transplants are as follows:

Kidney - Kidney transplantation is determined to be medically necessary when there is medical documentation of chronic end stage renal disease and no absolute contraindication to kidney transplantation.

Heart - Based on the medical necessity guidelines from the American College of Cardiology/American Heart Association (ACC/AHA).

Heart/Lung - Based on the joint medical necessity guidelines from the American Thoracic Society, American Society for Transplant Physicians and the International Society for Heart and Lung Transplantation (ISHLT).

Lung - Based on the medical necessity guidelines from the International Society for Heart and Lung Transplantation (ISHLT).

Liver - Based on the medical necessity guidelines from the Clinical Practice Committee of the American Society of Transplantation and the United Network for Organ Sharing (UNOS).

Pancreas - Based on the medical necessity guidelines from the American Diabetes Association and the American Society for Transplant Physicians.

Pancreas/Kidney - Pancreatic/kidney transplantation is primarily performed on diabetics with end stage renal disease. Based on the medical necessity guidelines from the American Diabetes Association and the American Society of Transplantation.

Intestinal - Based on the medical necessity guidelines from The American Society of Transplantation, the American Gastroenterological Association and the Centers for Medicare and Medicaid Services.

Corneal - Corneal transplantation of autologous or donor limbal stem cells is determined to be medically necessary when there is documentation in the medical record of limbal stem cell deficiency which is refractory to conventional treatments.

Hematopoietic Stem Cell Transplantation from Bone Marrow or Peripheral Stem Cells -

Hematopoietic stem cell transplantation (HSCT) is defined as the administration of hematopoietic stem cells from sources such as bone marrow, peripheral blood, or umbilical cord blood. Autologous HSCT (auto-HSCT) uses hematopoietic progenitor cells derived from the individual with the disorder while allogeneic HSCT (allo-HSCT) uses hematopoietic stem cells from someone other than the individual receiving the transplant. Based on the medical necessity guidelines from The American Society for Blood and Marrow Transplantation, certain conditions can be treated with either autologous HSCT or allogeneic HSCT. For specific conditions medically necessary treatment may be with only autologous HSCT or only allogeneic HSCT.

SERVICES

2.a. (1) Outpatient Hospital Services (42 CFR 440.20(a)(3))

Prior authorization is required for an admission for same day surgical services.

(2) Psychiatric Partial Hospitalization (42 CFR 440.20(a)(3))

Psychiatric Partial Hospitalization is an active outpatient psychiatric day or evening treatment session. The services are provided by an approved Psychiatric Partial Hospitalization provider. The following is a description of the service components and professional qualifications. These service components are provided to the individual, if necessary, in accordance with their individualized care plan:

- **Individual, Group, and Family psychotherapy**

  - Individual Therapy: Psychotherapy provided to one person with a diagnosed mental disorder
  - Group Therapy: Psychotherapy provided to no less than two and no more than ten persons with diagnosed mental disorders
  - Family Therapy: Psychotherapy provided to two or more members of a family. At least one family member shall have a diagnosed mental disorder

  Psychotherapy can be provided by any of the following professionals:

  a) Psychiatrist: A physician who has completed a 3 year residency in psychiatry and is licensed to practice in the state.
  b) Psychologist: A person licensed to practice psychology in the state.
  c) Outpatient Mental Health Professional: A person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology, nursing or rehabilitation or activity therapies; who has a graduate degree and one year of mental health clinical experience.

- **Health Education:** Include basic physical and mental health information; nutrition information and assistance in purchasing and preparing food, personal hygiene instruction, basic health care information, child care information and family planning information and referral and information on prescribed medications. Health Education can be provided by any of the following professionals:

  a) Psychiatrist
  b) Psychologist
  c) Outpatient Mental Health Professional
  d) Mental Health Worker: A person with a minimum of a bachelor's degree in a generally recognized clinical discipline including psychiatry, social work, psychology, nursing, rehabilitation or activity therapies, acting under the direction of the mental health professional to implement an element of
  e) Registered Nurse: An individual licensed by the State Board of Nursing to practice professional nursing
  f) Licensed Practical Nurse: A person who is a graduate of a school approved by the State Board of Nursing.

2.a. (2) Psychiatric Partial Hospitalization (42 CFR 440.20(a)(3)) (continued)

- **Instruction in basic care of the home or residence for daily living**: This includes guidance that helps the individual to care for their home and perform regular household chores to maintain a healthy and safe living environment. This can be provided by any of the following professionals - Psychiatrist, Psychologist, Outpatient Mental Health Professional, Mental Health Worker, Registered Nurse, or Licensed Practical Nurse.

- **Instruction in basic personal financial management for daily living:** This includes basic instruction on budgeting, money management and related areas to help the individual have the financial stability to achieve the goals identified in the care plan. This can be provided by any of the following professionals - Psychiatrist, Psychologist, Outpatient Mental Health Professional, Mental Health Worker, Registered Nurse, or Licensed Practical Nurse

- **Medication Management:** This involves administration of a drug and evaluation of the individual's physical and mental condition during the course of prescribed medication. This can be provided by any of the following professionals - Psychiatrist, Physician, Registered Nurse, or Licensed Practical Nurse.

- **Guidance on Social Skills**: This includes providing guidance to communicate and interact with other members of the society without undue conflict or disharmony. This can be provided by any of the following professionals - Psychiatrist, Psychologist, Outpatient Mental Health Professional, Mental Health Worker, Registered Nurse, or Licensed Practical Nurse.

- **Crisis Management:** This includes counseling and intervention to assist individuals in the management of the crises that they are experiencing due to psychiatric events or psychological issues. This can be provided by any of the following professionals - Psychiatrist, Psychologist, Outpatient Mental Health Professional, Mental Health Worker, Registered Nurse, or Licensed Practical Nurse.

- **Referral:** This includes activities that assist in linking the individual with medical, social and educational providers, or other programs and services that are capable of providing the needed services identified in the care plan. This can be provided by any of the following professionals - Psychiatrist, Psychologist, Outpatient Mental Health Professional, Mental Health Worker, Registered Nurse, or Licensed Practical Nurse.

SERVICES

2a. (3) Short Procedure Unit (SPU) Services (42 CFR 416.2)

Prior authorization is required for an admission for same day surgical services.

SERVICES

RESERVED

SERVICES

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SERVICES

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SERVICES

2.b. Rural Health Clinic Services (42 CFR 440.20(b))

Rural Health Clinic (RHC) services are defined in section 1905(a)(2)(B) of the Social Security Act. RHC services include services provided by practitioners identified in section 1861(aa)(1) of the Social Security Act, which includes physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and visiting nurses and other ambulatory services. RHC services also include services and supplies that are furnished as incident to professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, clinical psychologist or clinical social worker and, for visiting nurse care, related medical supplies other than drugs and biologicals. Other ambulatory services are services provided by podiatrists, optometrists, audiologists, dentists, dental hygienists, chiropractors, licensed professional counselors, licensed marriage and family therapists, physical therapists, occupational therapists and speech-language pathologists.

Limitations

Limitations on other ambulatory services furnished in the RHC are the same as defined for those services in the State Plan.

SERVICES

RESERVED

SERVICES

2c. Federally Qualified Health Center Services (1905(a)(2)(C) of the Social Security Act)

Federally Qualified Health Centers (FQHC) services are defined in sections 1905(a)(2)(C) of the Social Security Act. FQHC services include services provided by practitioners identified in section 1861(aa)(3) of the Social Security Act, which includes physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and visiting nurses, and other ambulatory services. FQHC services also include services and supplies that are furnished as incident to professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, clinical psychologist, or clinical social worker and, for visiting nurse care, related medical supplies other than drugs and biologicals. Other ambulatory services are services provided by podiatrists, optometrists, audiologists, dentists, dental hygienists, chiropractors, licensed professional counselors, licensed marriage and family therapists, physical therapists, occupational therapists and speech-language pathologists.

Limitations

Limitations on other ambulatory services furnished in the FQHC are the same as defined for those services in the State Plan.

3. Other Laboratory and X-Ray Services (42 CFR 440.30)

Provider Qualifications

1. The provider must have a current appropriate level of Clinical Laboratory Improvement Amendments (CLIA) certification for the laboratory tests performed at the physical address where the laboratory service is provided.

   Exemption: Not-for-profit or Federal, State or local government laboratories that engage in limited (not more than a combination of fifteen (15) moderately complex or waived tests per certificate) public health testing may have a single CLIA certification for multiple physical addresses where the laboratory service is provided.

SERVICES

4b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

All individuals under the age of 21 will receive all medically necessary services coverable under 1905(a), regardless of whether the service is otherwise covered under the state plan.

SERVICES

RESERVED

4.b.1 Services provided by School-Based Service Providers

Services are only provided to beneficiaries under 21 years of age.

Services provided by school-based service providers, known as the School-Based ACCESS Program (SBAP) in Pennsylvania, are provided or purchased by Local Education Agencies (LEAs) that are government units enrolled in the Medical Assistance (MA) Program to MA-eligible beneficiaries for whom the service is medically necessary and documented in the Individualized Education Program (IEP). LEAs that are government units include school districts, charter schools, intermediate units, vocational-technical schools and preschool early intervention programs. LEAs are enrolled in the MA Program as the qualified providers of service. Direct services must be delivered by qualified provider types, as identified below.

School-Based Rendering Providers Qualifications and Service Definitions

Assistive Technology Devices (42 CFR 440.70(b)(3))

Definition:

An assistive technology device (ATD) is any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability and prescribed by a physician.

Qualified Provider Types:

ATDs are obtained by the LEA from a licensed medical supplier.

Nursing Services (42 CFR 440.60(a))

Definition:

Nursing services are professional services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and relevant to the medical needs of the beneficiary provided through direct interventions that are within the scope of the professional practice of a Registered Nurse (RN) or Licensed Practical Nurse (LPN) during a face-to-face encounter and on a one-to-one basis.

Limitation:

Nursing services provided must be documented in a service log.

Qualified Provider Types:

Nursing services are provided by a currently licensed RN, currently licensed LPN, or currently licensed Certified Registered Nurse Practitioner (CRNP).

Nurse Practitioner Services (42 CFR 440.166 and 440.60)

Definition:

Nurse practitioner services are services provided within their scope of practice.

Qualified Provider Types:

Nurse practitioner services are provided by a currently licensed CRNP.

Occupational Therapy Services (42 CFR 440.110(b))

Definition:

Occupational therapy services are services, including necessary supplies and equipment as well as direct assistance with the selection, acquisition, training, or use of an ATD, prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided in an individual or group setting by or under the supervision of a currently licensed occupational therapist within the scope of his or her professional practice.

Qualified Provider Types:

Occupational therapy services are provided by or under the supervision of a currently licensed occupational therapist.

The standards for supervision by a licensed occupational therapist are set forth in state law, currently codified at 49 Pa.Code § 42.22 (relating to supervision of occupational therapy assistants). Supervision is conducted and documented by the licensed occupational therapist.

Orientation, Mobility and Vision Services (42 CFR 440.130(d))

Definition:

Orientation, mobility and vision services are restorative in nature for maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level in accordance with the rehabilitation benefit at 42 CFR 440.130(d). Orientation, mobility, and vision services provide sequential instruction to individuals with visual impairment in the use of their remaining senses to determine their position within the environment and in techniques for safe movement from one place to another to maintain independent lives. These services are prescribed by a physician or other licensed practitioner of the healing arts within their scope of practice under law and provided by an Orientation and Mobility Specialist in an individual setting.

Qualified Provider Types:

Orientation, mobility and vision services are provided by an individual who is certified as an Orientation and Mobility Specialist.

Personal Care Services (42 CFR 440.167)

Definition:

Personal care services are prescribed by a physician in accordance with a plan of treatment, or otherwise authorized for the individual in accordance with a service plan approved by the State and provided on a one-to-one basis to treat physical or mental impairments or conditions.

Qualified Provider Types:

Personal care services are provided by an individual who is not a legally responsible relative and who is 18 years of age or older and possesses a high school diploma or general equivalency diploma, a current certification in first aid, and a current certification in cardiopulmonary resuscitation (CPR).

Physical Therapy Services (42 CFR 440.110(a))

Definition:

Physical therapy services are services, including necessary supplies and equipment as well as direct assistance with the selection, acquisition, training, or use of an ATD, prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided in an individual or group setting by or under the supervision of a currently licensed physical therapist within the scope of his or her professional practice.

Qualified Provider Types:

Physical therapy services are provided by or under the supervision of a currently licensed physical therapist.

The standards for supervision by a licensed physical therapy are set forth in state law, currently codified at 49 Pa.Code § 40.173 (Supervision of occupational therapy assistants). Supervision is conducted and documented by the licensed physical therapist.

SERVICES

Physician Services (42 CFR 440.50(a))

Definition:

Physician services are services provided within their scope of practice.

Qualified Provider Types:

Physician services are provided by a currently licensed doctor of medicine or currently licensed doctor of osteopathy.

Psychological, Counseling and Social Work Services (42 CFR 440.130(d))

Definition:

Psychological, Counseling and Social Work Services are services prescribed by a physician or other licensed practitioner of the healing arts within their scope of practice under State law and include assessment and evaluation, treatment planning, and individual and group therapy provided by a psychologist, counselor, therapist or social worker within the scope of their professional practice.

Assessment

Assessment consists of the diagnosis and evaluation, medical, social and developmental history of the child.

Planning

Planning is the development of treatment plans based on the assessment, which establish specific, attainable goals and which designate responsibility for activities proposed to achieve these goals. Planning also includes periodic evaluations of progress, reviews of activities, evaluating and updating the treatment plan and its goals.

Treatment

Treatment includes a multi-systemic approach to addressing the child's mental health needs. Such approaches include counseling and therapies.

Qualified Provider Types:

Assessment, planning and treatment are provided by:

- A currently licensed psychologist;
- A psychologist who is currently certified by the Pennsylvania Department of Education to practice school psychology;
- A currently licensed professional counselor;
- A currently licensed Marriage and Family Therapist; or
- A currently licensed social worker.

Limitation: Psychological, counseling and social work services provided must be documented in a service log.

Special Transportation Services (42 CFR 440.170(a))

Definition:

Special transportation services are services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and include:

1. Travel to and from school and between schools or school buildings on a day when a Medicaid service is on the IEP to be rendered on school premises and special transportation is included on the IEP as a separate service;
2. Travel and from off-site premises on a day when a Medicaid service is on the IEP to be rendered off-site and special transportation is included on the IEP as a separate service; and
3. Use of specialty adapted vehicle (such as a specially adapted bus or van).

Qualified Provider Types:

Special transportation services are provided by a school or other entity under contract with the LEA to provide the services.

Special transportation services must be provided in accordance with the Public School Code of 1949 (24 P.S. §§ 1-101—27-2702), the Vehicle code (75 Pa.C.S. §§ 101-9701), regulations at 22 Pa.Code Chapter 23 (relating to pupil transportation) and 67 Pa.Code Chapters 71 and 171 (relating to school bus drivers and school buses and school vehicles).

Limitations:

- Special transportation services must be provided on the same date of service that a Medicaid-covered service, required by the beneficiary's IEP, is received.
- Special transportation services must be provided on a specially adapted school vehicle or other vehicle to or from the location where the Medicaid service is received.
- Special transportation services must represent a one-way trip.
- Special transportation services provided must be documented in a transportation log.

Speech, Language and Hearing Services (42 CFR 440.110(c))

Definition:

Speech, language and hearing services are services, including necessary supplies and equipment as well as direct assistance with the selection, acquisition, training, or use of an ATD, prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law and provided in an individual or group setting by or under the supervision of a speech pathologist, audiologist or teacher of the hearing impaired within the scope of his or her professional practice.

SERVICES

Limitation:

Speech, language and hearing services provided must be documented in a service log.

Qualified Provider Types:

Speech, language and hearing services are provided by:

- A speech pathologist who:
  - Has a Certificate of Clinical Competence (CCC) from the American Speech-Language-Hearing Association (ASHA); or
  - Has completed the equivalent educational requirements and work experience necessary for the CCC; or
  - Has completed the academic program and is acquiring supervised work experience to qualify for the CCC; or
  - Is currently licensed as a speech-language pathologist; or
- A currently licensed audiologist; or
- A teacher of the hearing-impaired who:
  - Has a current professional certificate issued by the Council on Education of the Deaf; or
  - Is currently licensed as a teacher of the hearing-impaired; or
  - Has a Master's degree, from an accredited college or university, with a major in teaching of the hearing impaired or in a related field with comparable course work and training.

Freedom of choice (42 CFR 431.51)

Consistent with section 1902(a)(23) of the Social Security Act, the Department assures that the provision of Medicaid services provided by school-based service providers will not restrict an individual's free choice of qualified providers for Medicaid services.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

4c. (i) Family planning services and supplies for beneficiaries of child-bearing age and for individuals eligible pursuant to Attachment S59 and in accordance with section 1905(a)(4)(C) of the Act, if this eligibility option is elected by the State.

Provided: ☒ No limitations ☐ With limitations

Please describe any limitations:

None

4c. (ii) Family planning-related services provided under the above State Eligibility Option.

Provided: ☐ No limitations ☒ With limitations

4d. Face-to-face tobacco cessation counseling services for pregnant women.

☒ Provided: ☒ No limitations ☐ With limitations+
☐ Not provided

+Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below.

5a. Physicians' services whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility or elsewhere.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

5b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a) (5) (B) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

SERVICES

4c(ii) Family planning-related services provided under the above State Eligibility Option.

Limitations

Family planning-related services are limited to medical diagnosis and outpatient treatment services provided in a family planning setting as part of, or as follow-up to, a family planning visit and will include certain services for the prevention and treatment of sexually transmitted diseases.

SERVICES

4d. Tobacco Cessation Counseling Services for Pregnant Women

Face-to-Face Counseling Services provided:

1. By or under supervision of a physician;

2. By any other health care professional who is legally authorized to furnish such services under state law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or

3. Any other health care professional legally authorized to provide tobacco cessation services under state law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time.)

SERVICES

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

6a. Podiatrists' services

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

6b. Optometrists' Services.

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

6c. Chiropractors' Services.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

6d. Other Practitioners' Services.

☒ Provided: ☒ No limitations ☐ With limitations
☐Not provided

7. Home Health Services

7a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☐ No limitations ☒ With limitations

7b. Home health aide services provided by a home health agency.

☒ Provided: ☐ No limitations ☒ With limitations

7c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations

7d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency.

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

8. Private duty nursing services.

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

*Service is only provided to beneficiaries under 21 years of age.

SERVICES

6. Medical Care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law.

6.b. Optometrists' Services (42 CFR 440.60)

1. Beneficiaries 21 years of age and older are limited to two (2) visits/encounters per CY.

SERVICES

RESERVED

SERVICES

RESERVED

SERVICES

6. Medical Care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law.

6.d. Other practitioners' services (42 CFR 440.60)

Certified Registered Nurse Practitioner (CRNP) services

CRNP services are those services provided by a CRNP, as licensed by the state who is certified by the State Board of Nursing and State Board of Medicine in a particular clinical specialty area who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in the state.

Licensed Pharmacist services

Licensed Pharmacists are covered under their scope of practice in accordance with state law.

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 of 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. For beneficiaries under 21 years of age, there are no limits for medically necessary home health nursing services.

3. 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.

SERVICES

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. For beneficiaries under 21 years of age, there are no limits for medically necessary home health aide services.

3. 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.

SERVICES

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 removable 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 of 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 banister 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 ($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.

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. For beneficiaries under 21 years of age, there are no limits for medically necessary home health physical therapy, occupational therapy, or speech pathology and audiology services.

3. 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.

SERVICES

8. Private duty nursing services (42 CFR 440.80)

Service is not provided to beneficiaries 21 years of age or older.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALL NEEDY

9. Clinic services

9a. Independent Medical Clinic services

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

9b. Psychiatric Clinic Services

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

9c. Drug and Alcohol and Methadone Maintenance Clinic Services

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

9d. Renal Dialysis Services

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

9e. Ambulatory Surgical Center (ASC) services

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

10. Dental services

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

11. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

11a. Physical Therapy

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

11b. Occupational Therapy

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

11c. Services for individuals with speech, hearing, and language disorders

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

*Service is only provided to beneficiaries under 21 years of age

9. Clinic Services

9b. Psychiatric Clinic services (42 CFR 440.90)

Provider Qualifications

Psychiatric clinics must have a certificate of compliance from the Department, Office of Mental Health and Substance Abuse Services.

9. Clinic Services (continued)

9c. Drug and Alcohol and Methadone Maintenance Clinic services (42 CFR 440.90)

Provider Qualifications

Drug and alcohol outpatient clinics must be fully or provisionally licensed by the Department of Drug and Alcohol Programs. A drug and alcohol clinic may provide methadone maintenance if approved to do so by the Department of Drug and Alcohol Programs.

9. Clinic Services (continued)

9d. Renal Dialysis services (42 CFR 405.2102)

Limitations

1. Initial training for home dialysis, provided in a renal dialysis clinic, is limited to twenty-four (24) sessions per beneficiary.

2. Dialysis procedures provided as back-up to home dialysis are limited to seventy-five (75) per calendar year.

9. Clinic Services (continued)

9e. Ambulatory Surgical Center (42 CFR 416)

Prior authorization is required for an admission for same day surgical services.

SERVICES

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SERVICES

10. Dental Services (42 CFR 440.100)

The following applies to compensable services for beneficiaries under 21 years of age.

Prior authorization is required for orthodontia, complete and partial dentures, crowns, surgical extractions of impacted teeth, and periodontal services.

SERVICES

10. Dental Services (42 CFR 440.100) (continued)

Limitations – The following limits apply to compensable services for beneficiaries 21 years of age and older.

1. Oral examination is limited to one per 180 days per beneficiary.

2. Dental prophylaxis is limited to one per 180 days per beneficiary.

3. Panoramic-maxilla or mandible, single film is limited to one per five years.

4. Prior authorization is required for orthodontia, complete and partial dentures, crowns, surgical extractions of impacted teeth, and periodontal services.

5. 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.

6. 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.

SERVICES

11. Physical Therapy and Related Services (42 CFR 440.110)

11a. Physical Therapy

Service is only provided to beneficiaries under 21 years of age.

Provider Qualifications

The service must be performed by a physical therapist that is currently licensed to practice in the Commonwealth and comply with 42 CFR 440.110.

11. Physical Therapy and Related Services (42 CFR 440.110) (continued)

11b. Occupational Therapy

Service is only provided to beneficiaries under 21 years of age.

Provider Qualifications

The service must be performed by an occupational therapist that is currently licensed to practice in the Commonwealth and comply with 42 CFR 440.110.

11. Physical Therapy and Related Services (42 CFR 440.110) (continued)

11c. Services for individuals with speech, hearing and language disorders

Service is only provided to beneficiaries under 21 years of age.

Provider Qualifications

The service must be performed by a speech pathologist and/or audiologist who is currently licensed to practice in the Commonwealth and comply with 42 CFR 440.110.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

12. Prescribed drugs, dentures and prosthetic devices; and, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12a. Prescribed drugs

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

12b. Dentures

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

12c. Prosthetic devices

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

12d. Eyeglasses

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in the plan.

13a. Diagnostic services

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

13b. Screening services

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

13c. Preventive services

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

*Service is only provided to beneficiaries under 21 years of age.

SERVICES

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.

12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses

12a. Prescribed Drugs (42 CFR 440.120(a)) (continued)

g. Compound prescriptions when:

i. The active ingredients are used in quantities insufficient to produce a therapeutic effect or response.

ii. The active ingredient or active ingredients used in a compound are noncompensable.

h. Non-legend drugs not specified in the excluded drug section of Attachment 3.1A/3.1B, Page 5cc and 5d.

i. The following items when prescribed for beneficiaries receiving skilled nursing and intermediate care facility services:

i. Intravenous solutions as a routine source of electrolytes, nutrition, and water for hydration except when used to prepare compound intravenous medications specifically ordered for and dispensed to a particular beneficiary. The payment for intravenous solutions is included in the nursing home per diem rate.

ii. Legend laxatives – Payment for all laxatives is included in the nursing home per diem rate.

j. Items prescribed or ordered by a prescriber who has been barred or suspended during an administrative action from participation in the Medical Assistance Program.

k. Prescriptions or orders filled by a pharmacy other than the one to which a beneficiary has been restricted because of misutilization or abuse.

l. Prescriptions for Erectile Dysfunction (ED) drugs unless used for FDA approved indications other than for the treatment of sexual or ED.

SERVICES

12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses

12a. Prescribed Drugs (42 CFR 440.120(a)) (continued)

1. Drug Rebate Agreements

   a. The Commonwealth is in compliance with section 1927 of the Social Security Act. The state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

   b. The Commonwealth will be negotiating supplemental rebates in addition to federal rebates provided for in Title XIX. Rebate agreements between the Commonwealth and a pharmaceutical manufacturer will be separate from the federal rebates.

   c. CMS authorized a rebate agreement between the Commonwealth and a drug manufacturer for drugs provided to Medicaid beneficiaries, the Pennsylvania Medicaid Supplemental Rebate Agreement.

   d. The Commonwealth will continue single state-specific supplemental rebates in addition to federal rebates provided for in Title XIX. The single state rebate agreements will be separate from the federal rebates. Supplemental rebates received by the Commonwealth in excess of those required under the federal drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the federal rebate agreement.

   e. CMS has authorized the Commonwealth of Pennsylvania to enter into the Pennsylvania Medicaid Supplemental Rebate Agreement, as amended January 1, 2024, for the Commonwealth of Pennsylvania.

   f. CMS has authorized the Commonwealth of Pennsylvania to enter into outcomes-based agreements with pharmaceutical manufacturers, for drugs provided to Medicaid beneficiaries using the “Pennsylvania Medicaid Outcomes-Based Supplemental Rebate Agreement,” beginning July 1, 2022.

   g. Supplemental rebates received by the Commonwealth in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

   h. All drugs covered by the program, irrespective of a prior authorization requirement, will comply with provisions of the national drug rebate agreement.

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY AND MEDICALLY NEEDY

SERVICES

Provision(s) (1935(d)(1))

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY AND MEDICALLY NEEDY

SERVICES

Provision(s) (1927(d)(2) and 1935(d)(2))

7. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

   The following drugs are covered:

   ☒(a) agents when used for anorexia, weight loss, weight gain
   ☐(b) agents when used to promote fertility
   ☒(c) agents when used for symptomatic relief of cough and colds, excluding mouthwashes, lozenges, troches, throat sprays, and rubs
   ☒(d) prescription vitamins and mineral products, including prenatal vitamins and fluoride
   ☒(e) nonprescription drugs
      i. Payment for non-legend drugs is limited to the following:
         A. Those drug products marketed by drug companies which have entered into rebate agreements with the federal government as provided under Section 4401 of the Omnibus Budget Reconciliation Act of 1990.
         B. Non-legend drug products when prescribed by a licensed prescriber within the scope of the prescriber's practice listed on the Department's website.

SERVICES

Provision(s) (continued) (1927(d)(2) and 1935(d)(2))

- ☐ (f) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- ☐ (g) DESI drugs and any identical, similar, or related products or combination of these products.

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12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses (continued)

12b. Dentures (42 CFR 440.120(b))

Limitations – The following limits apply to denture services:

Beneficiaries 21 years of age and older are limited to one (1) upper arch complete or partial denture, and one (1) lower arch complete or partial denture, per lifetime. Prior authorization is required for complete or partial dentures. Additional dentures require a Benefit Limit Exception. A Benefit Limit Exception will be approved if one of the following criteria is met:

1. The department determines the beneficiary has a serious chronic systemic illness or other serious health condition and the denial of the exception will jeopardize the life of the beneficiary.

2. The department determines the beneficiary 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 beneficiary.

3. The department determines that granting a specific exception is a cost effective alternative for the Medical Assistance Program; or

4. The department determines that granting an exception is necessary to comply with Federal law.

Denture relines, either full or partial, are limited to one (1) arch, every two (2) years.

12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses (Continued)

12c. Prosthetic and Orthotic devices (42 CFR 440.120(c))

The clinical purpose of prosthetics is to provide replacement, corrective or supportive devices that help to improve health outcomes.

Limitations – The following limits apply to services for prosthetic and orthotic devices:

1. Prior authorization is required for all prescribed prosthetic and orthotic devices.

2. Beneficiaries 21 years of age and older are not eligible for orthopedic shoes.

3. Coverage for molded shoes is limited to molded shoes prescribed for severe foot and ankle conditions and deformities of such degree that the beneficiary is unable to wear ordinary sturdy shoes with or without corrections and modifications.

4. Coverage for modifications to orthopedic shoes and molded shoes is limited to only those modifications necessary for the application of a brace or splint.

5. Coverage for low vision aids and eye prostheses is limited to one (1) per beneficiary per two (2) years. An eye ocular is limited to one (1) per year.

6. Beneficiaries 21 years of age and older are not eligible for hearing aids.

12. Prescribed Drugs, Dentures, Prosthetic Devices and Eyeglasses (Continued)

12d. Eyeglasses (42 CFR 440.120(d))

Limitations

1. Beneficiaries 21 years of age and older and diagnosed with aphakia are limited to:

    a. Four (4) eyeglass lenses per CY.

    b. Two (2) eyeglass frames per CY. Deluxe frames are not included.

    c. Four (4) contact lenses per CY.

SERVICES

13. Diagnostic, Screening, Preventive, and Rehabilitative Services

13a. Diagnostic Services (42 CFR 440.130(a))

Medicaid services not otherwise covered under the State Plan are limited to beneficiaries under 21 years of age.

13. Diagnostic, Screening, Preventive, and Rehabilitative Services

13b. Screening Services (42 CFR 440.130(b))

Medicaid services not otherwise covered under the State Plan are limited to beneficiaries under 21 years of age.

13. Diagnostic, Screening, Preventive, and Rehabilitative Services

13c. Preventive Services (42 CFR 440.130(c))

Medicaid services not otherwise covered under the State Plan are limited to beneficiaries under 21 years of age.

All U.S. Food and Drug Administration approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration are covered without cost-sharing, as described in Section 1905(a)(13)(B) of the Social Security Act. Coverage and billing codes of approved vaccines and their administration will be updated as necessary to reflect changes to ACIP recommendations.

Limitations

1. Coverage for tobacco cessation counseling services to individuals 21 years of age and older is limited to seventy (70), fifteen (15) minute units per CY.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

d. Rehabilitative Services.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations

b. Nursing facility services.

☒ Provided: ☒ No limitations ☐ With limitations

SERVICES

13. Diagnostic, Screening, Prevention and Rehabilitative Services (42 CFR 440.130)

13d. Rehabilitative Services

(i) Family-Based Mental Health Rehabilitative Services (42 CFR 440.130(d))

Family Based Mental Health Rehabilitative Services are a service array that is recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law, and includes assessment, planning and individual and family therapy provided primarily in the home of a child or adolescent with a mental illness or a serious behavior disorder which is intended to forestall child and adolescent psychiatric hospitalization and other out of the home placements. This service is licensed by the Department of Human Services. This service may also be provided in other community sites, such as the child's school. The following is a description of the service components and provider qualifications:

- **Assessment**

  Assessment consists of using the following:

(1) Diagnosis and evaluation of the child or adolescent by a qualified provider of the healing arts. This can be provided by any of the following professionals:
   a. A psychiatrist who is licensed to practice psychiatry in the Commonwealth
   b. A physician who is licensed to practice medicine in the Commonwealth
   c. A psychologist who is licensed to practice psychology in the Commonwealth

(2) A medical history of the child or adolescent, including a copy of a current physical examination.

   This history can be compiled by any of the following professionals:
   a. A psychiatrist
   b. A physician
   c. A CRNP who is licensed to practice in the Commonwealth
   d. A psychologist
   e. A certified Family Based Mental Health Professional who has achieved certification through the Office of Mental Health and Substance Abuse Services, Department of Human Services
   f. A certified Family Based Mental Health Worker who has achieved certification through the Office of Mental Health and Substance Abuse Services, Department of Human Services
   g. A certified Family Based Mental Health Supervisor who has achieved certification through the Office of Mental Health and Substance Abuse Services, Department of Human Services
   h. A Family Based Mental Health Professional who is currently enrolled in a Department approved Family Based training program. Family Based Mental Health Professionals are either licensed mental health professionals or an individual with a graduate degree in a human service field plus 2 years of experience in a Child Adolescent Service System Program (CASSP) system.
   i. A Family Based Mental Health Worker who is currently enrolled in a Department approved Family Based training program. A Family Based Mental Health worker has a bachelor's degree in a human service field or at least 12 college level semester hours in humanities or social services, plus one year of experience in a CASSP system.
   j. A Family Based Mental Health Supervisor who is currently enrolled in a Department approved Family Based training program. A Family Based Mental Health Supervisor is either a licensed mental health professional or an individual with a graduate degree in a human service field plus 3 years of direct care experience with children or adolescents in a CASSP system program including two years supervisory experience in any program of the CASSP system or has a supervisory certificate from the American Association of Marriage and Family Therapists.

13d. (i) Family-Based Mental Health Rehabilitative Services (42 CFR 440.130(d))(continued)

(3) A social and developmental history of the child or adolescent, including the roles of other members of the consumer family. This history can be compiled by any of the following:
   a. A psychiatrist
   b. A physician
   c. A CRNP
   d. A psychologist
   e. A certified Family Based Mental Health Professional
   f. A certified Family Based Mental Health Worker
   g. A certified Family Based Mental Health Supervisor
   h. A Family Based Mental Health Professional who is currently enrolled in a Department approved Family Based training program.
   i. A Family Based Mental Health Worker who is currently enrolled in a Department approved Family Based training program.
   j. A Family Based Mental Health Supervisor who is currently enrolled in a Department approved Family Based training program.

- **Planning**:

  The development of treatment plans based on the assessment, which establish specific, attainable goals and which designate responsibility for activities proposed to achieve these goals. Planning also includes periodic evaluations of progress, reviews of activities, evaluating and updating the treatment plan and its goals, and discharge planning. This planning will be provided, in collaboration with the family and youth, by any of the following professionals:

a. A certified Mental Health Professional
b. A certified Mental Health Worker
c. A certified Mental Health Supervisor
d. A Family Based Mental Health Professional who is currently enrolled in a Department approved Family Based training program.
e. A Family Based Mental Health Worker who is currently enrolled in a Department approved Family Based training program.
f. A Family Based Mental Health Supervisor who is currently enrolled in a Department approved Family Based training program.

- **Treatment**

  Individual and family therapy from an ecosystemic approach to family therapy as taught by the Department approved Family Based Training Program. Specific therapies are to be incorporated within this model in response to specific needs of the child, such as trauma focused therapy. This therapy can be provided by the following professionals:

a. A certified Mental Health Professional
b. A certified Mental Health Worker
c. A certified Mental Health Supervisor
d. A Family Based Mental Health Professional who is currently enrolled in a Department approved Family Based training program.
e. A Family Based Mental Health Worker who is currently enrolled in a Department approved Family Based training program.
f. A Family Based Mental Health Supervisor who is currently enrolled in a Department approved Family Based training program.

SERVICES

13d. Rehabilitative Services (continued)

(ii) Mental Health Crisis Intervention Services (42 CFR 440.130(d))

Mental Health Crisis Intervention (MHCI) Services are a service array that is recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law, and includes immediate, crisis oriented services provided to a beneficiary and their family, who exhibits an acute problem of disturbed thought, behavior, mood or social relationships. The services are accessible 24 hours a day to provide a rapid response to crisis situations which threaten the well-being of the individual or others. Agencies providing these services must be licensed by the Department as Mental Health Crisis Intervention Service providers. Mental Health Crisis Intervention includes *screening, assessment, intervention, counseling, and disposition services.* The following is a description of these service components and professional qualifications:

- **Screening:** A formal process to determine whether a mental health crisis or emergency may exist by gathering initial information on the current situation and individuals involved to formulate the level of response needed. The initial screening must address health and safety issues of everyone involved in the crisis. The purpose is to establish the need for further assessment by a crisis worker or to determine if other services would best address the individual's current circumstances.
- **Assessment:** The formal process to evaluate the individual's safety risk and dangerousness of the crisis situation. Information related to the presenting problem, sources of stress, environment, interpersonal relationships, mental health symptoms, strengths and vulnerabilities that maybe contributing to the current crisis situation are gathered to formulate the appropriate intervention process**.**
- **Intervention:** A short-term, intensive mental health service initiated during an identified crisis situation. The purpose is to help the individual cope with immediate stressors, provide a sense of safety and stabilize the acute situation.
- **Counseling:** A series of strategies to address the crisis situation and mitigate distress. Specific strategies may include establishing rapport, active listening, problem solving techniques, stress management, or psycho-education based upon the crisis assessment.
- **Disposition Services:** Assistance in connecting with appropriate resources including formal and informal support systems. This may include providing follow-up contact for ongoing support, facilitating referrals to community mental health services, providing information and referrals for community resources for basic needs, engaging informal support networks such as family, friends, faith-based resources based upon the crisis situation.

All service components described above can be provided by any of the following professionals:

a) A MHCI Mental Health Professional who meets one of the following criteria:
   - o A master's degree in social work, psychology, rehabilitation, activity therapies, counseling, education or related fields and 3 years of mental health direct care experience
   - o A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, counseling, education or a related field, or be a registered nurse, and 5 years of mental health direct care experience, 2 of which shall include supervisory experience
   - o A bachelor's degree in nursing and 3 years of mental health direct care experience

13d. (ii) Mental Health Crisis Intervention Services (42 CFR 440.130(d))(continued)

- A registered nurse license, certified in psychology or psychiatry

b) Crisis workers who are not MHCI mental health professionals shall be supervised by a MHCI mental health professional and shall meet one of following:
   - Have a bachelor's degree with major course work in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, nursing, counseling, education or a related field.
   - Be a registered nurse
   - Have a high school diploma or equivalency and 12 semester credit hours in sociology, social welfare, psychology, gerontology or other social sciences and 2 years of experience in public or private human services with 1 year of mental health direct care experience
   - Have a high school diploma or equivalency and 3 years of mental health direct care experience in public or private human services with employment as a mental health staff person prior to January 1, 1992
   - Be a consumer or a family member who has 1 year of experience as an advocate or leader in a consumer or family group, and has a high school diploma or equivalency.

c) A MHCI Service Medical Professional who meets one of the following:
   - A psychiatrist
   - A physician with 1 year of mental health service experience in diagnosis, evaluation and treatment
   - A certified registered nurse practitioner authorized in accordance with 49 Pa. Code Section 21.291 (relating to institutional health care facility committee; committee determination of standard policies and procedures) to diagnose mental illness

.

13d. Rehabilitative Services (continued)

(iii) Mobile Mental Health Treatment (MMHT) (42 CFR 440.130(d))

MMHT is a service array that is recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law to reduce the disabling effects of an illness or disability and restore the beneficiary to the best possible functional level in the community. The purpose of MMHT is to provide therapeutic treatment to reduce the need for more intensive levels of service including crisis intervention or inpatient hospitalization.

MMHT includes: *evaluation; individual, group, and family therapy; and medication visits* in a beneficiary's residence or approved community site. MMHT may be provided by any licensed psychiatric outpatient clinic enrolled in the MA Program. The following is a description of these service components and professional qualifications:

- **Evaluation:** A face to face interview which shall include an assessment of the psychiatric, medical, psychological, social, vocational, and educational factors important to the beneficiary. This can be provided by any of the following professionals:

  a) Psychiatrist: A physician who has completed a 3 year residency in psychiatry and is licensed to practice in this Commonwealth

  b) Psychologist: A person licensed to practice psychology in this Commonwealth.

  c) MMHT Mental Health Professional: A person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology or nursing or rehabilitation or activity therapies that has a graduate degree and one year of mental health clinical experience.

- **Psychotherapy:** The treatment, by psychological means, of the problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the beneficiary with the object of removing, modifying or retarding existing symptoms, of mediating disturbed patterns of behavior, and of promoting positive personality growth and development. This includes:

  - **Individual Therapy:** Psychotherapy provided to one person with a diagnosed mental disorder

  - **Group Therapy:** Psychotherapy provided to no less than two and no more than ten persons with diagnosed mental disorders

  - **Family Therapy:** Psychotherapy provided to two or more members of a family. At least one family member shall have a diagnosed mental disorder

  Psychotherapy can be provided by any of the following professionals:

  d) Psychiatrist

  e) Psychologist

  f) MMHT mental health professional: A person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology or nursing or rehabilitation or activity therapies that has a graduate degree and one year of mental health clinical experience.

13d. (iii) Mobile Mental Health Treatment (MMHT) (42 CFR 440.130(d))(continued)

- **Medication Visits**: A minimum 15-minute visit only for administration of a drug and evaluation of a beneficiary's physical and mental condition during the course of prescribed medication. This visit is provided to an eligible beneficiary by any of the following professionals:
  - **a)** Psychiatrist
  - **b)** Physician: An individual licensed under the laws of this Commonwealth to practice medicine and surgery within the scope of the Medical Practice Act of July 20, 1974
  - **c)** Certified Registered Nurse Practitioner (CRNP): A registered nurse licensed in this Commonwealth who is certified by the State Board of Nursing and State Board of Medicine in a particular clinical specialty area who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a physician licensed to practice medicine in this Commonwealth
  - **d)** Registered Nurse: An individual licensed by the State Board of Nursing to practice professional nursing or
  - **e)** Licensed practical nurse who is a graduate of a school approved by the State Board of Nursing or who has successfully completed a course in the administration of medication approved by the State Board of Nursing.

13d. Rehabilitative Services (continued)

(iv) Peer Support Services (42 CFR 440.130(d))

Peer Support Services (PSS) are mental health rehabilitative services recommended by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to reduce the disabling effects of an illness or disability and restore the beneficiary to the best possible functional level in the community. PSS are self-directed and person-centered with a resiliency and recovery focus. The purpose of PSS is for Certified Peer Specialists (CPS) to use their lived experience to help other individuals going through a similar experience successfully navigate the recovery process, provide support, inspire hope, and build confidence that recovery from mental illness and co-occurring substance abuse is not only possible, but probable.

Providers must be licensed by the Office of Mental Health and Substance Abuse Services (OMHSAS) as a PSS provider and be enrolled in, and comply with, all requirements that govern participation in, the Medical Assistance Program.

PSS include: *mentoring, crisis support, development of community roles and natural supports, individual advocacy, self-help, self-improvement, and social network*. The following is a description of these service components:

- **Mentoring:** To serve as a role model for a beneficiary in recovery; to coach and guide through shared experiences.
- **Crisis support:** Assisting the beneficiary to recognize the early signs of relapse and how to implement identified coping strategies.
- **Development of Community Roles and Natural Supports:** Assisting the beneficiary to gain information about school, job training, work, housing and how to become an active community member.
- **Individual Advocacy**: Assisting the beneficiary toward a proactive role in his or her own recovery.
- **Self Help:** Cultivating the beneficiary's ability to make informed, independent choices.
- **Self-improvement**: Planning and facilitating practical activities leading to increased self-worth and improved self-concepts.
- **Social Network:** Assisting the beneficiary to develop and maintain positive personal and social support networks.

All service components described above are provided by a Certified Peer Specialist (CPS) whose qualifications are listed below:

- Be a self-identified individual with a mental health diagnosis and who has reached a point in their recovery pathway where they can positively support others in similar situations.
- Be eighteen (18) years of age or older.
- Have completed a peer support services training approved by the Department.

13d. (iv) Peer Support Services (42 CFR 440.130(d))(continued)

- Obtain and maintain, current, valid, and in good standing the CPS credential through a certification entity identified by the Department.

Supervision: A PSS mental health professional shall maintain clinical oversight of PSS, which includes ensuring that services and supervision are provided consistent with the service requirements. An individual qualifies as a PSS mental health profession if they meet either (a) or (b) below:

a) A Mental Health Professional who meets one of the following criteria:
   - o A master's degree in social work, psychology, rehabilitation, activity therapies, counseling, education or related fields and three (3) years of mental health direct care experience
   - o A bachelor's degree in sociology, social work, psychology, gerontology, anthropology, political science, history, criminal justice, theology, counseling, education or a related field, or be a registered nurse, and five (5) years of mental health direct care experience, two (2) of which shall include supervisory experience
   - o A bachelor's degree in nursing and three (3) years of mental health direct care experience
   - o A registered nurse license, certified in psychology or psychiatry

b) A Mental Health Professional who is trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology or nursing or rehabilitation or activity therapies who has a graduate degree and one year of mental health clinical experience.

Care Coordination: The provider will ensure the initial and all subsequent Individual Service Plans will specify the following: measurable goals and objectives written in individualized and outcome-oriented language; the services to be provided, including the expected frequency and duration; the location where the services will be provided; and the CPS's role in relating to the individual receiving services and involved other persons.

13d. Rehabilitative Services (continued)

(v) Community-Based Care Management Services by Opioid Use Disorder Centers of Excellence (42 CFR 440.130(d))

Community-Based Care Management (CBCM) Services by Opioid Use Disorder Centers of Excellence (COEs) are rehabilitative services specifically designed for individuals with an opioid use disorder (OUD). These services are designed to increase access to Medication Assisted Treatment (MAT), improve coordination between physical and behavioral healthcare providers, and keep individuals engaged in the recovery process along the full continuum of care. These services are recommended by a physician or other licensed practitioner of the healing arts within the scope of practice under state law.

COEs use CBCM teams to coordinate the care of individuals with an OUD. In addition to providing physical and/or behavioral healthcare services, including MAT, onsite, COEs use a blend of licensed and unlicensed, clinical, and non-clinical staff to coordinate the care needs of an individual to ensure that their clinical and non-clinical needs are met.

CBCM services include the provision of the following services: *screening and assessment, care planning, referrals, and monitoring*. The following is a description of these service components:

(1) Screening and Assessment
   a. Assessments to identify an individual's needs related to Social Determinants of Health, administered in home and community-based settings whenever practicable.
   b. Level of Care Assessments, which may be completed either by the COE or through a referral. If a level of care assessment results in a recommendation of MAT, the COE must provide education related to MAT.
   c. Screenings for clinical needs that require referrals or treatment.

(2) Care Planning
   a. Development of integrated, individualized care plans that include, at a minimum, an individual's treatment and non-treatment needs, the individual's preferred method of care management (face-to face meetings, phone calls, or secure messaging application), and the identities of the individual's CBCM team members, as well as the members of the individual's support system.
   b. Care coordination with an individual's primary care provider, mental health service provider, drug and alcohol treatment provider, pain management provider, obstetrician or gynecologist, and Managed Care Organization (MCO), as applicable.
   c. Facilitating referrals to necessary and appropriate clinical services according to the individual's care plan.
   d. Facilitating referrals to any ASAM Level of Care that is clinically appropriate according to a Level of Care Assessment.
   e. Facilitating referrals to necessary and appropriate non-clinical services according to the results of the individual's needs identified through a Social Determinants of Health screening.

SERVICES

13d. (v) Opioid Use Disorder Centers of Excellence Services (42 CFR 440.130(d))(continued)

(3) Monitoring

a. Individualized follow-up with an individual and monitoring of an individual's progress per the individual's care plan, including referrals for clinical and non-clinical services.
b. Continued and periodic re-assessment of an individual's Social Determinants of Health needs.
c. Performing Urine Drug Screenings at least monthly or as identified in the care plan.

COE CBCM services can be provided by a certified recovery specialist, physicians, licensed nurses, licensed clinical social workers, licensed professional counselors, care managers and drug and alcohol counselors.

Certified recovery specialists are individuals with personal, lived experience of their own recovery who have completed 78 instructional hours of Recovery Specialist training and are certified as a recovery specialist.

Care managers are individuals with a degree in nursing, social work, or social services.

Drug and alcohol counselors are individuals certified by a certification body to provide alcohol, drug, or addiction counseling services.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

15a. Intermediate care facility services for individuals with intellectual disability (ICF/IID) and for other related conditions (ORC) (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided*

15b. Including such services in a public institution (or distinct part thereof) for individuals with intellectual disability or persons with related conditions.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided*

16. Inpatient psychiatric facility services for individuals under 21 years of age.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

17. Nurse-midwife services.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided
☒ Provided in accordance with section 2302 of the Affordable Care Act

*Service is only provided to beneficiaries under 21 years of age.

SERVICES

RESERVED

SERVICES

RESERVED

SERVICES

18. Hospice Services (42 CFR 418)

Limitations

1. Coverage for inpatient respite care is limited to no more than five (5) consecutive days in a sixty (60) day certification period.

2. Beneficiary must be certified as being terminally ill by a doctor of medicine or osteopathy and agree to waive rights to MA Program covered services related to the treatment of the terminal condition for which hospice care was elected or a related condition.

3. In accordance with section 2302 of the ACA, individuals under the age of 21 may receive hospice care concurrently with curative care.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

19. Case management services and Tuberculosis related and services (42 CFR 440.169(b))

19a. Case management services as defined in, and to the group specified in, Enclosure A and Supplements 2-5 to ATTACHMENT 3.1A/3.1B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided

19b. Special tuberculosis (TB) related services under section 1902(z)(2) of the Act.

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided

20. Extended services for pregnant women (42 CFR 440.210(a)(3))

20a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

_____ Additional coverage++

20b. Services for any other medical conditions that may complicate pregnancy.

_____ Additional coverage++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only (Supplement 1)

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by qualified provider (in accordance with section 1920 of the Act).

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act). (42 CFR 440.185(a))

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided*

23. Nurse Practitioners services (42 CFR 440.166(b) and (c))

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided

*Service is only provided to beneficiaries under 21 years of age.

SERVICES

22. Respiratory Care Services, in accordance with section 1902(e)(9)(A)-(C) of the Act (42 CFR 440.185(a))

Service is not provided to beneficiaries 21 years of age or older.

SERVICES

RESERVED

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

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

24a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations

24b. Services provided in Religious Nonmedical Health Care Institutions

☐ Provided: ☐ No limitations ☐ With limitations
☒Not provided*

24c. Nursing facility services for beneficiaries under 21 years of age.

☒ Provided: ☒ No limitations ☐ With limitations
☐Not provided*

24d. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations

24e. Personal care services in beneficiaries home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☐ Provided: ☐ No limitations ☐ With limitations
☒Not provided*

*Service is only provided to beneficiaries under 21 years of age.

SERVICES

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (42 CFR 440 170)

24a. Transportation (42 CFR 440 170(a))

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 beneficiary'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 beneficiary'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.

SERVICES

iii. Brokered Transportation

☒ Provided under section 1902(a)(70) for Philadelphia County only.

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provided transportation and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36(b)-(f).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(1):

☒ (1) statewideness (indicate areas of State that are covered)

☒ (10)(B) comparability (indicate participating beneficiary groups)

☒ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

☒ wheelchair van

☒ taxi

☐ stretcher car

☒ bus passes

☒ tickets

☐ secured transportation

☐ such other transportation as the Secretary determines appropriate (please describe)

(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).

SERVICES

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

- ☒ Low-income families with children (section 1931)
- ☒ Low-income pregnant women
- ☒ Low-income infants
- ☒ Low-income children 1 through 5
- ☒ Low-income children 6-19
- ☒ Qualified pregnant women
- ☒ Qualified children
- ☒ IV-E Federal foster care and adoption assistance children
- ☒ TMA beneficiaries (due to employment)
- ☒ TMA beneficiaries (due to child support)
- ☒ SSI beneficiaries
- ☒ Persons essential to beneficiaries under Title I, X, XIV, or XVI
- ☒ Individuals provided extended benefits under section 1925

SERVICES

(5) The broker contract will provide transportation to the following categorically needy optional populations:

☒ Optional low-income pregnant women

☒ Optional low-income infants

☒ Optional targeted low-income children

☒ Individuals under 21 who are under State adoption assistance agreements

☒ Individuals under age 21 who were in foster care on their 18th birthday

☒ Individuals who meet income and resource requirements of AFDC or SSI

☒ Individuals who would meet the income and resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency

☐ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law

☐ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution

☐ Individuals infected with TB

☒ Individuals screened for breast or cervical cancer by CDC program

☒ Individuals receiving COBRA continuation benefits

☐ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard

☒ Individuals receiving home and community based waiver services that would only be eligible under State plan if in a medical institution

☒ Individuals terminally ill if in a medical institution and will receive hospice care

☒ Individuals aged or disabled with income not above 100% FPL

☐ Individuals receiving only an optional State supplement in a 209(b) State

☐ Individuals working disabled who buy into Medicaid (BBA working disabled group)

☒ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group

☐ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids)

☒ Employed individuals with a medically improved disability (as defined in section V)

☒ Individuals described in section 1902(aa)

☒ Individuals screened for breast or cervical cancer by CDC program

☒ Individuals receiving COBRA continuation benefits

☒ Individuals residing in Personal Care Homes

SERVICES

(6) The State will pay the contracted broker by the following method:

☒ (i) risk capitation

☐ (ii) non-risk capitation

☐ (iii) other (e.g., brokerage fee and direct payment to providers)

SERVICES

24. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary. (42 CFR 440 170) (continued)

24b. Services provided in religious Nonmedical Health Care Institutions (42 CFR 440 170(b))

Services are only provided to beneficiaries under 21 years of age.

SERVICES

24. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary (42 CFR 440 170) (continued)

24d. Emergency Hospital Services (42 CFR 440 170(e))

Services are necessary to prevent the death or serious impairment of the health of the beneficiary and because of the threat to the life or health of the beneficiary necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet:

(i) The condition of participation under Medicare; or
(ii) The definition of inpatient or outpatient hospital services under 42 CFR 440.10 and 442 CFR 440.20

SERVICES

24. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary. (42 CFR 440 170) (continued)

24e. Personal care services in beneficiary's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Services are only provided to beneficiaries under 21 years of age.

25. Case Management Services

☐ Provided ☐ No limitations ☐ With limitations
☒ Not provided*

*Service is only provided to beneficiaries under 21 years of age.

SERVICES

25. Case Management Services (42 CFR 440.169(a))

Services are only provided to beneficiaries under 21 years of age.

SERVICES

RESERVED

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1A.

_X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

_____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

SERVICES

RESERVED

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

Freestanding Birth Center Services

27a. Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☒No limitations ☐With limitations ☐None licensed or approved

Please describe any limitations:

None

27b. Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☒No limitations ☐With limitations
☐Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

None

Check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY AND MEDICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trial

*The state needs to check each assurance below.

Provided: __X____

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_X_ Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

_X_ A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

_X_ A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

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

TARGETED SUPPORT MANAGEMENT
Individuals with an Intellectual Disability, Autism, Developmental Disability, or Medically Complex Condition

Target Group (42 Code of Federal Regulations 441.18 (a)(8)(i) and 441.18(a)(9)):
Individuals who meet one of the following sets of criteria are eligible for Targeted Support Management:

- Individuals with an intellectual disability diagnosis based on the results of a standardized intellectual psychological testing, which reflects a full scale score of 70 and below (based on two standard deviations below the mean) and the intellectual disability occurred prior To age 22.
- Individuals who have a diagnosis of autism based on the results of a diagnostic tool(s), have been determined eligible for an Intermediate Care Facility for Other Related Conditions (ICF/ORC) level of care, and autism manifested prior to age 22.
- Individuals age 0 through 8 who have a diagnosis of developmental disability, which is defined as a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in an intellectual disability or autism, who are determined eligible for an ICF/ORC level of care, and the disability manifested prior to the age of 9 and is likely to continue indefinitely.
- Individuals age 0 through 21 with medically complex conditions who are determined eligible for an ICF/ORC level of care and who have one or more chronic health conditions that meet both of the following: (a) cumulatively affect three or more organ systems and (b) require medically necessary skilled nursing intervention to execute medical regimens to use technology for respiration, nutrition, medication administration or other bodily functions.

To be determined eligible for ICF/ORC level of care, the applicable target groups as described Above must meet the following:

- Have substantial functional limitations in three or more areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction and/or capacity for independent living based on a standardized adaptive functioning test.

All target groups must be eligible for Medical Assistance under the State Plan.

- X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 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):
  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.

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

TARGETED SUPPORT MANAGEMENT
Individuals with an Intellectual Disability, Autism, Developmental Disability, or Medically Complex Condition

X___ Services are not comparable in amount duration and scope (§1915(g)(1)). Definition of services (42 CFR 440.169): Targeted support 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 support management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, education, social or other services or supports. Targeted support management includes the following assistance:
- Gathering information related to educational, social, emotional, and medical events by interviewing the individual, family, medical providers, educators and others necessary to complete an assessment of the individual.
- Identifying the strengths, skills, abilities, and preferences of the individual.
- Utilizing standardized assessment and planning tools, using a life course framework to assist individuals and families to identify both the immediate and long-term vision for the person including the types of information, community resources, experiences, opportunities, and specialized services and supports necessary to promote growth and development and to achieve the person's desired outcomes including: acquiring independent living skills, employment, and establishing a social network outside the family.
- Identifying the individual's needs for services and supports and completing the related documentation.

An initial assessment shall be completed within 45 days of referral with reassessments completed annually thereafter.

- ❖ Development (and periodic revision) of a specific individual plan that is based on the information collected through the assessment that:
- Includes the active participation of the individual and others specified by the individual in the development of the plan.
- Specifies the individual's desired outcomes including: acquiring independent living skills, employment, and establishing a social network outside the family.
- Identifies a course of action to address the individual's needs and to achieve his or her desired outcomes including in-home and community supports and services.
- ❖ Specifies the services and supports necessary to address the individual's needs and to achieve his or her desired outcomes. 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, and educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the individual plan.

State Plan under Title XIX of the Social Security Act
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TARGETED SUPPORT MANAGEMENT
Individuals with an Intellectual Disability, Autism, Developmental Disability, or Medically Complex Condition

-
- ❖ Monitoring and follow-up activities:
- Activities and contacts that are necessary to ensure the individual plan is implemented and adequately addresses the eligible individual's needs, including ensuring the individual's health and safety, 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 meeting, to determine whether the following conditions are met:
    - o Services are being furnished in accordance with the individual plan;
    - o Services in the individual plan are adequate, and
    - o Changes in the needs or status of the individual are reflected in the individual plan. Monitoring and follow-up activities include making necessary adjustments in the individual plan and service arrangements with providers.

Face-to-face monitoring shall occur at least once a year that is separate from the annual service plan meeting. Monitoring shall occur more frequently as needed to ensure the individual's needs are met; as well as to maintain a continuing relationship between the individual, family members, and any providers responsible for services.

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 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Targeted Support Management Organization Qualifications:

1. The Executive Director must have five years of professional level experience in the field of disability services, including three years of administrative, supervisory, or consultative work; and a bachelor's degree.
2. The Executive Director must have knowledge of ODP's intellectual disability, autism and developmental disability service system and successfully complete ODP's Applicant Orientation to Enrollment and Provision of Quality Services.
3. Have a service location in Pennsylvania.
4. Function as a conflict-free entity. A conflict-free organization, for purposes of rendering this service, is an independent, separate, or self-contained agency that does not have a fiduciary relationship with an agency providing direct services and is not part of a larger corporation that provides direct services. To be conflict free, an organization may not provide direct or indirect services funded by ODP to individuals with an intellectual disability, autism, developmental disability, or complex medical condition.

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TARGETED SUPPORT MANAGEMENT
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5. Have an annual training plan to improve the knowledge, skills and core competencies of the Organization's personnel.
6. Have an orientation program that includes the following:
- Person-centered practices including respecting rights, facilitating community integration, supporting families, honoring choice and supporting individuals in maintaining relationships.
- The prevention, detection and reporting of abuse, suspected abuse and alleged abuse in accordance with 35 P.S. §§ 10225.101-10225.704, 6 Pa. Code Chapter 15, 23 Pa.C.S. §§ 6301-6386, 55 Pa. Code Chapter 3490, 35 P.S. §§ 10210.101-10210.704 and applicable adult protective services regulations.
- Individual rights.
- Recognizing and reporting incidents.

7. Personnel must be employees of the organization.
- Only under extraordinary circumstances can an organization contract with an agency to provide temporary targeted support management services and must have ODP prior approval.

8. Each Support Manager Supervisor can supervise a maximum of seven Support Managers.
9. Meet the requirements for operating a not-for-profit, profit, or governmental organization in Pennsylvania.
10. Have current state motor vehicle registration, inspection and automobile insurance for all vehicles owned, leased, and/or hired an used as a component of the targeted support management service.
11. Have Commercial General Liability Insurance or provide evidence of self-insurance as Specified by insurance standards.
12. Have Workers' Compensation Insurance in accordance with state law.
13. Have sufficient targeted support management personnel to carry out all functions to operate.
14. Comply with and meet all standards of ODP's monitoring process including:
- Timely submission of self-assessment tool,
- Overall compliance score of 86% or higher, and
- Comply with ODP's Corrective Action Plan and Directed Corrective Action Plan process.

15. Ensure 24-hour access to organization personnel (via direct employees or a contact) for Response to emergency situations that are related to the targeted support management service.
16. Have the ability to utilize ODP's Information System to document and perform targeted support management activities.
17. Comply with Health Insurance Portability and Accountability Act (HIPAA).

Minimum Support Manager Supervisors Qualifications:

1. Must have knowledge of Pennsylvania's intellectual disability, autism service and developmental disability system which includes successful completion of:
- Person-Centered Thinking training
- Person-Centered Planning training

2. Must meet the following educational and experience requirements:

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TARGETED SUPPORT MANAGEMENT
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- A bachelor's degree with a major coursework in sociology, social-welfare, psychology, gerontology, criminal justice or other related social science; and two years of experience as a Support Manager; or
- Have a combination of experience and education equaling at least six years of experience in public or private social work including at least 24 college-level credit hours in sociology, social work, psychology, gerontology, criminal justice or other related social science.

3. Have a Pennsylvania State Police criminal history record check prior to the date of hire. If the prospective Support Manager Supervisor is not a resident of the Commonwealth of Pennsylvania or has not been a resident of the Commonwealth of Pennsylvania for at least two years prior to the date of employment, a Federal Bureau of Investigation criminal history record check must be obtained prior to the date of hire.

If a criminal history clearance and/or the criminal history record check identifies a criminal record, the Targeted Support Management Organization must make a case-by-case decision about whether to hire the person that includes consideration of the following factors:

- The nature of the crime;
- Facts surrounding the conviction;
- Time elapsed since the conviction;
- The evidence of the individual's rehabilitation; and
- The nature and requirements of the job.

Documentation of the review must be maintained for any Support Manager Supervisor that was hired whose criminal history clearance results or criminal history check identified a criminal record.

4. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.

5. Have a valid driver's license if the operation of a vehicle is necessary to provide targeted Support management.

6. Complete a minimum of 24 hours of training each year.

Minimum Support Manager Qualifications:

1. Meet the following minimum educational and experience requirements:

- A bachelor's degree, which includes or is supplemented by at least 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social science; or

- Two years' experience as a County Social Service Aide 3 and two years of college level course work, which includes at least 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social science; or

- Any equivalent combination of experience and training which includes 12 college credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social

science and one year of experience as a County Social Services Aide 3 or similar position performing paraprofessional case management functions.

2. Have a Pennsylvania State Police criminal history record check prior to the date of hire. If the Prospective Support Manager is not a resident of the Commonwealth of Pennsylvania or has not been a resident of the Commonwealth of Pennsylvania for at least two years prior to the date of employment, a Federal Bureau of Investigation criminal history record check must be obtained prior to the date of hire.

If a criminal history clearance and/or the criminal history record check identifies a criminal record, the Targeted Support Management Organization must make a case-by-case decision about whether to hire the person that includes consideration of the following factors:

- The nature of the crime;
- Facts surrounding the conviction;
- Time elapsed since the conviction;
- The evidence of the individual's rehabilitation; and
- The nature and requirements of the job.

Documentation of the review must be maintained for any Support Manager that was hired whose criminal history clearance results or criminal history check identified a criminal record.

3. Have child abuse clearance (when the participant is under age 18) per 23 Pa. C.S. Chapter 63.
4. Have a valid driver's license if the operation of a vehicle is necessary to provide targeted support management.
5. Newly hired Support Managers will successfully complete ODP required Orientation Curriculum.
6. Complete a minimum o 24 hours of training a year.

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 Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with an intellectual disability, autism, developmental disability or medically complex condition. Providers are limited to qualified Medicaid providers

of case management services capable of ensuring that individuals with an intellectual disability, autism, developmental disability, or medically complex condition receive needed services.

Individuals deemed eligible for targeted support management will be offered the choice of any provider who meets the qualification criteria specified above for this service and that are enrolled to provide this service. The education and training qualification criteria ensure that support managers who provide this service have the skills, knowledge and experience to meet the needs of individuals with an intellectual disability, autism, developmental disability or medically complex condition.

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 services; (iv) The nature, content, units of the case management services received and whether goals specified in the individual plan have been achieved; (v) Whether the individual has declined services in the individual 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).

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Case management does not include, and 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 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 case parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP is only available for Targeted Support Management 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))

Individuals who are enrolled in and receiving case management services under any HCBS program administered via an 1115, 1915(b) and (c) or 1915(a), (b) or (c) waivers are not eligible to receive Targeted Support Management.

Requirements and Limits
Applicable to Specific Services

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY
State/Territory: Pennsylvania
COVERED GROUPS: All
Expanded Prenatal Care Services (Reference 19)

Provide coverage and reimbursement of additional prenatal care services

A. Comparability of Services: Services are not comparable in amount; duration and scope. The authority of §9501(b) of COBRA 1985 allows an exception to provide services to pregnant women without regard to the requirements of §1902(a)(10)(b).

B. Definition of Services: Expanded prenatal care services will offer a more comprehensive and coordinated prenatal care package of services to improve pregnancy outcome. The qualified prenatal care services provider may perform the following services:

1. Intake Package — Initiates the client into the program. Includes confirmation of the pregnancy; assignment of a care coordinator; orientation to and enrollment into the program; initiation of a care coordination record which is a permanent and integral part of the client's record; problem identification and development of the initial care plan; and health promotion (1 per client per pregnancy).

2. Comprehensive Childbirth Preparation or Childbirth Preparation Review

   Full series for women who have not previously attended such a program, particularly nulliparous women or a review series for those who previously attended a childbirth preparation course (1 per client per pregnancy).

3. Outreach Bonus for First Trimester Recruitment

   When the provider's active outreach efforts result in a client's prenatal care being initiated in the first trimester and care continues with the same qualified provider throughout the second and third trimester.

4. Outreach Visit — A home or community visit by a social worker, nurse, or community health worker to initiate a woman, who has already been identified as pregnant and in need of prenatal care, into the program. To follow up missed appointments when the client cannot be reached by telephone or when otherwise warranted. (3 visits per pregnancy)

5. Home Assessment/Client Education

   A home visit by a nurse or social worker to more fully understand the environment, social or physical, that produces stress for the client during pregnancy; to provide health education when the client is unable to attend on-site; to teach parenting skills in the context of the environment in which the client lives; to help the client organize her home and life situation in order to facilitate her ability to follow prescribed health regimens; and to help the client prepare and care for her newborn infant. (2 units per visit/2 visits per week, 1 unit = 45 minutes)

6. Obstetrical Home Care

   Home care by a physician or a nurse midwife to provide components of obstetrical care to clients who have great difficulty utilizing the traditional medical system.

7. Prenatal Home Nursing Care

   Home care by a registered nurse under the direction of the obstetric care physician or practitioner for the purpose of monitoring a high-risk medical/obstetrical condition requiring bed rest or limited mobility as an alternative to hospitalization.

8. Home Health Aide Care

   Assists in the implementation of care plans established by the obstetric care physician or practitioner and overseen by the employee's home health agency to monitor vital signs and assist the bedridden pregnant woman with her hygiene, competently applies infection control and safety measures and is knowledgeable about the danger signs of pregnancy, knows how and whom to communicate to assure that timely and appropriate medical care is received.

9. Personal Care Services

As a prior authorized service, personal care services are provided in the recipient's home in accordance with the recipient's plan of treatment as prescribed by a physician. (2 units per visit/2 visits per week, 1 unit = 45 minutes)

10. Indepth Nutrition Counseling

Nutrition counseling is provided for clients with identified, persistent, suboptimal dietary behaviors at least during the pregnancy. The need for this service must be identified in the Care Coordination Record and the Comprehensive Problem List. Nutrition counseling may be provided by a nutritional or registered dietician depending on the nature and complexity of the problem.

11. Psychosocial Counseling

Provided for problems that threaten the client's ability to cope with her pregnancy and her role as a mother. Such problems include premature or unwanted pregnancy, abuse, neglect and abandonment. The need for this service must be identified in the Care Coordination Record and Comprehensive Problem List. Psychosocial counseling may be provided by a social worker or psychologist depending on the nature and complexity of the problem.

12. Smoking (Tobacco) Cessation Counseling

One to one smoking cessation counseling by the medical provider or the care coordinator supplemented by culturally appropriate self-help materials. The need for this service must be identified in the Care Coordination Record and the Comprehensive Problem List.

13. Substance Abuse Problem Identification and Referral Counseling

Substance abuse problem identification and referral counseling by qualified provider staff followed by referral to inpatient hospital detoxification and outpatient drug and alcohol rehabilitation counseling. The service is to be provided by or under the direction of the social worker in charge of psychosocial services as outlined in the maternity services manual.

14. Genetic Risk Identification
Information and Referral

Genetic risk information and referral links the genetic screening regularly done during pregnancy and the more in-depth genetic testing and counseling, done by a genetic specialist, for a specific identified genetic risk. It must be conducted by the obstetric care practitioner. (2 units per pregnancy, 1 unit = 45 minutes)

15. Prenatal Parenting Program

An organized program to improve the parenting skills for clients and their partners who are not prepared psychologically for their role as parent and/or who are lacking in the necessary child care knowledge and skills as described in the maternity services manual.

16. Prenatal Exercise Series

Weekly exercise classes especially for pregnant woman. An optional service to both the provider and client. (1 per client per pregnancy)

17. Urgent Transportation

Payment for urgent transportation where the obstetrician must see the client to access her immediate health condition. (Receipted services)

18. Basic Maternity Services

Payment for first, second, and third trimester basic maternity care package as described in the maternity services manual.

19. High Risk Maternity Services

Payment for first, second, and third trimester high medical/obstetrical risk care package as described in the maternity services manual.

20. Second Trimester High Risk Maternity
Package with Delivery

This service may be billed when the client delivers during the second trimester.

21. Third Trimester High Risk Maternity Services

A qualified provider may bill for this service, when applicable, as described in the maternity services manual.

C. Qualified Providers: The provider, whether approved as a hospital obstetric clinic, community health center, migrant health center, rural health center, birthing center, family planning clinic, home health agency, or private obstetric or family practice, must have a concentration or specialization in prenatal services. The provider must employ one or more care coordinators and must meet the requirements described in Section II, Program Requirements of the Maternity Services Manual.

Source: Healthy Beginnings Plus Maternity Services Manual and the Healthy Beginnings Plus Program Fee Schedule, Provider Billing Guide

State Plan under Title XIX of the Social Security Act
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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 compete 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;

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- 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 on annual monitoring, to determine whether the following conditions are met:
  - o Services are being furnished in accordance with the individual's care plan;
  - o Services in the care plan are adequate; and
  - o 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;

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c. Demonstrate the ability to provide comprehensive full time case management services;
d. Administrative capacity to document and maintain individual case management records in accordance with state and federal requirements;
e. Ability to meet state and federal requirements for documentation, billing and audits.
f. Hold a current certificate of compliance from the State to provide case management services to individuals with serious mental illness.

Case management is provided by a staff person who meets one of the following requirements:

a. A Bachelor's degree; or,

b. Registered nurse; or

c. A high school diploma and 12 semester credit hours in sociology, social welfare, psychology, gerontology, or other social science and two years of experience in direct contact with mental health consumers; or

d. A high school diploma and five years of mental health direct care experience in public or private human services with employment as a case management staff person prior to April 1, 1989.

Mental health direct care experience is working directly with mental health service consumers (adults, children, or adolescents) providing services involving casework or case management, individual or group therapy, crisis intervention, early intervention, vocational training, residential care, or social rehabilitation in a mental health facility or in a facility or program that is publicly funded to provide services to mental health consumers, or in a nursing home, a juvenile justice agency, or a children and adolescent services agency.

Case management staff who were employed as case managers prior to September 1, 1993 under federal standards that existed prior to April 1, 1993 are exempt from the qualifications standards listed above.

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.

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TARGETED CASE MANAGEMENT SERVICES
Individuals with Severe Mental Illness

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
X Target group consists of eligible individuals with serious mental illness or serious emotional disturbance. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with serious mental illness receive needed services. Agencies providing case management services will need a certificate of compliance from the state. This certificate of compliance ensures the provider is appropriately qualified to serve individuals with serious mental illness.

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).

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TARGETED CASE MANAGEMENT SERVICES
Individuals with Severe Mental Illness

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 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))

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TARGETED CASE MANAGEMENT SERVICES
Individuals with Severe Mental Illness

RESERVED

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

TARGETED CASE MANAGEMENT SERVICES
Individuals with Severe Mental Illness

RESERVED

Supplement 3 to Attachment 3.1-A

State of _Pennsylvania_
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.
_____
_____

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. __X__ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are: (See Page 1a)

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. __X__ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II – Compliance and State Monitoring of the PACE Program.

C. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1. _____ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

Individuals receiving services under this program are eligible under the following eligibility groups:

- A Special Income level equal to 300% of the SSI Federal benefit (FBR) (42 CFR 435.217)

(a). Sec. 435.726—States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1.____ The following standard included under the State plan (check one):

(a) _____ SSI
(b) _____ Medically Needy
(c) _____ The special income level for the institutionalized
(d) _____ Percent of the Federal Poverty Level: _____%
(e) _____ Other (specify):_____

2.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

3.____ The following formula is used to determine the needs allowance:

_____
_____

Note: If the amount protected for PACE enrollees in item1 is equal to , or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1.____ SSI Standard
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5.____ The following percentage of the following standard that is not greater than the standards above: ____% of _____ standard.
6.____ The amount is determined using the following formula:

_____
_____
7.____ Not applicable (N/A)

(C.) Family (check one):

1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above: ____% of _____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7.____ Not applicable (N/A)

(2) Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. _____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735—**States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
(A) Individual (check one)
1.____ The following standard included under the State plan (check one):
(a) _____ SSI
(b) _____ Medically Needy
(c) _____ The special income level for the institutionalized
(d) _____ Percent of the Federal Poverty Level: _____%
(e) _____ Other (specify):_____
2.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
3.____ The following formula is used to determine the needs allowance:
_____
_____

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B.) Spouse only (check one):

1.____ The following standard under 42 CFR 435.121:
_____

2.____ The Medically Needy Income Standard
_____

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4.____ The following percentage of the following standard that is not greater than the standards above: ____% of _____ standard.

5.____ The amount is determined using the following formula:
_____
_____

6.____ Not applicable (N/A)

(C.) Family (check one):

1.____ AFDC need standard

2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

4.____ The following percentage of the following standard that is not greater than the standards above: ____% of _____ standard.

5.____ The amount is determined using the following formula:
_____
_____

6.____ Other

7.____ Not applicable (N/A)

(2) Medical and remedial care expenses in 42 CFR 435.735.

Spousal Post Eligibility

3. _____ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a

Spousal Post Eligibility

State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance consistent with the minimum monthly maintenance needs allowance described in section 1924(d), a family allowance, for each family member, calculated as directed by section 1924(d)(1)(C), and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.
Yes ____ **No** ____

Note: states must elect the use the post-eligibility treatment-of-income rules in section 1924 of the Act in the circumstances described in the preface to this section.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A).____ The following standard included under the State plan (check one):

1. _____ SSI
2. _____ Medically Needy
3. _____ The special income level for the institutionalized
4. _____ Percent of the Federal Poverty Level: _____%
5. _____ Other (specify):_____

(B). ____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C). ____ The following formula is used to determine the needs allowance:

_____
_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____
_____
_____
_____
_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be less than the cost to the agency of providing State plan approved services to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the amount the state would have otherwise paid for a comparable population.

1. _x_ Rates are set at a percent of the amount that would otherwise been paid for a comparable population.
2. _x_ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. _x_ Adjusted Community Rate (please describe)
1. _x_ Other (please describe)

The rates will be paid as a percentage of the amount that would have otherwise been paid (AWOP) and set on an annual basis after negotiation with the LIFE providers. Consideration of differences between the Medicaid population from which the PACE AWOP is developed and the actual enrollment in the PACE plan, including relative acuity will also be made.

[Reserved]

Rate Methodology

The Department will determine on an annual basis the rates paid to the Program of All-Inclusive Care of the Elderly (PACE) plans as a percentage of the *amount that would have otherwise been paid* (AWOP). The AWOP percentage will be determined after negotiation with the LIFE providers and consideration of differences between the Medicaid population from which the PACE AWOP is developed and the actual enrollment in the PACE plans including relative acuity. The AWOP is based on the current Medicaid delivery system costs derived from a comparable population (55 or older) or nursing facility and Home and Community-Based Services (HCBS) eligible. In order to develop the AWOP, the data from sub-populations (Dually Eligible and Non-Dually Eligible) of nursing facility and HCBS clients was blended into the final AWOP table. Paid Medicaid claims were the source data for the AWOP calculation. Detailed claims data was obtained from the State's Provider Reimbursement and Operations Management System (PROMISe).

The following two groups will be used to determine payment for PACE:
Dually Eligible Individuals (Medicaid and Medicare)
Non-Dually Eligible Individuals (Medicaid Only)

The State assures CMS that the capitated rates are less than comparable Medicaid costs as defined by the PACE AWOP.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval, and will include the name, organizational affiliate of any actuary used, and attestation/description of the capitation rates.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

CASE MANAGEMENT SERVICES

A. Target Group:

Those pregnant women with a high incidence of medical and/or social problems which could constitute a serious hazard and may result in complications, prolonged hospitalization or death to the mother and/or fetus.

B. Areas of State in which services will be provided:

|_X_| Entire State

HIO participants are excluded from these services.

|___| Only in the following geographic areas (authority of section 1915(g)(1)) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services:

|___| Services are provided in accordance with section 1902(a)(10)(B) of the Act.

|_X_| Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management is a service which provides targeted medical assistance clients with access to comprehensive medical and social services to encourage the cost effective use of medical and community resources, while ensuring the client's freedom of choice, and promoting the well-being of the individual.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

Under the authority of Section 1915(g) of the Social Security Act, case management services are those which will assist pregnant women, with high risk factors, who are eligible under Medicaid to gain knowledge of and access to needed medical, social, educational, and other services.

Activities to be undertaken by the case manager are as follows:

1. Screening – All individuals who request or are referred for case management are evaluated for eligibility in the targeted group.

2. Assessment – Based on the medical treatment plan established by the client's physician, the client and the case manager will develop a realistic goal. The client's situation will be evaluated and needed services identified.

3. Development and Implementation of a Service Coordination Plan (SOP) – The case manager in conjunction with the client, will develop an action plan that specifies concrete activities which are to be completed so that the established agreed upon goal can be achieved. The case manager must react promptly to emergency situations which may jeopardize the goal of the SCP.

4. Linkage and Coordination of Services – Locating resources and making referrals or arrangements for treatments and support services relative to service plan implementation.

5. Client facilitator – At times, it may be necessary for the case manager to act as a facilitator in resolving access problems that arise in implementing the SCP.

6. Monitoring – Insuring appropriate quantity, quality, and effectiveness of services in accordance with the SCP.

7. Reassessment – confer with the client and review the SCP periodically as determined by the Department, for continuity of needs and services received.

E. Qualification of Providers

Enrollment will be accomplished in accordance with section 1902(a)(23) of the act.

Case Manager Qualifications.

a. RN licensed in Pennsylvania with a minimum of 1 year case management experience, 12 semester hours of psychology, sociology, and other social welfare courses, 1 year experience working with pregnant women and documented case management training.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

b. MSW/MSS with a minimum of 1 year case management experience, and documented case management training.

c. BSW/BSS with a minimum of 1 year case management experience, and documented case management training.

d. MSN/or equivalent Master's Nursing degree with a minimum of 1 year case management experience, and documented case management training.

e. BSN/or equivalent nursing degree with a minimum of 1 year case management experience, and documented case management training.

Documented case management training includes college credit, and/or workshop certificate (formal in or out-service training). Case management (CM) applicants without documented case management training but possessing other qualifications can apply to state staff for a waiver. An additional year of documented case management experience may be substituted for formal case management training via the waiver.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

F. 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 recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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

TARGETED CASE MANAGEMENT SERVICES
Individuals who have contracted AIDS (Acquired Immune Deficiency Syndrome) or symptomatic HIV (Human Immune-Deficiency Virus)

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
The target group consists of categorically needy and medically needy clients who have contracted:

1. AIDS (Acquired Immune Deficiency Syndrome) or symptomatic HIV (Human Immune-Deficiency Virus)

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to ___ 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 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; and
  - monthly assessments of effectiveness and need for services due to changes in the individual's medical condition.

- 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: Pennsylvania

TARGETED CASE MANAGEMENT SERVICES
Individuals who have contracted AIDS (Acquired Immune Deficiency Syndrome) or symptomatic HIV (Human Immune-Deficiency Virus)

- 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 these 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, 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.
  - Initial contact with the recipient or recipient's representative within 30 days with follow-up meetings at least every six months due to changes in medical condition and related service needs.

_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 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Minimum Case Manager Qualifications:

1. Registered Nurse licensed in Pennsylvania with a minimum of 1 year case management experience, combination of 12 semester hours of psychology, sociology, and other social welfare courses, 1 year experience working with medically ill patients and documented case management training.

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TARGETED CASE MANAGEMENT SERVICES
Individuals who have contracted AIDS (Acquired Immune Deficiency Syndrome) or symptomatic HIV (Human Immune-Deficiency Virus)

1. Master's of Social Work/Master's of Social Science with a minimum of 1 year case management experience, and documented case management training.
2. Bachelor's of Social Work/Bachelor's of Social Science with a minimum of 1 year case management experience, and documented case management training.
3. Master's of Science in Nursing/or equivalent Master's Nursing degree with a minimum of 1 year case management experience, and documented case management training.
4. Bachelor's of Science in Nursing/or equivalent nursing degree with a minimum of 1 year case management experience, and documented case management training.

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.

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.

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 care 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.

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

TARGETED CASE MANAGEMENT SERVICES
Individuals who have contracted AIDS (Acquired Immune Deficiency Syndrome) or symptomatic HIV (Human Immune-Deficiency Virus)

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 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 it 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))

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

TARGETED CASE MANAGEMENT SERVICES
Children Under Age Three With a
Developmental Delay

Target Group (42 Code of Federal Regulations 441.18(a)(8)(I) and 441.18(a)(9)):

The target group consists of children under the age of three who are assessed with:

1. A developmental delay.

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 30 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 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;
  - monthly assessments, necessary due to the frequent changes in the infant or toddlers' growth and development.

- 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: Pennsylvania

TARGETED CASE MANAGEMENT SERVICES
Children Under Age Three With a
Developmental Delay

- 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 these 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, 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.
  - Quarterly face-to-face monitoring with infants and toddlers and their families in the home to:
    - coordinate the provision of Early Intervention services and other services (such as medical services for other than diagnostic and evaluation purposes) that the infant or toddler needs or is being provided;
    - provide guidance to the family in identifying available service providers;
    - facilitate the timely delivery of early intervention services;
    - inform the family of the availability of advocacy services;
    - offer the family opportunities and support for the infant or toddler with a disability to participate in community activities with other children;
    - inform the family of appropriate community resources.

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

TARGETED CASE MANAGEMENT SERVICES
Children Under Age Three With a
Developmental Delay

_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 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Minimum Case Manager Qualifications:

1. A Bachelor's of Social Sciences (BSS) degree from an accredited college or university which includes 12 college credits in Early Intervention, early childhood special education, early childhood education, child development, special education, family counseling, family studies, social welfare, psychology or other comparable social sciences, and 3 years of full-time or full-time equivalent experience working with or providing counseling to children, families or individuals with developmental disabilities and documented case management training.

2. A Bachelors of Arts (BA) degree from an accredited college or university which includes 12 college credits in Early Intervention, early childhood special education, early childhood education, child development, special education, family counseling, family studies, social welfare, psychology or other comparable social sciences, and 3 years of full-time or full-time equivalent experience working with or providing counseling to children, families or individuals with developmental disabilities and documented case management training.

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: Pennsylvania

TARGETED CASE MANAGEMENT SERVICES
Children Under Age Three With a
Developmental Delay

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
X 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.

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 care 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 §441.169 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 §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care

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

TARGETED CASE MANAGEMENT SERVICES
Children Under Age Three With a
Developmental Delay

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 it 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))

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

[RESERVED]

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

[RESERVED]

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

[RESERVED]

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Pennsylvania

[RESERVED]

A. Non-Emergency Medical Transportation (NEMT) Brokerage Program specific responsibilities:

(1) The NEMT broker is responsible for arranging transportation to MA covered services for MA recipients residing in Philadelphia County who do not otherwise have transportation available. The specific responsibilities of the broker are:

- Inform and educate MA Recipients regarding transportation services
- Operate a call center
- Manage the program to ensure cost effective, appropriate transportation services are provided
- Maximize cost-effectiveness and quality services through coordination with local programs and stakeholders
- Verify MA Recipient Eligibility and transportation services need
- Authorize transportation services, schedule and dispatch trips
- Ensure quality of services through a complaint tracking system
- Maintain confidentiality of information
- Report consumer fraud

(2) The NEMT broker is a non-governmental entity that will not itself provide transportation under the contract with the State or subcontract with or refer to a transportation provider with which it has a financial interest or relationship.

(3) Payment to the NEMT broker is made based on a capitated per member per month fee (PMPM).

State of Pennsylvania

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) _X_ MAT as described and limited in this Supplement 8 to Attachment 3.1A.

ATTACHMENT 3.1A/3.1B identifies the medical and remedial services provided to the categorically needy.

State of Pennsylvania

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to Categorically Needy (continued)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020, and ending September 30, 2025

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

a. Individual, Group, and Family Therapy

- Counseling services and behavioral health therapies are activities using social, psychological, medical or support services to assist individuals to deal with the causative effects or consequences of drug or alcohol use.
- A family therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgement, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

b. Individual, group, and family therapies are provided by counselors and/or counselor assistants within the licensed drug/alcohol outpatient clinic.

State of Pennsylvania

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to Categorically Needy (continued)

c. Qualifications for each practitioner

- A counselor must meet at least one of the following groups of qualifications:
  - Current licensure in this Commonwealth as a physician.
  - A Master's Degree or above from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field which includes a practicum in a health or human service agency, preferably in a drug and alcohol setting.
  - A Bachelor's Degree from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field and 1 year of clinical experience in a health or human service agency, preferably in a drug and alcohol setting.
  - An Associate Degree from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field and 2 years of clinical experience in a health or human service agency, preferably in a drug and alcohol setting.
  - Current licensure in this Commonwealth as a registered nurse and a degree from an accredited school of nursing and 1 year of counseling in a health or human service agency, preferably in a drug and alcohol setting.
  - Full certification as an addiction counselor by a statewide certification body which is a member of a National certification body or certification by another state government's substance abuse counseling certification board.

  A counselor must complete at least 25 hours of training annually.

- A counselor assistant who does not meet the educational and experimental qualifications for the position of counselor may be employed as a counselor assistant if the requirements of at least one of the following paragraphs are met.
  - A Master's Degree in a human service area.
  - A Bachelor's Degree in a human service area.
  - Licensure in this Commonwealth as a registered nurse.
  - An Associate Degree in a human service area.
  - A high school diploma or General Education Development (GED) equivalent.

  A counselor assistant must complete at least 40 hours of training the first year and 30 clock hours annually thereafter.

- Supervision – Counselors are supervised by a clinical supervisor. A counselor assistant is supervised by a full-time clinical supervisor or counselor.

State of Pennsylvania

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to Categorically Needy (continued)

iv. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)

__X__ Generic first policy
__X__ Preferred drug lists
__X__ Clinical criteria
__X__ Quantity limits

_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

- MAT drugs and biologicals
  - Coverage of non-generic and non-preferred drugs and biologicals may be subject to prior authorization documenting a trial of preferred products, or medical necessity. Prescriptions may be limited to clinically appropriate quantities and/or frequencies unless medical necessity is documented via prior authorization.
- Counseling and behavioral therapies related to MAT
  - There are no limitations on amount, duration, or scope.

PRA Disclosure Statement – This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020 and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State of Pennsylvania

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(b)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) _X_ MAT as described and limited in this Supplement 1 to Attachment 3.1B.

ATTACHMENT 3.1A/3.1B identifies the medical and remedial services provided to the medically needy.

State of Pennsylvania

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

The state covers the following counseling services and behavioral health therapies are covered as part of MAT.

a. Individual, Group, and Family Therapy

- Counseling services and behavioral health therapies are activities using social, psychological, medical or support services to assist individuals to deal with the causative effects or consequences of drug or alcohol use.
- A family therapy service that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgement, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

b. Individual, group, and family therapies are provided by counselors and/or assistant counselors within the licensed drug/alcohol outpatient clinic.

State of Pennsylvania

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

c. Qualifications for each practitioner

- A counselor must meet at least one of the following groups of qualifications:
  - Current licensure in this Commonwealth as a physician.
  - A Master's Degree or above from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field which includes a practicum in a health or human service agency, preferably in a drug and alcohol setting.
  - A Bachelor's Degree from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field and 1 year of clinical experience in a health or human service agency, preferably in a drug and alcohol setting.
  - An Associate Degree from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field and 2 years of clinical experience in a health or human service agency, preferably in a drug and alcohol setting.
  - Current licensure in this Commonwealth as a registered nurse and a degree from an accredited school of nursing and 1 year of counseling in a health or human service agency, preferably in a drug and alcohol setting.
  - Full certification as an addiction counselor by a statewide certification body which is a member of a National certification body or certification by another state government's substance abuse counseling certification board.

  A counselor must complete at least 25 hours of training annually.

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  - A Master's Degree in a human service area.
  - A Bachelor's Degree in a human service area.
  - Licensure in this Commonwealth as a registered nurse.
  - An Associate Degree in a human service area.
  - A high school diploma or General Education Development (GED) equivalent.

  A counselor assistant must complete at least 40 hours of training the first year and 30 clock hours annually thereafter.

- Supervision – Counselors are supervised by a clinical supervisor. A counselor assistant is supervised by a full-time clinical supervisor or counselor.

State of Pennsylvania

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

iv. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)

__X__ Generic first policy
__X__ Preferred drug lists
__X__ Clinical criteria
__X__ Quantity limits

_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

- MAT drugs and biologicals
  - Coverage of non-generic and non-preferred drugs and biologicals may be subject to prior authorization documenting a trial of preferred products, or medical necessity. Prescriptions may be limited to clinically appropriate quantities and/or frequencies unless medical necessity is documented via prior authorization.
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