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

1. Individual Practitioners, i.e., Physicians, Dentists, Chiropractors, Optometrists, Podiatrists

   Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician, dentist, chiropractor, optometrist, and podiatrist services. The agency's fee schedule rate was set as of July 1, 2016, and is effective for services provided on or after that date. All rates are published on the Department of Human Services' website at:
   http://www.dhs.pa.gov/publications/forproviders/schedules/mafeeschedules/index.htm

2. Prescribed Drugs

   A. Method of Payment – The Department's payment for a compensable brand name drug or generic drug is based on Actual Acquisition Cost (AAC), as defined in 42 CFR 447.502, plus a professional dispensing fee.

      1. For brand name drugs, payment is the lower of
         - The provider's usual and customary charge to the general public,
         - The National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee, or
         - In the absence of a NADAC, Wholesale Acquisition Cost (WAC) minus 3.3%, plus a professional dispensing fee.

      2. For generic drugs, payment is the lower of
         - The provider's usual and customary charge to the general public,
         - The NADAC plus a professional dispensing fee, or
         - In the absence of a NADAC, WAC minus 50.5%, plus a professional dispensing fee.
         - The CMS established Federal Upper Limit (FUL) plus a professional dispensing fee, or
         - The Department's State Maximum Allowable Cost (State MAC), plus a professional dispensing fee.

      3. Professional Dispensing Fee – The professional dispensing fee is $10.00, based on a State-Conducted survey of enrolled pharmacies. For Medical Assistance beneficiaries with a pharmacy benefit resource which is a primary third-party payer to Medical Assistance, the Department will pay a $0.50 claim transmission fee.

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

2. Prescribed Drugs (continued)

4. Payment for the following is:
    a. Drugs purchased by a 340B covered entity will be paid at AAC, up to the 340B ceiling price, plus a professional dispensing fee;
    b. Drugs purchased by 340B covered entities outside of the 340B program will be paid according to the same methodology as A.1., A.2., and A.3. above;
    c. Drugs dispensed by 340B contract pharmacies will be paid according to the same methodology as A.1., A.2., and A.3. above;
    d. Physician administered drugs acquired through the federal 340B drug pricing program will be paid at AAC up to the 340B ceiling price.
    e. Drugs acquired through the Federal Supply Schedule (FSS) will be paid at AAC plus a professional dispensing fee;
    f. Drugs acquired at a nominal price (outside of 340B or FSS) will be paid at AAC plus a professional dispensing fee;
    g. Drugs dispensed by long term care pharmacies will be paid according to the same methodology as A.1., A.2., and A.3. above.

5. Payment for specialty drugs, including hemophilia clotting factor, is covered under the Section 1915(b) Waiver for FFS Selective Contracting Programs (Specialty Pharmacy Drug Program).

6. Payment for prescriber administered drugs is limited to ingredient cost (no dispensing fee) based on the following amounts:

    a. For brand name drugs, the lower of
        - The provider's usual and customary charge, or
        - WAC + 3.2%.

    b. For generic drugs, the lower of
        - The provider's usual and customary charge,
        - WAC + 0%
        - FUL, or
        - State MAC.

7. Investigational drugs are not a covered service under Pennsylvania's Medicaid pharmacy program.

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

RESERVED

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

SERVICE		LIMITATIONS
3.	Outpatient Clinic Services	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient clinic services. The agency's fee schedule (rate) was last updated on June 25, 2012, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm State Agency Fee Schedule Based on Established Criteria.* Outpatient clinic provider qualifications are located under item 9a. "Independent Medical Clinics", in Attachments 3.1-A and 3.1-B Payment Limitations Clinic visits are limited to one visit per day per MA beneficiary for the same condition. Clinics have the option of billing either the fee for a specific compensable procedure performed in the clinic or, but not in addition to, the flat visit fee, except that diagnostic medical services such as electrocardiograms, electroencephalograms, electromyographies and diagnostic or therapeutic radiology services provided during routine examination and treatment services are compensable in addition to the flat visit fee or fee for a specific compensable procedure. Endoscopic procedures, such as rhinoscopy, otoscopy or indirect laryngoscopy performed in the course of the visit are not compensable in addition to the flat visit fee.

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

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

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

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

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

SERVICE	LIMITATIONS
6. Transportation for recipients is available in two modes: Ambulance (both emergency and non-emergency) and non-emergency non-ambulance	
i. Transportation – Emergency and Non-Emergency Ambulance	Payment is based on a flat fee schedule rate as determined by the level of support per trip. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ambulance services. The agency's fee schedule rates were last updated on January 1, 2024, and are effective for services provided on or after that date. All rates are published on the agency's website at: https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/MA-Fee-Schedule.aspx. Payment Limitations 1. If more than one person is transported during the same trip, either to the same destination or a different destination, payment is made for transportation of the person whose destination is the greatest distance. No additional payment is allowed for the additional person. 2. Ground mileage is paid for each loaded mile from point of pick-up to destination. 3. Air mileage is paid for each loaded mile beyond 20 loaded miles of a trip from point of pick-up to destination. Provider Qualifications Ambulance service providers must be licensed by the Pennsylvania Department of Health.
ii. Transportation – Non-Emergency Medical Transportation	Transportation provided through section 1902(a)(70) non-emergency medical transportation brokerage program.
iii. Brokerage Program	Payment is made based on a capitated Per member, Per Month Fee.

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

SERVICE	LIMITATIONS
8. Rural Health Clinic Services	Payment is made on the basis of an all-inclusive visit fee established by the Department. See page 2c for descriptions of the prospective payment system (PPS) and supplemental payments under managed care. Alternative Payment Methodology a) Managed Care Organizations (MCOs) Effective with dates of service on and after January 1, 2016, MCOs began paying rates that are not less than the Fee-for-Service (FFS) provider specific PPS rate to RHCs that participate in the MCO network. Beginning June 1, 2017, RHCs participating in MCO provider networks have the option to elect to receive payments from MCOs that are at least equal to their FFS provider specific PPS rate. If the RHC does not elect this option, the Department will make supplemental payments to RHCs that equal the difference between the payment under the PPS rate and the payment provided by the MCO.

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

SERVICE	LIMITATIONS
8. Federally Qualified Health Center Services	For core services, payment is made on the basis of an all-inclusive visit fee established by the Department. Prospective Payment System (PPS) a. For the period January 1, 2001, through September 30, 2001, the Department will pay FQHCs/RHCs, on a per visit basis, 100% of the average of their audited reasonable costs related to the provision of Medicaid covered services during Fiscal Years 1999 and 2000, adjusted to account for any increase or decrease in the scope of such services furnished by the FQHC/RHC during that fiscal year. b. Beginning October 1, 2001, and for each fiscal year thereafter, the Department will pay FQHCs/RHCs, on a per visit basis, the amount paid for the preceding fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care services for the current fiscal year, adjusted to take into account any increase or decrease in the scope of such services furnished by the FQHC/RHC during that fiscal year. c. For FQHCs/RHCs newly qualified after the fiscal year 2000, the Department will pay for the initial year, on a per visit basis, 100% of the reasonable costs related to provision of Medicaid-covered services of other centers/clinics located in the same or adjacent areas with similar caseloads. In the absence of such other centers/clinics, the Department will use the FQHC's/RHC's cost report to set the rate. For the next fiscal year, the Department will pay, on a per visit basis, the amount paid for the initial year, adjusted to reflect the actual audited reasonable costs of the FQHC/RHC, increased by the percentage increase in the MEI applicable to primary care services for the current fiscal year and adjusted to take into account any increase or decrease in the scope of such services furnished by the FQHC/RHC during that fiscal year. For subsequent fiscal years, the Department will use the payment methodology set forth in (b) above. Alternative Payment Methodologies (APMs) a. Managed Care Organizations (MCOs) Effective with dates of service on and after January 1, 2016, MCOs began paying rates that are not less than the Fee-for-Service (FFS) provider specific PPS rate to FQHCs that participate in the MCO network. Beginning June 1, 2017, FQHCs participating in MCO provider networks have the option to elect to receive payments from MCOs that are at least equal to their FFS provider specific PPS rate. If the FQHC does not elect this option, the Department will make supplemental payments to FQHCs that equal the difference between the payment under the PPS rate and the payment provided by the MCO. b. FQHC Delivery Services – Inpatient Hospital Effective with dates of service on and after December 1, 2016, the Department pays FQHCs that agree to this APM the practitioner's delivery fee from the MA Program Fee Schedule for a delivery performed by FQHC personnel in the acute care general hospital inpatient setting. The APM payment is a rate that is at least equal to the FQHC's provider specific PPS rate.

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

Alternative Payment Methodology for Public FQHCs Located in a City of the First Class

SERVICE	LIMITATIONS

c. Public FQHCs Located in a City of the First Class

Effective with dates of service on and after April 1, 2019, through March 31, 2024, the Department pays FQHCs that are located in and operated by a city of the first class and agree to this APM, a Medical Assistance Encounter Rate (MAER) for medical services as determined by the Department as follows. State fiscal year 2016-2017 data is utilized unless otherwise noted. The MAER is determined by dividing the Medicaid portion of the FQHC's total medical costs applicable to FQHC services by the FQHC's number of Medicaid visits. The FQHC's medical costs applicable to FQHC services are identified in the FQHC's Medicaid cost report most recently reviewed and accepted by the Department. The Medicaid portion of costs is determined by applying the FQHC's Medicaid patient percentage to the FQHC's total medical costs applicable to FQHC services. The FQHC's Medicaid patient percentage is calculated as a patient-weighted average Medicaid patient percent for the combined FQHC and FQHC look-alike as identified in the Health Resources & Services Administration (HRSA) 2017 Health Center Profile. The number of Medicaid visits are identified in the Department's MMIS data. A city of the first class is a city with more than one million residents.

The MAER is a rate that is at least equal to the FQHC's provider-specific PPS rate on an encounter basis. For those FQHCs contracting with a Medicaid Managed Care Organization (MCO), the Department will determine whether each Medicaid MCO, at a minimum, reimbursed the FQHC at least 100% of the MAER on a quarterly basis. The Department will provide supplemental payments (wrap payments) to an FQHC in an amount equal to the difference between the MCO's payment and 100% of the MAER multiplied by the number of visits. The Department will make wrap payments on a quarterly basis.

Effective April 1, 2024, the FQHC's payment rate will revert to the PPS rate effective on March 30, 2019, as adjusted annually by the Medicare Economic Index.

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

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

9.a School-Based Service Providers

School-based service providers provide the following services in LEAs through the School-Based ACCESS Program:

Assistive Technology Devices
Nursing Services
Nurse Practitioner Services
Occupational Therapy Services
Orientation, Mobility and Vision Services
Personal Care Services
Physical Therapy Services
Physician Services
Psychological, Counseling and Social Work Services
Special Transportation Services
Speech, Language and Hearing Services

General Description of Payment Methodology

Effective with dates of service on or after July 1, 2013, school-based services provided by Local Education Agencies (LEAs), including special transportation services, will be paid on a cost basis. LEAs will initially be paid provider-specific interim rates for school-based direct health-related services per unit of service. The provider-specific interim rate is the provisional rate established for a specific service for a time period pending completion of cost reconciliation and cost settlement for that period. On an annual basis, a provider-specific cost reconciliation and cost settlement for all overpayments and underpayments will be processed.

The units of service are defined by each Health Insurance Portability and Accountability act (HIPAA) compliant current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Direct health-related services may be encounter-based or in 15-minute unit increments.

Effective with dates of service on or after January 1, 2015, LEAs that are government units and enrolled in the Medical Assistance (MA) Program as the qualified providers of service, may contract with Approved Private Schools (APS) to provide school-based services. The cost of providing school-based services will be modified to include the contracted cost of services provided by APSs. This cost will be included in the government unit's LEA cost report as a contracted cost. The LEA will not apply the cognizant agency indirect rate to the APS contracted cost when determining the overall cost of school-based services. The reimbursement unit will be included on the government unit LEA's cost report as a contracted cost. The APS is not required to submit a cost report or certify utilization of public funds.

Specific Components of Cost-Based Payment Methodology

Total direct and indirect costs of providing health-related services, less any federal payments for these costs, will be captured utilizing the following sources:

a. Annual cost reports received from LEAs;
b. Pennsylvania Department of Education (PDE) Unrestricted Indirect Cost Rate (UICR);
c. Random Moment Time Study (RMTS) Activity Code 4b (Direct Health-related Services), Activity Code 5b (Transportation related to Medicaid services) and

Activity Code 10 (General Administration); Direct Health-related RMTS Percentage; and

d. Provider specific Individualized Education Program (IEP) Ratios.

Allowable costs will be multiplied by the Direct Health-related RMTS Percentage. The product will be multiplied by the Medicaid Eligibility Rate to determine the total reimbursable costs for each participating LEA.

Cost Reports

Each LEA will complete an annual cost report for all school-based direct health-related services delivered during the previous state fiscal year (July 1 through June 30). The cost report is due within eight (8) months after the close of the fiscal year. The cost report will:

- Document the LEA's total Medicaid-allowable direct and indirect costs for delivering school-based direct health-related services, based on the CMS cost allocation methodology which includes a CMS approved cost report, utilization of a CMS time study and application of the cost reconciliation methodology outlined in this section.; and
- Each LEA certifies annually through its cost report the total computable costs, the amount of interim payments and the number of units billed for the fiscal year. With regard to LEA's that do not contract with APSs, certifiable costs are limited to each LEA's UICR.

The annual cost report includes a certification of funds statement, certifying the LEA's actual incurred costs and expenditures. The annual cost reports are subject to a desk review by the Department or its designee.

Allowable costs include:

- Direct health-related services, including salaries, benefits, health-related purchased services; and health-related supplies and materials.
- Indirect costs using the provider-specific UICR applicable in the fiscal year, as approved by Pennsylvania's cognizant agency for education services, the U.S. Department of Education.
- Transportation costs, including only those personnel and non-personnel costs associated with special education reduced by any federal payments for those costs. The costs identified on the cost report include the following:
  - Bus Drivers
  - Mechanics
  - Substitute Drivers
  - Fuel
  - Repairs & Maintenance
  - Rentals
  - Contract Use Cost
  - Depreciation
- Costs for services provided by an APS under contract with the government unit LEA are included on the cost report as a contracted cost.

Each LEA certifies annually through its cost report the total actual incurred allowable costs and expenditures, including the federal and non-federal share, the amount of interim payments and the number of units billed for the fiscal year. Certifiable indirect costs are limited to each LEA's UICR.

Direct Health-related Random Moment Time Study Percentage

The time study is used to determine the percentage of time that personnel spend on direct health-related services, general and administrative time and all other activities to account for 100% of time to assure that there is no duplicate claiming. This time study methodology will utilize two mutually exclusive cost pools representing individuals performing direct health-related services and administrative activities. The appropriate time study results will be applied to both cost pools.

IEP Ratio Determination – Medicaid Eligibility Rate

An LEA-specific IEP ratio will be established for each participating LEA. When applied, this IEP ratio will reduce the direct health-related cost pool by the percentage of beneficiaries eligible for MA who have an IEP.

The names and birthdates of MA-eligible beneficiaries with an IEP will be identified and matched against the Department's December 1 eligibility files to determine the percentage of those who are eligible for MA. The numerator of the rate will be the MA-eligible beneficiaries with an IEP, and the denominator will be the total number of students with an IEP.

Cost Reconciliation and Settlement

The cost reconciliation process is completed within twelve (12) months after the close of the fiscal year. The total allowable costs based on the CMS-approved cost allocation methodology are compared to the LEA's interim payments for school-based health-related services paid for dates of service during the fiscal year, as documented in the Department's claims processing system.

If a LEA's interim payments exceed the actual, certified costs the LEA incurred for school-based health-related services to MA beneficiaries, the LEA will return an amount equal to the overpayment.

If the actual, certified costs the LEA incurred for school-based health-related services exceed the interim payments, the Department will pay the federal share of the difference to the LEA in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the LEA.

The Department will issue a notice of cost settlement that denotes the amount due to or from the LEA.

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

CARE OR SERVICE	POLICY/METHODS USED TO ESTABLISH PAYMENT RATES
10. Prosthesis, Appliances, Medical Equipment and Supplies	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of prosthesis, appliances, medical equipment and supplies. The agency's fee schedule (rate) was last updated on December 10, 2012, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm. State Agency Fee Schedule Based on Established Criteria.* 1. One (1) month's rental fee will be applied to the purchase price of durable medical equipment. 2. Home health agencies are not reimbursed for supplies routinely needed as part of furnishing home health care.
11. Laboratory and X-ray Services	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of laboratory and x-ray services. The agency's fee schedule (rate) was last updated on December 10, 2012, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm. State Agency Fee Schedule Based on Established Criteria.*
12. Public and Private Skilled Nursing Facility Services	See Attachment 4.19-D.
13. Public and Private Intermediate Care	See Attachment 4.19-D.
14. ICF/MR (Intermediate Care Facility Services for the Intellectually Disabled)	See Attachment 4.19-D.
15. Screening Services	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of screening services. The agency's fee schedule (rate) was last updated on June 14, 2010, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm. State Agency Fee Schedule Based on Established Criteria.*
16. Outpatient Hospital Services	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule (rate) was last updated on June 5, 2012, and is effective for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm. State Agency Fee Schedule Based on Established Criteria.* Hospitals that qualify for disproportionate share payments as per attachment 4.19A, Part III.
17. Inpatient Psychiatric Services	See Attachment 4.19-A.
18. Birth Center Services	Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of birth center services. Freestanding birth centers are paid a facility fee. Physicians and Certified Nurse Midwives providing services in the freestanding birth centers are paid using fee schedule rates as referenced in section 4.19B, page 1 of the State Plan under Individual Practitioner Services. The agency's fee schedule rates were set as of September 1, 2013. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm. State Agency Fee Schedule Based on Established Criteria.*
19. Targeted service management for persons with intellectual disabilities	See Attachment 4.19B Page 8.

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

CARE OR SERVICE	POLICY/METHODS USED TO ESTABLISH PAYMENT RATES

Provision is maded for prior authorization of selected services.

Fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population.

20.	Case Management Services	State Agency Fee Schedule Based on Established Criteria.*

20. Mental Health Rehabilitative Services

See Attachment 4.19B, Page 11.

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

Maximum reimbursement fees for medical assistance covered services are determined on the basis of the following: fees will not exceed the medicare upper limit when applicable; will be consistent with efficiency, economy and quality of care; and will be sufficient to assure the availability of services to clients.

When fees are changed and when procedures, services or items are added to, or deleted from the Medical Assistance Program Fee Schedule, (except for the mandate HCFA Common Procedure Coding System (HCPCS) Updates), the Department publishes a public notice in the Pennsylvania Bulletin.

Participation in the program will be limited to providers of services who accept, as payment in full, the amounts paid in accordance with the fee schedule.

Except for rural health clinics, federally qualified health centers, partial hospitalization facilities, and pharmacies, payment for care or services under methods described in this section will not exceed the 75th percentile of prevailing customary charges for such services.

Any significant increase, decrease, or modification in this payment structure will not become operative until such change has been incorporated into this plan as an amendment to and approved by the Secretary, DHHS, in accordance with applicable regulations.

The State Agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or services or fee plus costs of material.

For all of the above, payment is limited to the amount of the provider's usual and customary charge to the general public, the Medical Assistance maximum fee or the maximum reimbursement limit except that, for partial hospitalization facilities, payment starting July 1, 1991 shall be determined according to specific rates that shall be paid regardless of those providers' usual and customary charges, which rates shall be set by the Department and shall not exceed the applicable maximum reimbursement limits.

For each disproportionate share hospital, an enhanced payment amount will be calculated by determining each hospital's percentage of the total expenditures made to all eligible disproportionate hospitals for outpatient services. Each hospital's disproportionate payment amount will be determined by applying this percentage to the total funds available for the purpose of making disproportionate payments.

EMERGENCY DEPARTMENT AND OUTPATIENT ACCESS PAYMENTS

(1) The Department will make additional outpatient payments to hospitals that meet all of the following criteria:

(a) Is an acute care general hospital that operates an emergency department.
(b) Is located in Philadelphia.
(c) Provides at least 1,000 emergency department visits in Pennsylvania (PA) Medical Assistance (MA) patients per year according to Fiscal Year (FY) 2008-2009 PA Department of Health Reports 1-A, 1-B and 4.
(d) Is not eligible for a disproportionate share payment for enhanced access to multiple types of medical care in economically distressed areas of PA as specified on page 21a of Attachment 4.19A.
(e) Does not furnish acute care inpatient services to patients who are predominantly under the age of 18.
(f) Is not eligible to receive a disproportionate share payment for enhanced access to emergency services as specified on page 21w of Attachment 4.19A of the current state plan.

(2) For each qualifying hospital, annual payment amounts will be determined as follows utilizing hospital data from FY 2009-2010 unless otherwise specified:

(a) The Department will calculate an annual payment to qualified hospitals in the lower of the following amounts:

(i) The ratio of the hospital's PA MA fee-for-service outpatient revenue to the total PA MA fee-for-service outpatient revenue for all qualified hospitals multiplied by the amount of funds allocated by the Department for these payments.

(ii) 2.91% of the hospital's net patient revenue as determined using net patient revenue as reported within "Revenue Reporting Form from Hospital Assessment" on file with the Department.

(b) If, after calculating the payment amounts in (2)(a), funds remain from the total funds allocated in the FY for these payments, the Department will increase the payment amount of a qualified hospital for which payment was authorized under (a)(i) by an amount equal to the ratio of the hospital's PA MA fee-for-service outpatient revenue to the total PA MA fee-for-service outpatient revenue of all qualified hospitals for which payment was calculated under (a)(i) multiplied by the funds remaining from the total funds allocated in the FY.

(c) The total payments made to a qualified hospital pursuant to (2)(a) and (b) shall not exceed the lower of:

(i) The payment amount permitted by the hospital's OBRA 93 hospital specific limit

(ii) 2.91% of the hospital's net patient revenue as determined using net patient revenue as reported within "Revenue Reporting Form from Hospital Assessment" on file with the Department.

For FY 2014-2015, the Department will allocate $89.478 million for this payment. Beginning with FY 2015-2016, the Department will allocate an annualized amount of $18.051 million for this payment. The Medicaid base and supplemental outpatient hospital payments in total may not exceed the Upper Payment Limit defined on page 4aa of Attachment 4.19B.

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

OUTPATIENT UPPER PAYMENT LIMIT CALCULATION

Using methodologies prescribed by CMS, DHS will prepare and submit outpatient Upper Payment Limit demonstrations in accordance with federal regulations and instructions from CMS.

LIMITATIONS-PHYSICIANS, DENTISTS, AND PODIATRISTS

1. The maximum allowable payment to a physician, dentists or podiatrists per hospitalization per recipient is $1,250.00 unless a procedure provided during the hospitalization has a fee which exceeds $1,250.00, in which case that fee is the maximum reimbursement for the period of hospitalization.

2. The maximum allowable payment to a physician, dentist, or podiatrist for outpatient services per recipient per day is $500.00 unless the outpatient procedure has a fee which exceeds $500.00, in which case that fee is the maximum reimbursement on a daily basis, for that day only.

3. Payment will not be made for services provided to more than two (2) persons during a visit to a recipient's home no matter how many others are seen.

4. Payment for two or more surgical, obstetrical or anesthesia services performed by the same physician, dentist or podiatrist is limited to 100% of the allowable fee for the highest payment procedures and 25% of the second highest paying procedure. No payment is made for any additional procedures.

5. Payment for surgical, obstetrical and anesthesia services includes the inpatient preoperative and antepartum care as well as all postoperative and postpartum care in the hospital and outpatient visits during the number of postoperative or postpartum days specified for each procedure in the Medical Assistance Program Fee Schedule. Additional payment will be made for visits for treatment of medical or surgical conditions if the diagnosis is different and unrelated to the surgery.

6. Payment is limited to one (1) visit (e.g. office, home, hospital emergency room, clinic, inpatient care, nursing facility or Early Periodic Screening, Diagnosis, and Treatment (EPSDT) per recipient per day per individual provider.

7. Payment is made to only one podiatrist for a particular service or procedure and all services must be billed in the name of the podiatrist providing the service.

8. Payment for an office visit includes payment for any injection of medication or local anesthesia.

9. Payment for inpatient consultation procedure codes 99251 through 99255, or their successor procedure codes, is limited to 2 units per period of hospitalization. One inpatient consultation equals one unit of service.

METHOD AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☐ The rates reflect all Medicare geographic/locality adjustments.

☒ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: (5 x GPCI rate + 62 x GPCI 99 rate) ÷ 67

GPCI 01 is Pennsylvania Geographic Practice Cost Index for the Philadelphia region
GPCI 99 is Pennsylvania Geographic Practice Cost Index for the rest of this Commonwealth

Pennsylvania is using the fee schedule that CMS sent to Pennsylvania on February 6, 2014. Pennsylvania will not adjust the fee schedule to account for any changes in Medicare rates throughout the year.

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

90460	90461	90465	90466	90467	90468
90471	90472	90473	90474	99217	99218
99219	99220	99224	99225	99226	99234
99235	99236	99288	99339	99340	99344
99345	99354	99355	99356	99357	99358
99359	99363	99364	99366	99367	99368
99374	99375	99377	99378	99379	99380
99401	99402	99403	99404	99406	99408
99409	99411	99412	99420	99429	99441
99442	99443	99444	99446	99447	99448
99449	99450	99455	99456	99466	99467
99481	99482	99485	99486	99487	99488
99489	99495	99496	99499		

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

	Procedure Code	Effective Date		Procedure Code	Effective Date
1	99477	7/13/2009	20	90636	8/30/2010
2	99315	6/14/2010	21	90650	8/30/2010
3	99316	6/14/2010	22	90654	12/15/2012
4	99460	6/14/2010	23	90670	8/30/2010
5	99461	6/14/2010	24	90681	7/13/2009
6	99462	6/14/2010	25	90696	7/13/2009
7	99463	6/14/2010	26	90743	8/30/2010
8	99465	6/14/2010	27	90672	6/17/2013
9	99468	6/14/2010	28	90686	6/17/2013
10	99469	6/14/2010	29	90661	5/28/2013
11	99471	6/14/2010	30	90685	1/06/2014
12	99472	6/14/2010	31	90688	1/06/2014
13	99475	6/14/2010	32	90673	6/23/2014
14	99476	6/14/2010			
15	99478	6/14/2010			
16	99479	6/14/2010			
17	99480	6/14/2010			
18	99464	1/03/2011			
19	99407	6/25/2012			

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: _____

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: **$10.00.**

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09.

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at: http://www.dpw.state.pa.us/provider/index.htm.

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at: http://www.dpw.state.pa.us/provider/index.htm.

Pennsylvania Vaccine Product Code to Vaccine Administration Code Crosswalk

VACCINE PRODUCT CODE	NATIONAL VACCINE ADMINISTRATION CODE*	RATE
90585	90460	$23.14
90632	90460	$23.14
90633	90460	$23.14
90634	90460	$23.14
90636	90460	$23.14
90645	90460	$23.14
90646	90460	$23.14
90647	90460	$23.14
90648	90460	$23.14
90649	90460	$23.14
90650	90460	$23.14
90654	90460	$23.14
90655	90460	$23.14
90656	90460	$23.14
90657	90460	$23.14
90658	90460	$23.14
90660	90460	$23.14
90661	90460	$23.14
90669	90460	$23.14
90670	90460	$23.14
90672	90460	$23.14
90673	90460	$23.14
90675	90460	$23.14
90676	90460	$23.14
90680	90460	$23.14
90681	90460	$23.14
90685	90460	$23.14
90686	90460	$23.14
90688	90460	$23.14
90690	90460	$23.14
90691	90460	$23.14
90692	90460	$23.14
90693	90460	$23.14
90696	90460	$23.14
90698	90460	$23.14
90700	90460	$23.14
90702	90460	$23.14
90703	90460	$23.14
90704	90460	$23.14
90705	90460	$23.14
90706	90460	$23.14
90707	90460	$23.14
90708	90460	$23.14
90710	90460	$23.14
90713	90460	$23.14
90714	90460	$23.14
90715	90460	$23.14
90716	90460	$23.14
90717	90460	$23.14
90719	90460	$23.14
90721	90460	$23.14
90723	90460	$23.14
90725	90460	$23.14
90727	90460	$23.14
90732	90460	$23.14
90733	90460	$23.14
90734	90460	$23.14
90735	90460	$23.14
90736	90460	$23.14
90743	90460	$23.14
90744	90460	$23.14
90746	90460	$23.14
90747	90460	$23.14
90748	90460	$23.14
90749	90460	$23.14
G0008	90460	$23.14
G0009	90460	$23.14

***Pennsylvania does not cover procedure code 90460.**
Procedure code 90460 is used only for crosswalk purposes for this SPA.

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

CARE OR SERVICE	POLICY/METHODS USED TO ESTABLISH PAYMENT RATES
17. Targeted case management services for persons with mental illness	See 4.19B Page 7

CARE OR SERVICE

18. Ambulatory Surgical Center (ACS Services)

Using paid claims history for inpatient hospital services provided between July 1, 1985 and June 30, 1986, the Department identified claims for same day admissions and discharges. The cost for each claim was calculated by applying the hospital's cost to charge ratios, as reported on its cost report for Fiscal Year 1984-85. The cost for each claim was adjusted to remove the effect of direct medical education, hospital based physicians and nursing school costs. The statewide average cost of each procedure was determined by first totaling the costs for all cases of a specific procedure. Each total was divided by the number of occurrences for that procedure.

The fee for the ASC/SPU support component was determined by increasing the statewide average cost of each procedure first by 4.7 percent and then by 1.95 percent. This takes into account inflation factors between the fiscal year of implementation.

Payment for procedures that are appropriate for same day surgery but are not included in the list of covered ASC/SPU services is limited to:

1. The specific fee for each procedure developed by the Department when enough data is obtained to establish a fee.

2. Prior to establishment of a fee, the statewide average cost of same day surgery developed by the Department.

19. Short Procedure Unit (SPU) (42 CFR 416.2)

Policy/Methods Used to Establish Payment Rates

See above item 18.

20. Targeted Case Management Services for Persons with AIDS or Symptomatic HIV (42 CFR 440.169(b))

Policy/Methods Used to Establish Payment Rates

See 4.19B page 10.

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

21. Hospice Services

Policy/Methods Used to Establish Payment Rates

1. The agency pays medical rates developed by CMS Medicaid and published on an annual basis for Hospice Services. The state-developed provider specific rates are the same for both governmental and private providers of hospice services within the same geographic factor from the Medicare wage index. For dates of service on or after January 1, 2016, the Department pays hospice providers for routine home care, continuous home care, inpatient respite care, general inpatient care, and service intensity add-on payment at rates established by CMS. The hospice provider specific rate payments are calculated as follows:

   Routine Home Care — Limited to one unit of service per day.
   Geographic Factor from the Medicare wage index X Wage Component Subject to Index + Non-Weighted Amount
   Routine Home Care pays two different rates, a higher rate for days 1-60, and a lower rate for days 61 and beyond.

   Continuous Home Care — Limited to 24 hourly units of service per day.
   Geographic Factor from the Medicare wage index X Wage Component Subject to Index + Non-Weighted Amount ÷ 24

   Inpatient Respite Care — Limited to one unit of service per day.
   Geographic Factor from the Medicare wage index X Wage Component Subject to Index + Non-Weighted Amount

   General Inpatient Care — Limited to one unit of service per day.
   Geographic Factor from the Medicare wage index X Wage Component Subject to Index + Non-Weighted Amount

   Service Intensity Add-On — Limited to one through 16 15-minute unit(s) of service per day during the beneficiary's last seven days of life
   Geographic Factor from the Medicare wage index X Wage Component Subject to Index + Non-Weighted Amount ÷ 24
   The SIA payment is in addition to the routine home care rate. The Service Intensity Add-on is provided for one through a maximum of 15-minute units of service combined for both nursing visit time and/or social work visit time per day.

   A. In accordance with Section 3004 of the Affordable Care Act (ACA) and effective with dates of service on and after October 1, 2013, hospice providers are paid based on their compliance of submission of quality data to CMS on an annual basis. Hospice providers that comply with the quality data submission to CMS are paid a higher rate in accordance with Table 1 in the Centers for Medicaid and CHIP Services, Financial Management Group's Annual Change in Hospice Payment Rates letter, which may be viewed by accessing the following website link: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Medicaid-Hospice-Payment-Rates.pdf.

   B. In accordance with Section 3004 of the ACA and effective with dates of service on and after October 1, 2013, hospice providers that do not comply with the quality data submission to CMS on an annual basis are paid the minimal amount the state may pay the hospice provider as calculated above and reflected by Table 2 in the Centers for Medicaid and CHIP Services, Financial Management Group's Annual Change in Hospice Payment Rates letter, which may be viewed by accessing the following website link: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Medicaid-Hospice-Payment-Rates.pdf. On an annual basis, the Department obtains the list of hospice providers who did not report the quality data from CMS.

2. Hospice providers are paid separately for direct care related to the beneficiary's terminal illness when provided by a hospice physician. Payment is made in accordance with the State Agency Fee Schedule based on established criteria. Physician payments are described on Attachment 4.19B, pages 1 and 4b.

3. An additional room and board per diem amount will be paid to hospices in connection with routine home care and continuous home care furnished to beneficiaries who have elected hospice care and are residing in skilled or intermediate care facilities. Payment is at least 95% of the rate that would have been paid by the State under the plan for facility services for that individual. The room and board rate is adjusted annually for each hospice provider using the following calculation:

   Room and Board — Limited to one unit of service per day.
   Previous year's Rate X Forecasted market basket percentage increase.

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

	CARE OR SERVICE	POLICY/METHODS USED TO ESTABLISH PAYMENT RATES
24.	Hospice services (continued)…	An average room and board per diem will be calculated for participating skilled nursing facilities within each Metropolitan Statistical Area. A wage index appropriate to each MSA will be applied to the wage component of each average room and board per diem to account for area differences in wages. The hospice will be paid the room and board per diem commensurate with the location of the nursing facility in which the recipient is residing.
25.	Medicare cost-sharing only for Qualified Medicare Beneficiaries	Payment is made for the Medicare Part A and Part B deductibles and coinsurance amounts for services provided to Qualified Medicare Beneficiaries as specified in Supplement 1 to Attachment 4.19B, pages 1 through 3.

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

TARGETED SUPPORT MANAGEMENT FOR PERSONS WITH AN INTELLECTUAL DISABILITY, AUTISM, DEVELOPMENTAL DISABILITY, OR MEDICALLY COMPLEX CONDITION

Targeted support management services for individuals with an intellectual disability, autism, developmental disability or medically complex condition shall be paid based on a fee-for-service basis.

Medical Assistance (MA) Fee Schedule rates are developed using a market-based approach. This process includes a review of the service definition and a determination of allowable cost components which reflect costs that are reasonable, necessary and related to the delivery of the service, as defined in Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. The Fee Schedule rate represents the statewide rate that DHS will pay for the service. In developing rates for targeted support management, the following occurs:

- ODP evaluated and used various independent data sources, such as a Pennsylvania-specific compensation study, and considered the expected expenses for the delivery of the services for the major allowable cost categories listed below:
    - Staff wages.
    - Staff-related expenses.
    - Productivity.
- Program Overhead-The program expenses and administration related expenses that were used in developing the Fee Schedule rate for targeted support management are enumerated in the Non-Residential assumption log under Supports Coordination on page 6. This document is available at https://www.dhs.pa.gov/Services/DisabilitiesAging/Documents/Current%20Rates%20ODP%20Fee%20Schedule%20Rate%20Tables%20and%20Assumption%20Logs%20Effective%20Starting%20July%201%202017/Non-Residential%20Assumptions%20Log%20(c289999).pdf

The expenses include:

- Wages for supervisors and directors.
- The costs associated with providing employee related expenses such as health insurance, life insurance and workers compensation to targeted support management staff.
- Paid time off for targeted support management staff.
- Costs for staff time to travel and mileage reimbursement.
- Office occupancy costs.
- Supply costs.
- Employee training costs.
    - A review of approved service definitions and determinations made about cost components that reflect costs necessary and related to the delivery of each service.
    - A review of the cost of implementing Federal, State and local statutes, regulations and ordinances.
- Administration
- Productivity
    - One MA Fee Schedule rate is developed and is effective August 20, 2017 for services provided on or after that date. The unit of service shall be a quarter hour segment. All rates are published on the agency's website at: http://www.dhs.pa.gov/providers/Providers/Pages/ODP-Rates.aspx. Except as otherwise noted in the Plan, State developed Fee Schedule rates are the same for both governmental and private individual providers. Providers are only reimbursed for allowable targeted support management services as reflected in the individual's plan. The agency's Fee Schedule rate was set as of August 20, 2017 and is effective for services provided on or after that date.

      Only providers who meet qualification criteria as outlined per Enclosure A to Attachment 3.1A/3.1B, pages 3 through 6 can provide targeted support management services for individuals with an intellectual disability, autism, developmental disability or complex medical condition.

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

TARGETED CASE MANAGEMENT SERVICES FOR INDIVIDUALS WITH SEVERE MENTAL ILLNESS

Rates for Targeted Case Management Services for Individuals with Severe Mental Illness (TCM-SMI) are established by the Department of Human Services (Department). In developing rates for TCM-SMI, the Department considers the expected expenses for the delivery of the services for the major allowable cost categories listed below:

- Wages for staff
- Employee-related expenses
- Productivity
- Program indirect expenses
- Administration-related expenses

For dates of service on or after October 1, 2015, the agency's rates for TCM-SMI are published on the agency website at:
http://www.dhs.pa.gov/publications/forproviders/remittanceadvicealertspromisebannerpages/C_209662#.Vz3ptPkrKUk

The rate shall be paid for each unit of service provided. The unit of service shall be a quarter hour of service or major portion thereof.

Deliverable services and provider qualification criteria for TCM-SMI are outlined in Supplement 2 to Attachment 3.1A/3.1B, pages 1-5.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF ARE

TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH AIDS OR HIV
Reimbursement for case management services shall be on a fee-for-service basis.

The rate will be established by the Department.

The unit of service shall be a quarter hour segment.

The agency's fee schedule rate is effective July 1, 2012, for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/outpatientfeeschedulesearch/index.htm. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners.

A description of the providers' qualifications can be found at Supplement 4 to Attachment 3.1-A, Page 2.

TARGETED CASE MANAGEMENT SERVICES FOR CHILDREN UNDER AGE THREE WITH A DEVELOPMENTAL DELAY
Reimbursement for case management services shall be on a fee-for-service basis.

The rate will be established by the Department.

The unit of service shall be a quarter hour segment.

The agency's fee schedule rate is effective July 1, 2012, for services provided on or after that date. All rates are published on the agency's website at: http://www.dpw.state.pa.us/publications/forproviders/schedules/mafeeschedules/index.htm. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners.

A description of the providers' qualifications can be found at Supplement 5 to Attachment 3.1-A, Page 3.

TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH SICKLE CELL ANEMIA OR RELATED HEMOGLOBINOPATHIES
[Reserved]

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

26. Mental Health Rehabilitation Services – Payment rates for mental health rehabilitation services are listed in the Medical Assistance Program Fee Schedule, which is posted on the Department's website at: http://www.dhs.pa.gov/publications/forproviders/schedules/mafeeschedules/index.htm
Subsequent adjustments to the fee schedule are announced by public notice published in the Pennsylvania Bulletin.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of mental health rehabilitation services. The agency's fee schedule rates were last updated on July 1, 2015, and are effective for dates of service on and after that date.

(I) Family-Based Mental Health Rehabilitative Services

(II) Mental Health Crisis Intervention Services

(III) Mobile Mental Health Treatment

(IV) Peer Support Services

State agency fee schedule based on established criteria.*

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

27. Community Based care Management by Opioid Use Disorder Centers of Excellence (COEs) – Payment rates for Community Based care Management by Opioid Use Disorder COEs are listed in the Medical Assistance Program Fee Schedule, which is posted on the Department's website at: https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/MA-Fee-Schedule.aspx. Subsequent adjustments to the fee schedule are announced by public notice published in the Pennsylvania Bulletin.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were last updated on January 1, 2022 and are effective for dates of service on or after that date.

State agency fee schedule based on established criteria.

METHODS AND STANDARDS OF RESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions (OPPCs)

The Medicaid Agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider Preventable Conditions

The Department identifies the following OPPCs for non-payment under Section(s) 4.19B.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
_____ Additional Other Provider-Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provision will be applies.

Payments for OPPCs will be adjusted in the following manner:

(1) Providers are mandatorily required to report OPPCs to the Department using modifiers PA (surgical or other Invasive procedure on wrong body part), PB (surgical or other invasive procedure on wrong patient), PC (surgical or other invasive procedure on patient) on their claims.
(2) No payment will be made for services for OPPCs.

In accordance with 42 CFR 447.26(c):

(1) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition Defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
(2) Reductions in provider payment may be limited to the extent that the following apply:
    a. The identified PPC will otherwise result in an increase in payment.
    b. The Department can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.
(3) The Department assures the Centers for Medicare and Medicaid Services that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

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

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

A. Prescribed Drugs

Unbundled prescribed drugs dispensed or administered for MAT shall be reimbursed using the same methodology as described in Attachment 4.19-B, section 2(A), for prescribed drugs.

B. Counseling Services and Behavioral Health Therapies

Counseling services and behavioral health therapies delivered as part of MAT shall be reimbursed using the same methodology as described in Attachment 4.19-B, section 3, for outpatient clinic services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Pennsylvania

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

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment.

1. Payments are limited to State Plan rates and payment methodologies for the groups and payments listed below and designated with the letters “SP”.

   For specific Medicare services which are not otherwise covered by this State Plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item 2 of this attachment (see 3, below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters “MR”.

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in items 2 and 3 of this attachment, for those groups and payments listed below and designated with the letters “NR”.

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item _ of this attachment (see 3, above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Pennsylvania

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

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A SP Deductibles SP Coinsurance
	Part B SP Deductibles SP Coinsurance
Other Medicaid Recipients	Part A SP Deductibles SP Coinsurance
	Part B SP Deductibles SP Coinsurance
Dual Eligible (QMB Plus)	Part A SP Deductibles SP Coinsurance
	Part B SP Deductibles SP Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Pennsylvania

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

Payment of Medicare Part A and Part B Deductible/Coinsurance

Medical Assistance pays for the unsatisfied portion of the deductible and any allowable coinsurance [Medicare cost-sharing amounts] for Medicare Part A and Part B services provided to Qualified Medicare Beneficiaries subject to the following:

1. For services that are covered by this State Plan (except those services specified in Item 3 below), Medical Assistance will pay Medicare cost-sharing amounts if the payment made by the Medicare Program for the service is less than the applicable Medical Assistance fee or payment (as determined and limited in accordance with the provisions of this plan and implementing Department regulations) for that service. If the Medicare payment for a service is less than the Medical Assistance fee or payment for that service, Medical Assistance will pay Medicare cost-sharing amounts to the extent that the Medicare payment and the Medical Assistance payment for the cost-sharing amounts combined do not exceed the applicable Medical Assistance fee or payment (as determined and limited in accordance with the provisions of this plan and implementing Department regulations) for the service. Medical Assistance will not pay Medicare cost-sharing amounts related to any service to the extent that the payment made under the Medicare Program for the service exceeds the applicable Medical Assistance fee or payment.

2. For specific Medicare services which are not otherwise covered by this State Plan, Medical Assistance will pay Medicare cost-sharing amounts to the extent that the payment made under Medicare and the Medical Assistance payment for the cost-sharing amounts combined do not exceed 80% of the Medicare approved amount.

3. For services provided by a Medicare-certified skilled nursing facility that is not an enrolled Medical Assistance nursing facility provider, Medical Assistance will pay Medicare cost-sharing amounts if the payment made by Medicare for the services does not exceed a maximum payment rate equal to the average rate, effective as of July 1 of the state fiscal year in which the services are rendered, for the peer group in which the facility would be classified if the facility was a Medical Assistance enrolled nursing facility provider. If the Medicare payment for a service is less than the maximum payment rate, Medical Assistance will pay Medicare cost-sharing amounts to the extent that the Medicare payment and the Medical Assistance payment for the cost-sharing amounts combined do not exceed the maximum payment rate.

Health Maintenance Organizations (HMOs)	The obstetrical and pediatric services are included in the rate base. All fee for ser service costs are identified and included in the rate base. Obstetrician and pediatricians participating in HMOs are comparable to the community participation.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA

ATTACHMENT 4.19B

Maximum Medicaid Payment Rates for
Listed Practitioner Pediatric Services

OFFICE MEDICAL SERVICES

NEW PATIENT

Procedure Code	Procedure Description	Maximum Payment
900000	Office medical service, new patient; brief service	$18.00
90010	limited service	$18.00
90015	intermediate service	$18.00
90017	extended service	$18.00
90020	comprehensive service	$18.00

ESTABLISHED PATIENT

90030	Office medical service, established patient; minimal service	$18.00
90040	brief service	$18.00
90050	limited service	$18.00
90060	intermediate service	$18.00
90070	extended service	$18.00
90080	comprehensive service	$18.00

EMERGENCY DEPARTMENT SERVICES (Refer to page 3 for additional local codes)

NEW PATIENT

90500	Emergency department service, new patient; minimal service	$13.00
90505	brief service	$13.00
90510	limited service	$13.00
90515	intermediate service	$13.00
90517	extended service	$13.00
90520	comprehensive service	$13.00

ESTABLISHED PATIENT

90530	Emergency department service, established patient; minimal service	$13.00
90540	brief service	$13.00
90550	limited service	$13.00
90560	intermediate service	$13.00
90570	extended service	$13.00
90580	comprehensive service	$13.00

Maximum Medicaid Payment Rates for
Listed Practitioner Pediatric Services

IMMUNIZATION INJECTIONS — Enrolled dispensing physicians may bill for the cost of the vaccine.
*Fee for the administration of the immunization.

Procedure Code	Procedure Description	Maximum Payment
90701	Immunization, active; diphtheria and tetanus Toxoids and pertussis vaccine (DTP)	$2.50*
90702	diphtheria and tetanus toxoids (DT)	$2.50
90704	mumps virus vaccine, live	$2.50
90705	measles virus vaccine, live, attenuated	$2.50
90706	rubella virus vaccine, live	$2.50
90707	measles, mumps and rubella virus vaccine, live	$2.50
90708	measles and rubella virus vaccine, live	$2.50
90709	rubella and mumps virus vaccine, live	$2.50
90712	poliovirus vaccine, live, oral (any type(s))	$2.50
90737	Hemophilus influenza B	$2.50

PREVENTIVE MEDICINE — Preventive services are covered as office medical service for EPST visits.

NEW PATIENT

90751	Initial history or examination related to the healthy individual, including anticipatory guidance; adolescent (age 12 through 17 years)
90752	late childhood (age 5 through 11 years)
90753	early childhood (age 1 through 4 years)
90754	infant (age under 1 year)
90755	Infant care to one year of age, with a maximum of 12 office visits during regular office hours, including tuberculin skin testing and immunization of DTP and oral polio
90757	Newborn care, in other than hospital setting, including physical examination of baby and conference(s) with parent(s)

ESTABLISHED PATIENT

90761	Interval history and examination related to the healthy individual, including anticipatory guidance, periodic type of examination; adolescent (age 12 through 17 years)
90762	late childhood (age 5 through 11 years)
90763	early childhood (age 1 through 4 years)
90764	infant (age under 1 year)
90774	Administration and medical interpretation of developmental tests
90778	Circadian respiratory pattern recording (pediatric pneumogram, 12 to 24 hour continuous recording, infant $220.00

Maximum Medicaid Payment Rates for
Listed Practitioner Pediatric Services

EMERGENCY DEPARTMENT SERVICES

Procedure Code	Procedure Description	Maximum Payment
W9025	Hospital visit, initial, outpatient; accident	$14.50
W9026	Hospital visit, initial, outpatient; emergency medical	$13.00
W9029	Non-emergency medical, hospital visit, emergency room	$11.50

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) VISITS

W0085	EPSDT – Screen, Birth through 18 months – 8 visits	$25.00
W0086	EPSDT – Screen, 19 months to 21 years of age – 8 visits Note: Children 14 years of age to 21 years of age who have had 16 screens (any combination of procedure codes W0085 and W0086) may have a maximum of four (4) additional visits of any combination of procedure codes W0090-W0094.	$33.50
W0090	EPSDT – Screen – Physician	$18.00
W0091	EPSDT – Screen - Independent clinic	$23.00
W0092	EPSDT – Screen – Basic Hospital clinic	$19.00
W0093	EPSDT – Screen – Hospital Outpatient clinic (Enrollment approval required)	$23.00
W0094	EPSDT – Screen – Rural Health Clinic	I.C.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA
OBSTETRICAL PRACTITIONER SERVICES

Maternity Care and Delivery

Procedure Code	Procedure Description	MA FEE	1992-93 Average Amount Paid
Incision			
59000	Amniocentesis, any method	50.00	49.96
59012	Cordocentesis (intrauterine), any method	50.00	50.00
59015	Chorionic villus sampling, any method	35.00	59.00
59020	Fetal contraction stress test	30.50	30.87
59025	Fetal non-stress test	17.50	17.53
59030	Fetal scalp blood sampling	-	-
59050	Initiation and/or supervision or internal fetal monitoring during labor by consultant with report (separate procedure)		
59100	Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)	409.50	340.00
Excision			
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	439.50	337.82
59121	tubal or ovarian, without salpingectomy and/or oophorectomy	511.00	328.19
59130	abdominal pregnancy	409.50	301.23
59135	interstitial, uterine pregnancy with partial resection of uterus	473.50	473.50
59136	interstitial, uterine pregnancy with partial resection of uterus	473.50	94.70
59140	cervical, with evacuation	265.00	190.81
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	409.50	333.19
59151	with salpingectomy and/or oophorectomy	511.00	400.45
59160	Curettage, postpartum (separate procedure)	160.00	271.90
Introduction			
59200	Insertion of cervical dilator	-	-
Repair			
59300	Episiotomy or vaginal repair, by other than attending physician	148.00	136.00
59320	Cerclage or cervix, during pregnancy; vaginal	193.00	266.25
59325	abdominal	193.00	129.50
59350	Hysterorrhaphy of reptured uterus	448.00	246.19

- = Noncovered

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA
OBSTETRICAL PRACTITIONER SERVICES

Maternity Care and Delivery

Procedure Code	Procedure Description	MA FEE	1992-93 Average Amount Paid
Delivery, Antepartum and Postpartum Care			
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	-	-
59410	Vaginal delivery only (with or without episiotomy and/or forceps) including postpartum care	800.00	791.53
59412	External cephalic version, with or without Tocolysis	-	-
59414	Delivery of placenta (separate procedure)	126.00	84.45
59430	Postpartum care only (separate procedure)	-	-
Cesarean Delivery			
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	-	-
59515	Cesarean delivery only including postpartum Care	800.00	791.60
59525	Subtotal or total hysterectomy after cesarean delivery	307.50	133.25
Abortion			
59812	Treatment of spontaneous abortion, any trimester, completed surgically	181.50	181.50
59820	Treatment of missed abortion, completed surgically; first trimester	194.00	194.00
59821	Second trimester	231.00	231.00
59830	Treatment of septic abortion, completed surgically	173.00	173.00
59840	Induced abortion, by dilation and curettage	81.50	136.78
59841	Induced abortion, by dilation and evacuation	306.00	300.26
59850	Induced abortion, by one or more intra-amniotic injections	246.00	-
59851	With dilation and curettage and/or evacuation	246.00	-
59852	With hysterectomy (failed intra-amniotic Injection)	246.00	-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA
PEDIATRIC PRACTITIONER SERVICES

Evaluation and Management

Procedure Code	Procedure Description	MA FEE	1992-93 Average Amount Paid
Office or Outpatient or Other Ambulatory Facility (Visit)			
New Patient			
99201	Physicians typically spend 10 minutes	20.00	19.97
99202	Physicians typically spend 20 minutes	20.00	20.00
99203	Physicians typically spend 30 minutes	20.00	19.88
99204	Physicians typically spend 45 minutes	20.00	20.00
99205	Physicians typically spend 60 minutes 1 per recipient, per provider, per lifetime	30.00	29.82
Established Patient			
99211	Typically 5 minutes are spent supervising or performing these services	20.00	19.45
99212	Physicians typically spend 10 minutes	20.00	19.94
99213	Physicians typically spend 15 minutes	20.00	20.00
99214	Physicians typically spend 25 minutes	20.00	19.99
99215	Physicians typically spend 40 minutes	20.00	19.98
Office of Other Outpatient Consultations			
New or Established Patient			
99241	Physicians typically spend 15 minutes	30.00	29.26
99242	Physicians typically spend 30 minutes	30.00	29.52
99243	Physicians typically spend 40 minutes	30.00	29.98
99244	Physicians typically spend 60 minutes	49.00	48.80
99245	Physicians typically spend 80 minutes	49.00	49.11
Confirmatory Consultations			
New or Established Patient			
99271	Usually the presenting problem(s) are self limited or minor	30.00	30.42
99272	Usually the presenting problem(s) are of low severity	30.00	30.40
99273	Usually the presenting problem(s) are of low moderate severity	30.00	30.00
99274	Usually the presenting problem(s) are of moderate to high severity	30.00	48.63
99275	Usually the presenting problem(s) are of moderate to high severity	49.00	49.00
Home Services			
New Patient			
99341	Usually the presenting problem(s) are of low severity	21.00 26.00 (OB)	21.00
99342	Usually the presenting problem(s) are of moderate severity	21.00 26.00 (OB)	21.00

Payment rate is the same for General Practitioners, Family Practitioners and pediatricians. Pennsylvania reimbursement system is fee-for-service. The fees listed on Supplement II, Attachment 4.19B represent the average payment regardless of Metropolitan Statistical Area (MSA) or similar area on any other geographical designation.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA
PEDIATRIC PRACTITIONER SERVICES

Procedure Code	Procedure Description	MA FEE	1992-93 Average Amount Paid
99343	Usually the presenting problem(s) are of high severity	21.00 26.00 (OB)	21.00
Established Patient			
99351	Usually the patient is stable, recovering or improving	21.00 26.00 (OB)	20.98
99352	Usually the patient is responding inadequately to therapy or has developed a minor complication	21.00 26.00 (OB)	21.00
99353	Usually the patient is unstable or has developed a significant complication or a significant new problem	21.00	21.00
Case Management Services			
Team Conferences			
99361	Approximately 30 minutes	-	-
99362	Approximately 60 minutes	-	-
Telephone Calls			
99371	Simple or brief	-	-
99372	Intermediate	-	-
99373	Complex or lengthy	-	-
Preventive Medicine Services			
New Patient			
99391	Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; new patient; infant (age under 1 year)	20.00	20.00
99392	Early childhood (age 1 through 4 years)	20.00	20.00
99393	Late childhood (age 5 through 11 years)	20.00	20.00
99394	Adolescent (age 12 through 17 years)	20.00	20.00
Counseling and/or Risk Factor Reduction Intervention			
New or Established Patient			
Preventive Medicine, Individual Counseling			
99401	Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 15 minutes	-	-

Case management as defined under Section 1905(a)(19) is a covered service for individuals under 21 years of age.
- = Noncovered

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA
PEDIATRIC PRACTITIONER SERVICES

Procedure Code	Procedure Description	MA FEE	1992-93 Average Amount Paid
99402	approximately 30 minutes	-	-
99403	approximately 45 minutes	-	-
99404	approximately 60 minutes	-	-
	Preventive Medicine, Group Counseling		
99411	Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting; approximately 30 minutes	-	-
99412	Approximately 60 minutes	-	-
	Other Preventive Medicine Services		
99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)	-	-
99429	Unlisted preventive medicine service	-	-
	Newborn Care		
99432	Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s)	-	-
	Immunizations		
90701	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP)	5.00	5.00
90702	diphtheria and tetanus toxoids (DT)	5.00	4.94
90703	tetanus toxoid	5.00	4.99
90704	mumps virus vaccine, live	5.00	5.00
90705	measles virus vaccine, live	5.00	5.00
90706	rebella virus vaccine, live	5.00	5.00
90707	measles, mumps and rubella virus vaccine, live	5.00	5.00
90708	measles and rubella virus vaccine, live	5.00	5.00
90709	rubella and mumps virus vaccine, live	5.00	5.00
90712	poliovirus vaccine, live, oral (any type(s))	5.00	5.00
90713	poliomyelitis vaccine	5.00	5.00
90714	typhoid vaccine	5.00	5.00
90717	yellow fever vaccine	5.00	2.50
90718	tetanus and diphtheria toxoids absorbed	5.00	4.93
90719	diphtheria toxoid	5.00	4.99
90724	influenza virus vaccine	5.00	4.99
90725	cholera vaccine	5.00	5.00
90726	rabies vaccine	5.00	5.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA
PEDIATRIC PRACTITIONER SERVICES

Procedure Code	Procedure Description	MA FEE	1992-93 Average Amount Paid
90727	plague vaccine	5.00	5.00
90728	BGC vaccine	5.00	5.00
90731	hepatitis B vaccine	5.00	5.00
90732	pneumococcal vaccine, polyvalent	5.00	5.00
90733	meningococcal polysaccharide vaccine (any group(s))	5.00	5.00
90737	hemophilus influenza B	5.00	5.00
90741	Immunization, passive; immune serum globulin, human (ISG)	5.00	5.00
90742	Specific hyperimmune serum globulin (eg; hepatitis B, measles, pertussis, rabies, Rho (D), tetanus, vaccinia, varicella-zoster	5.00	4.99

Maximum Medicaid Payment Rates for
Listed Practitioner Obstetrical Services

Procedure Code	Procedure Description	MA Fee	1992-93 Average Amount Paid
HEALTHY BEGINNINGS PLUS PROGRAM			
W5950	Healthy Beginnings Plus Intake Package	$175.00	$174.84
W5951	First Trimester Basic Maternity Care Package	$76.00	75.81
W5952	Second Trimester Basic Maternity Care Package	$138.00	137.72
W5953	Third Trimester Basic Maternity Care Package	$961.00	1,227.98
W5957	Comprehensive Childbirth preparation	$60.00	57.57
	(OR)		
W5958	Childbirth Preparation Review	$20.00	19.90
W5954	First Trimester High Risk Maternity Care Package	$114.00	113.33
W5955	Second Trimester High Risk Maternity Care Package	$252.00	251.00
W5956	Third Trimester High Risk Maternity Care Package	$1,151.00	1,430.82
W5968	Outreach Visit	$45.00	44.97
W5974	Home Assessment/Client Education	$69.00	84.43
W5966	Obstetrical Home Care	$120.00	118.75
W5960	Prenatal Home Nursing Care	$69.00	75.97
W5961	Outreach Bonus for First Trimester Recruitment	$100.00	99.93
W5972	Home Health Aide Care	$45.00	44.82
W5971	Homemaker Service (Prior approval required)	$40.00 PA	96.81
W5970	Psychosocial Counseling	$15.00	29.65
W5962	Nutrition Counseling	$15.00	21.38
W5963	Smoking (Tobacco) Cessation Counseling	$15.00	15.58
W5964	Substance Abuse Problem Identification and Referral Counseling	$25.00	$30.10
W5965	Genetic Risk Assessment, Information and Referral Counseling	$60.00	60.32
W5967	Parenting Program	$30.00	29.89
W5973	Prenatal Exercise Series	$65.00	60.89
W5969	Urgent Transportation Only (car)	.22 mile	.28
W5981	Urgent Transportation Only (public carrier)	*	3.96
W5982	Mileage, Additional Allowance for Home Visits	.10 mile	1.34
W5975	First Trimester, Basic Maternity Care, Visit	$23.00	24.73
W5976	First Trimester, High Risk Maternity Care, Visit	$23.00	24.65
W5977	Second Trimester, Basic Maternity Care, Visit	$23.00	24.69
W5978	Second Trimester, High Risk Maternity Care, Visit	$23.00	24.83
W5979	Third Trimester, Basic Maternity Care, Visit	$23.00	24.78
W5980	Third Trimester, High Risk Maternity Care, Visit	$23.00	24.73
W5983	Basic Third Trimester Package – delivery not performed by designated HBP provider	$175.00	457.00
W5984	High Risk Third Trimester Package – delivery not performed by designated HBP provider	$250.00	$24.93
W5985	Second Trimester Delivery – delivery not performed by designated HBP provider	$1130.00	1,351.26

* Payment is the actual cost of public transportation which can be by bus, subway or taxi; therefore, the fee is dependent upon the type of transit service.

*NC = noncovered

Maximum Medicaid Payment Rates for
Listed Practitioner Pediatric Services

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) VISITS

Procedure Code	Procedure Description	Maximum Payment 2/1/92	1992-93 Average Amount Paid
W0085	EPSDT – Screen, Birth through 18 months – 8 visits	$65.00	64.83
W0086	EPSDT – Screen, 19 months to 21 years of age – 8 visits Note: Children 14 years of age to 21 years of age who have had 16 screens (any combination of procedure codes W0085 and W0086) may have a maximum of four (4) additional visits of any combination of procedure codes W0090-W0094.	$65.00	64.71
W0090	EPSDT – Screen – Physician	$65.00	
W0091	EPSDT – Screen – Independent clinic	$65.00	
W0092	EPSDT – Screen – Basic Hospital clinic	$65.00	
W0093	EPSDT – Screen -Hospital Outpatient clinic (Enrollment approval required)	$65.00	
W0094	EPSDT – Screen – Rural Health Clinic	*	49.17
CASE MANAGEMENT			
W0052	Case Management – (1 unit = 15 minutes)	$7.50/unit	-

* Rural Health Clinics are paid at the rate established by Medicare and are provider specific.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA

Adequacy of Access	
Obstetrical Standards	
A. Practitioner Participation	Refer to the attached list of general practice physicians' and obstetricians/gynecologists' participation for 1992. At this time, there are no participating obstetricians in Perry County. Recipients have access to care from obstetricians in neighboring counties, Cumberland and Dauphin.
Pediatric Standards	
A. Practitioner Participation	Refer to the attached list of general practice physicians' and pediatricians' participation for 1992.
Obstetrical/Pediatric Standards	
A. Other obstetrical and pediatric providers and practitioner participation	Refer to the attached list of independent medical clinics, Federally Qualified Health Centers, Rural Health Clinics, Healthy Beginnings Plus providers, midwives and certified registered nurse practitioners. In addition, enrolled hospital outpatient clinics provide obstetrical/pediatric services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: COMMONWEALTH OF PENNSYLVANIA

COUNTY	CO. NO.	TOTAL LICENSED OB+MIDWIVES+ CRNPS+FPS	TOTAL PARTICIPATING OB+MIDWIVES+ CRNPS+FPS	PERCENTAGE	TOTAL LICENSED PED+FP+CRNP	TOTAL PARTICIPATING PED+FP+CRNP	PERCENTAGE
Adams	01	11	7	.62	37.8	35	.92
Allegheny	02	419.8	233	.55	1,058.3	798	.75
Armstrong	03	6	6	1.00	24.9	22	.88
Beaver	04	27.5	20	.72	92.7	66	.67
Bedford	05	4	2	.50	15.1	13	.86
Berks	06	69	51	.73	198.2	189	.82
Blair	07	35	22	.63	92.3	77	.83
Bradford	08	13	9	.69	25.5	24	.94
Bucks	09	121.6	53	.44	355.6	261	.73
Butler	10	15.8	8	.51	29.8	24	.86
Cambria	11	28.6	15	.53	94.6	91	.86
Carbon	13	7	4	.57	21.4	20	.93
Centre	14	20	14	.70	52.5	42	.80
Chester	15	81.4	42	.52	236.6	168	.71
Clarion	16	4.7	2	.43	23.4	22	.94
Clearfield	17	7	5	.71	27.3	25	.91
Clinton	18	4	3	.75	17	16	.94
Columbia	19	16.5	15	.91	54.7	44	.80
Crawford	20	11	12	1.09	36.7	33	.89
Cumberland	21	28	12	.43	88.9	70	.78
Dauphin	22	117.9	62	.53	201.9	210	1.0
Delaware	23	139.9	74	.53	343.9	229	.66
Cameron/Elk	12/24	5.4	3	.56	33.4	33	.97
Erie	25	59	36	.56	169.1	166	.98
Fayette	26	13.9	6	.43	48	39	.81
Forest****	27	0	0	0	0	1	0
Franklin	28	24	20	.83	60.2	56	.93
Fulton	29	1	2	2.00	2.1	2	.95
Greene	30	4.9	3	.61	14.2	11	.77
Huntingdon	31	9.8	4	.41	17.8	16	.89
Indiana	32	14.7	6	.41	34.1	31	.90
Jefferson	33	9.8	13	1.33	24.1	23	.95
Lackawanna	35	36	20	.56	103.4	83	.80
Lancaster	36	89.6	52	.58	276.1	218	.78
Lawrence	37	6.4	4	.66	22.7	21	.92
Lebanon	38	19.8	16	.80	64.3	55	.85
Lehigh	39	90.7	55	.61	201.7	127	.62
Luzerne	40	66.9	38	.57	196.5	171	.87
Lycoming	41	28.6	37	1.29	93	80	.86
McKean	42	4	2	.50	14.5	12	.82
Mercer	43	23.6	15	.64	53.6	47	.87
Mifflin/Juniata**	44/34	14.5	7	.48	35.5	28	.87
Monroe	45	14.9	7	.47	40.9	31	.73
Montgomery	46	326.8	164	.50	675.8	448	.66
Montour	47	17.6	9	.51	59.6	46	.77
Northampton	48	40	24	.60	88.6	50	.56

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: COMMONWEALTH OF PENNSYLVANIA

COUNTY	CO. NO.	TOTAL LICENSED OB+MIDWIVES+ CRNPS+FPS	TOTAL PARTICIPATING OB+MIDWIVES+ CRNPS+FPS	PERCENTAGE	TOTAL LICENSED PED+FP+CRNP	TOTAL PARTICIPATING PED+FP+CRNP	PERCENTAGE
Northumberland	49	7.7	4	.52	33	25	.75
Perry*	50	2.7	0	0	13	11	.84
Philadelphia	51	493.5	229	.46	1,051.5	666	.63
Potter	53	3	4	1.29	12	7	.66
Schuylkill	54	24.6	6	.24	63.5	54	.85
Snyder****	55	0	0	0	0	0	0
Somerset	56	11.5	7	.61	26.2	24	.91
Sullivan***,****	57	0	4	0	1	1	1.0
Susquehanna	58	3.7	5	1.35	13.1	10	.76
Tioga	59	4	7	1.63	21.6	21	.97
Union	60	10	13	1.30	21.5	21	.97
Venango	61	10.1	6	.65	22.9	21	.91
Warren	62	5.7	3	.53	21.1	17	.80
Washington	63	25.9	15	.58	99.4	78	.78
Wayne/Pike**	64/52	7.6	4	.53	25.9	18	.69
Westmoreland	65	54.8	32	.58	148.8	138	.92
Wyoming	66	3	8	2.42	14.3	13	.90
York	67	73.6	39	.53	200.6	170	.84

Perry County recipients have access to obstetrical care in Dauphin County. Non-medical assistance persons as well as medical assistance clients generally obtain their medical care in the Harrisburg, Carlisle, and Hershey areas. There is an enrolled Rural Health Clinic in Perry County.

Mifflin and Juniata Counties and Wayne and Pike Counties are combined because they have joint medical associations and are not densely populated. They also have geographic proximity, low medical assistance populations and the general population crosses county lines for medical services.

In Sullivan County, one physician enrolled who does not bill independently but provides services as a national health care physician at the Sullivan County Medical Center.

Bucks County medical assistance clients and the general population cross county lines to Lehigh, Northampton, and Montgomery Counties for medical services.

Clarion County medical assistance clients and the general population cross county lines to Armstrong and Butler Counties for medical services.

Fayette County medical assistance clients and the general population cross county lines to Greene, Somerset, Washington and Westmoreland Counties for medical services.

Mifflin and Juniata Counties medical assistance clients and the general population cross county lines to Centre and Northumberland Counties for medical services.

Cumberland County medical assistance clients and the general population cross county lines to Adams, Dauphin, Franklin and York Counties for medical services.

Huntingdon County medical assistance clients and the general population cross county lines to Centre and Blair Counties for medical services.

Indiana County medical assistance clients and the general population cross county lines to Armstrong, Cambria, Clearfield, Elk and Jefferson Counties for medical services.

Monroe County medical assistance clients and the general population cross county lines to Carbon, Lehigh, Northampton and Pike Counties for medical services.

Philadelphia County medical assistance clients and the general population cross county lines to Chester, Delaware and Montgomery Counties for medical services. In addition, several hospitals in Philadelphia provide medical services in their outpatient clinic which are not included in this data. The Health Insuring Organization (HealthPASS Contractor) also has 161 obstetricians to provide medical services to medical assistance clients.

Schuylkill County medical assistance clients and the general population cross county lines to Berks, Columbia, Lehigh and Northumberland Counties for medical services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA

County Name	Co. No.	GENERAL PRACTICE Family Practitioners Tot Pny.	Part Phy.	Claims	GENERAL PRACTICE Family Practitioners Obstetrics – Claims **	
Adams	01	32	31	11,155	0	0
Allegheny	02	560	403	222,694	4	22
Armstrong	03	19	17	21,869	4	108
Beaver	04	82	59	81,616	6	119
Bedford	05	13	11	12,966	0	0
Berks	06	191	150	63,463	2	56
Blair	07	77	64	61,108	2	57
Bradford	08	20	18	26,348	3	117
Bucks	09	237	177	67,140	0	0
Butler	10	20	17	12,817	0	0
Cambria	11	89	80	83,734	2	6
Carbon	13	19	18	16,983	0	0
Centre	14	39	31	15,943	2	40
Chester	15	141	104	31,836	0	0
Clarion	16	23	22	30,910	1	48
Clearfield	17	22	20	22,216	1	11
Clinton	18	15	15	22,713	2	94
Columbia	19	41	36	23,854	8	86
Crawford	20	31	28	53,775	7	260
Cumberland	21	72	59	34,547	1	8
Dauphin	22	189	141	37,871	0	0
Delaware	23	203	132	53,960	0	0
Cameron/Elk	12/24	12	12	13,582	0	0
Erie	25	174	144	145,845	6	156
Fayette	26	37	29	47,521	0	0
Forest	27	-	-	-	0	0
Franklin	28	54	51	48,514	6	86
Fulton	29	2	2	2,691	0	0
Greene	30	12	9	10,108	0	0
Huntingdon	31	14	13	15,678	0	0
Indiana	32	25	23	24,978	0	0
Jefferson	33	19	18	27,859	6	91
Lackawanna	35	80	63	44,452	1	6
Lancaster	36	243	192	122,283	12	69
Lawrence	37	18	17	17,828	0	0
Lebanon	38	53	48	30,298	7	66
Lehigh	39	146	114	45,949	1	26
Luzerne	40	165	145	136,554	4	25
Lycoming	41	85	72	68,072	23	171
McKean	42	12	10	19,558	0	0
Mercer	43	40	38	43,461	1	5
Mifflin/Juniata	44/34	28	26	24,608	0	0
Monroe	45	27	20	8,525	0	0

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA

County Name	Co. No.	GENERAL PRACTICE Family Practitioners Tot Pny.	Part Phy.	Claims	GENERAL PRACTICE Family Practitioners Obstetrics – Claims **	
Montgomery	46	436	301	99,222	0	0
Montour	47	20	14	3,042	1	4
Northampton	48	71	52	19,911	0	0
Northumberland	49	29	22	22,813	1	19
Perry	50	12	10	5,534	0	0
Philadelphia	51	441	306	210,873	0	0
Potter	53	8	5	9,615	2	13
Schuylkill	54	57	46	25,881	0	0
Snyder	55	-	-	-	0	0
Somerset	56	23	22	30,660	0	0
Sullivan	57	1	1	202	4	38
Susquehanna	58	11	9	4,440	4	38
Tioga	59	19	19	35,765	6	144
Union	60	18	18	16,068	6	63
Venango	61	16	15	24,326	1	4
Warren	62	18	15	12,325	0	0
Washington	63	88	70	57,908	2	14
Wayne/Pike	64/52	18	12	6,312	2	5
Westmoreland	65	131	114	128,278	2	79
Wyoming	66	14	13	24,555	7	93
York	67	167	145	72,449	2	26

* One physician enrolled who does not bill independently but provides services as a National Health care physician at the Philadelphia College of Osteopathic Medicine satellite clinic at the Sullivan County Medical Center.

** General practitioners and family practice physicians who provide obstetrical services in addition to pediatric services.

NOTE: The number of practitioners participating in a particular county is sometimes greater than the number who are licensed because this occurs when a practitioner's license address is in a different county than the practice address.

Total Licensed – 4,979
Total Enrolled – 3,888
Total # Claims – 2,793,056
Total # Del – 152
Total # Claims – 2,273

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA

OBSTETRICS

County Name	Co. No.	Tot Phy.	Part Phy.	Claims
Adams	01	5	5	3,931
Allegheny	02	296	225	201,614
Armstrong	03	2	2	9,918
Beaver	04	14	14	22,239
Bedford	05	2	2	7,310
Berks	06	31	44	15,281
Blair	07	22	20	33,679
Bradford	08	9	6	7,162
Bucks	09	66	52	19,034
Butler	10	8	8	10,326
Cambria	11	13	13	35,500
Carbon	13	4	4	7,726
Centre	14	13	12	6,786
Chester	15	49	42	17,773
Clarion	16	1	1	2,201
Clearfield	17	4	4	10,934
Clinton	18	1	1	1,045
Columbia	19	10	7	4,340
Crawford	20	5	5	6,086
Cumberland	21	11	9	3,192
Dauphin	22	84	62	43,906
Delaware	23	85	65	28,890
Cameron/Elk	12/24	3	3	2,806
Erie	25	31	29	33,947
Fayette	26	6	6	23,244
Forest	27	-	-	-
Franklin	28	12	12	6,705
Fulton	29	-	-	-
Greene	30	3	3	4,058
Huntingdon	31	4	4	1,736
Indiana	32	8	6	12,884
Jefferson	33	7	7	7,904
Lackawanna	35	21	19	17,478
Lancaster	36	40	36	18,352
Lawrence	37	4	4	5,748
Lebanon	38	10	9	7,002
Lehigh	39	63	50	25,739
Luzerne	40	38	34	44,846
Lycoming	41	13	11	3,808

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA

OBSTETRICS

County Name	Co. No.	Tot Phy.	Part Phy.	Claims
McKean	42	2	2	6,356
Mercer	43	14	13	19,968
Mifflin/Juniata **	44/34	7	6	7,467
Monroe	45	8	7	10,301
Montgomery	46	222	163	78,441
Montour	47	13	8	7,653
Northampton	48	27	24	23,683
Northumberland	49	3	3	1,399
Perry	50	1	0	-
Philadelphia	51	384	213	129,355
Potter	53	2	2	5,470
Schuylkill	54	6	6	9,571
Snyder	55	-	-	-
Somerset	56	6	6	12,423
Sullivan	57	-	-	-
Susquehanna	58	2	1	831
Tioga	59	1	1	390
Union	60	7	7	8,426
Venango	61	6	5	6,116
Warren	62	3	3	5,314
Washington	63	13	13	11,370
Wayne/Pike	64/52	2	2	5,786
Westmoreland	65	29	28	48,472
Wyoming	66	1	1	3,803
York	67	43	37	8,296

* Recipients have access to obstetrical care in neighboring counties, such as Cumberland and Dauphin counties. Non-medical assistance persons as well as medical assistance clients generally obtain their medical care in the Harrisburg, Carlisle, Camp Hill and Hershey areas. There is an enrolled Rural Health Clinic in Perry County.

** Mifflin and Juniata counties and Wayne and Pike counties are combined because they have joint medical associations and are not densely populated. They also have geographic proximity, low medical assistance populations and the general population crosses county lines for medical services.

NOTE: The number of practitioners participating in a particular county is sometimes greater than the number who are licensed because this occurs when a practitioner's license address is in a different county than the practice address.

Total licensed – 1,800
Total Enrolled – 1,387
Total Claims – 1,126,621

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA

PEDIATRICS

County Name	Co. No.	Tot Phy.	Part Phy.	Claims
Adams	01	5	4	6,734
Allegheny	02	458	363	309,898
Armstrong	03	5	5	15,360
Beaver	04	9	8	35,257
Bedford	05	2	2	11,026
Berks	06	35	31	29,460
Blair	07	14	13	47,638
Bradford	08	5	5	8,230
Bucks	09	111	82	35,230
B,308utler	10	7	7	22,388
Cambria	11	14	11	27,352
Carbon	13	2	2	7,308
Centre	14	12	11	12,716
Chester	15	83	64	56,642
Clarion	16	0	0	0
Clearfield	17	5	5	11,416
Clinton	18	2	1	1,589
Columbia	19	13	8	7,027
Crawford	20	5	5	16,813
Cumberland	21	14	11	8,179
Dauphin	22	98	69	49,702
Delaware	23	139	83	39,016
Cameron/Elk	12/24	1	1	779
Erie	25	23	22	37,499
Fayette	26	10	10	61,127
Forest	27	0	0	0
Franklin	28	5	5	3,402
Fulton	29	0	0	0
Greene	30	2	1	39
Huntingdon	31	3	3	9,224
Indiana	32	8	8	11,257
Jefferson	33	5	5	33,363
Lackawanna	35	21	20	25,044
Lancaster	36	28	25	24,671
Lawrence	37	4	4	34,659
Lebanon	38	10	7	5,906
Lehigh	39	53	49	41,240
Luzerne	40	29	26	47,484
Lycoming	41	7	7	16,119
McKean	42	2	2	10,719
Mercer	43	13	9	22,769
Mifflin/Juniata	44/34	7	6	5,510
Monroe	45	13	11	16,220

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE COMMONWEALTH OF PENNSYLVANIA

County Name	Co. No.	Tot Phy.	Part Phy.	Claims
Montgomery	46	219	141	81,682
Montour	47	39	32	28,238
Northampton	48	17	17	13,704
Northumberland	49	4	3	8,756
Perry	50	1	1	633
Philadelphia	51	592	342	276,273
Potter	53	4	3	7,865
Schuylkill	54	9	8	30,411
Snyder	55	0	0	0
Somerset	56	2	2	10,887
Sullivan	57	0	0	0
Susquehanna	58	2	1	99
Tioga	59	2	2	1,951
Union	60	3	3	8,605
Venango	61	6	6	15,389
Warren	62	3	2	234
Washington	63	9	8	22,421
Wayne/Pike	64/52	7	6	14,051
Westmoreland	65	23	22	61,664
Wyoming	66	0	0	0
York	67	30	25	64,081

** Mifflin and Juniata counties and Wayne and Pike counties are combined because they have joint medical association and are not densely populated. They also have geographic proximity, low medical assistance populations and the general population crosses county lines for medical services.

NOTE: The number of practitioners participating in a particular county is sometimes greater than the number who are licensed because this occurs when a practitioner's license address is in a different county than the practice address.

Total # licensed – 2,854
Total # enrolled – 1,635
Total # claims – 1,812,956

County Name	Co No	Licensed Midwives	Enrolled Midwives	County Name	Co. No.	Licensed Midwives	Enrolled Midwives
Adams	01	1	2	Lackawanna	35	1	-
Allegheny	02	9	4	Lancaster	36	10	4
Armstrong	03	-	-	Lawrence	37	-	-
Beaver	04	-	-	Lebanon	38	1	-
Bedford	05	-	-	Lehigh	39	4	4
Berks	06	6	5	Luzerne	40	3	-
Blair	07	1	-	Lycoming	41	3	3
Bradford	08	1	-	McKean	42	-	-
Bucks	09	14	1	Mercer	43	2	1
Butler	10	2	-	Mifflin	44	2	1
Cambria	11	1	-	Monroe	45	2	-
Cameron	12	-	-	Montgomery	46	22	1
Carbon	13	-	-	Montour	47	1	-
Center	14	-	-	Northampton	48	1	-
Chester	15	6	-	Northumberland	49	-	-
Clarion	16	-	-	Perry	50	-	-
Clearfield	17	-	-	Philadelphia	51	28	16
Clinton	18	1	-	Pike	52	-	-
Columbia	19	-	-	Potter	53	-	-
Crawford	20	1	-	Schuylkill	54	-	-
Cumberland	21	4	2	Snyder	55	-	-
Dauphin	22	2	-	Somerset	56	1	1
Delaware	23	11	9	Sullivan	57	-	-
Elk	24	-	-	Susquehanna	58	-	-
Erie	25	1	1	Tioga	59	-	-
Fayette	26	-	-	Union	60	-	-
Forest	27	-	-	Venango	61	-	-
Franklin	28	3	2	Warren	62	-	-
Fulton	29	1	2	Washington	63	-	-
Greene	30	-	-	Wayne	64	2	-
Huntingdon	31	3	-	Westmoreland	65	2	2
Indiana	32	-	-	Wyoming	66	-	-
Jefferson	33	-	-	York	67	3	-
Juniata	34	1	-				

Total Licensed Midwives 157 Total Enrolled Midwives 61

* Midwives may be licensed in one County and provide services in another county.

County Name	Co No	Licensed Midwives	Enrolled Midwives	County Name	Co. No.	Licensed Midwives	Enrolled Midwives
Adams	01	8	-	Lackawanna	35	26	-
Allegheny	02	348	32	Lancaster	36	51	1
Armstrong	03	9	-	Lawrence	37	7	-
Beaver	04	17	1	Lebanon	38	13	-
Bedford	05	1	-	Lehigh	39	27	2
Berks	06	42	8	Luzerne	40	25	-
Blair	07	13	-	Lycoming	41	10	1
Bradford	08	5	1	McKean	42	5	-
Bucks	09	76	2	Mercer	43	6	-
Butler	10	28	-	Mifflin	44	4	-
Cambria	11	16	-	Monroe	45	9	-
Cameron	12	-	-	Montgomery	46	208	6
Carbon	13	4	-	Montour	47	6	-
Centre	14	15	-	Northampton	48	20	1
Chester	15	63	-	Northumberland	49	6	-
Clarion	16	4	-	Perry	50	-	-
Clearfield	17	3	-	Philadelphia	51	185	18
Clinton	18	-	-	Pike	52	1	-
Columbia	19	7	-	Potter	53	-	-
Crawford	20	7	-	Schuylkill	54	5	-
Cumberland	21	29	-	Snyder	55	-	-
Dauphin	22	49	-	Somerset	56	12	-
Delaware	23	149	7	Sullivan	57	-	-
Elk	24	4	-	Susquehanna	58	1	-
Erie	25	21	-	Tioga	59	6	-
Fayette	26	10	-	Union	60	5	-
Forest	27	-	1	Venango	61	9	-
Franklin	28	12	-	Warren	62	1	-
Fulton	29	1	-	Washington	63	24	-
Greene	30	2	1	Wayne	64	9	-
Huntingdon	31	8	-	Westmoreland	65	48	2
Indiana	32	11	-	Wyoming	66	3	-
Jefferson	33	1	-	York	67	36	-
Juniata	34	1	-				

Total Licensed CRNPs-1732 Total Enrolled CRNPs-84

Health Maintenance Organizations (HMOs)	The obstetrical and pediatric services are included in the rate base. All fee for service costs are identified and included in the rate base. Obstetrician and pediatricians participating in HMOs are comparable to the community participation.

Adequacy of Access	
Obstetrical Standards	
A. Practitioner Participation	Refer to attached list of general practice and obstetrical/gynecologists participation for 1988. At this time, there are no participating obstetricians in Perry County. Recipients still have access to care from obstetricians in neighboring counties, Cumberland and Dauphin.
Pediatric Standards	
A. Practitioner Participation	Refer to attached list of general practice and pediatricians participation for 1988.

State Plan Under Title XIX of the Social Security Act
State Commonwealth of Pennsylvania

COUNTY NAME	CO NO	GENERAL PRACTICE TOT PHY	PART PHY	CLAIMS	% Part
Adams	01	23	23	5,449	100.0%
Allegheny	02	444	343	162,121	77.3%
Armstrong	03	22	19	18,337	86.4%
Beaver	04	71	61	75,831	85.9%
Bedford	05	10	10	7,676	100.0%
Berks	06	158	124	37,194	78.5%
Blair	07	59	58	29,176	98.3%
Bradford	08	15	12	11,877	80.0%
Bucks	09	151	115	14,845	76.2%
Butler	10	20	19	7,691	95.0%
Cambria	11	77	70	46,710	90.9%
Carbon	13	18	17	8,932	94.4%
Centre	14	42	30	8,217	71.4%
Chester	15	77	64	10,880	83.1%
Clarion	16	23	22	23,821	95.7%
Clearfield	17	19	19	11,219	100.0%
Clinton	18	21	20	26,460	95.2%
Columbia	19	33	32	15,025	97.0%
Crawford	20	26	23	29,763	88.5%
Cumberland	21	32	26	12,559	81.3%
Dauphin	22	149	102	34,559	68.5%
Delaware	23	164	122	29,213	74.4%
Elk/Cameron	24/12	18	18	12,221	100.0%
Erie	25	115	88	70,342	76.5%
Fayette	26	33	30	59,283	90.9%
Forest	27	1	1	3,332	100.0%
Franklin	28	63	60	27,758	95.2%
*Fulton	29	5	5	0	0.0%
Greene	30	13	10	5,554	76.9%
Huntingdon	31	10	10	5,373	100.0%
Indiana	32	21	16	8,863	76.2%
Jefferson	33	20	19	14,254	95.0%
Lackawanna	35	85	77	33,662	90.6%
Lancaster	36	199	191	61,801	96.0%
Lawrence	37	23	22	21,301	95.7%
Lebanon	38	43	37	5,921	86.0%
Lehigh	39	112	78	19,514	69.6%
Luzerne	40	138	124	76,892	89.9%
Lycoming	41	62	54	28,285	87.1%
Mckean	42	10	9	8,020	90.0%
Mercer	43	35	32	45,575	91.4%
Mifflin/Juniata	44/34	24	22	14,788	91.7%
Monroe	45	27	21	2,196	77.8%
Montgomery	46	301	221	43,273	73.4%
Montour	47	28	18	2,379	64.3%
Northampton	48	80	59	18,925	73.8%
Northumberland	49	26	25	12,205	96.2%
Perry	50	9	9	5,260	100.0%
Philadelphia	51	458	323	171,233	70.5%
Potter	53	6	6	4,825	100.0%
Schuylkill	54	60	48	18,427	80.0%
**Snyder	55	2	2	0	0.0%
Somerset	56	24	23	24,231	95.8%
Sullivan	57	1	1	123	100.0%
Susquehanna	58	13	13	4,197	100.0%
Tioga	59	22	22	13,356	100.0%
Union	60	16	15	4,189	93.8%
Venango	61	26	23	18,406	88.5%
Warren	62	15	14	10,411	93.3%
Washington	63	69	65	22,047	94.2%
Wayne/Pike	64/52	17	15	3,331	88.2%
Westmoreland	65	142	129	118,981	90.8%
Wyoming	66	9	9	8,430	100.0%
York	67	125	107	28,719	85.6%
My TOTALS		4,156	3,395	1,685,438	81.7%
TOTALS FROMS PMS REPORT		4,156	3,395	1,685,438	
Difference ……		0	0	0	

State Plan Under Title XIX of the Social Security Act
State Commonwealth of Pennsylvania

COUNTY NAME	CO NO	PEDIATRICS TOT PHY	PART PHY	CLAIMS	% PART	OB/GYN TOT PHY	PART PHY	CLAIMS	% PART
Adams	01	6	4	1,832	66.7%	5	4	1,965	80.0%
Allegheny	02	301	245	112,428	81.4%	275	222	104,183	80.7%
Armstrong	03	3	3	5,398	100.0%	3	3	1,960	100.0%
Beaver	04	9	7	24,343	77.8%	14	14	6,093	100.0%
Bedford	05	2	2	4,496	100.0%	3	3	4,815	100.0%
Berks	06	23	19	5,697	82.6%	43	39	3,290	90.7%
Blair	07	13	11	19,279	84.6%	15	15	12,772	100.0%
Bradford	08	4	4	2,622	100.0%	6	5	1,826	83.3%
Bucks	09	67	53	19,394	79.1%	42	39	8,207	92.9%
Butler	10	7	6	10,042	85.7%	7	7	4,695	100.0%
Cambria	11	13	12	11,833	92.3%	19	16	15,172	84.2%
Carbon	13	2	2	3,685	100.0%	6	6	4,318	100.0%
Centre	14	10	9	2,416	90.0%	7	7	3,785	100.0%
Chester	15	52	42	10,852	80.8%	31	28	6,674	90.3%
Clarion	16	1	1	0	100.0%	1	1	690	100.0%
Clearfield	17	5	5	4,561	100.0%	7	7	5,972	100.0%
Clinton	18	2	2	6,512	100.0%	2	1	638	50.0%
Columbia	19	8	6	2,641	75.0%	4	4	279	100.0%
Crawford	20	4	4	5,558	100.0%	3	3	1,334	100.0%
Cumberland	21	14	12	3,640	85.7%	8	6	2,176	75.0%
Dauphin	22	75	55	18,366	73.3%	67	55	13,575	82.1%
Delaware	23	97	73	15,889	75.3%	66	54	13,944	81.8%
Elk/Cameron	24/12	2	2	628	100.0%	3	3	4,221	100.0%
Erie	25	20	19	22,715	95.0%	24	24	24,421	100.0%
Fayette	26	3	3	6,966	100.0%	7	7	15,647	100.0%
Forest	27	0	0	0	0.0%	0	0	0	0.0%
Franklin	28	6	6	2,015	100.0%	9	9	3,255	100.0%
Fulton	29	0	0	0	0.0%	0	0	0	0.0%
Greene	30	3	3	923	100.0%	3	3	5,163	100.0%
Huntingdon	31	4	4	6,497	100.0%	2	2	652	100.0%
Indiana	32	4	4	1,932	100.0%	9	9	3,620	100.0%
Jefferson	33	8	8	20,087	100.0%	5	5	988	100.0%
Lackawanna	35	19	18	12,720	94.7%	24	23	14,977	95.8%
Lancaster	36	25	21	11,712	84.0%	31	30	8,528	96.8%
Lawrence	37	5	5	12,961	100.0%	7	7	8,332	100.0%
Lebanon	38	8	6	2,967	75.0%	8	7	1,864	87.5%
Lehigh	39	36	31	14,681	86.1%	43	38	14,208	88.4%
Luzerne	40	32	29	32,662	90.6%	33	31	17,370	93.9%
Lycoming	41	6	6	5,216	100.0%	13	13	4,310	100.0%
Mckean	42	3	3	6,436	100.0%	3	3	1,818	100.0%
Mercer	43	11	9	9,424	81.8%	11	11	9,211	100.0%
Mifflin/Juniata	44/34	6	6	1,624	100.0%	5	5	1,506	100.0%
Monroe	45	10	8	2,789	80.0%	11	9	1,542	81.8%
Montgomery	46	159	121	44,267	76.1%	118	99	16,453	83.9%
Montour	47	33	22	14,648	66.7%	13	11	3,977	84.6%
Northampton	48	24	23	8,090	95.8%	30	22	10,555	73.3%
Northumberland	49	3	2	5,231	66.7%	5	5	3,520	100.0%
Perry	50	1	1	90	100.0%	1	0	0	0.0%
Philadelphia	51	538	347	209,470	64.5%	401	283	80,117	70.6%
Potter	53	2	2	3,417	100.0%	1	1	2,821	100.0%
Schuylkill	54	11	10	9,707	90.9%	6	6	6,747	100.0%
Snyder	55	0	0	0	0.0%	0	0	0	0.0%
Somerset	56	2	2	5,303	100.0%	7	6	5,363	85.7%
Sullivan	57	0	0	0	0.0%	0	0	0	0.0%
*Susquehanna	58	2	2	637	100.0%	*2	2	0	0.0%
Tioga	59	2	2	1,704	100.0%	2	2	468	100.0%
Union	60	3	3	946	100.0%	6	5	1,942	83.3%
Venango	61	8	7	15,267	87.5%	8	8	6,674	100.0%
Warren	62	2	2	1,135	100.0%	4	4	1,431	100.0%
Washington	63	10	9	7,426	90.0%	12	12	12,481	100.0%
Wayne/Pike	64/52	7	5	3,764	71.4%	1	1	461	100.0%
Westmoreland	65	23	20	36,143	87.0%	30	30	33,976	100.0%
**Wyoming	66	1	1	0	0.0%	**1	1	0	0.0%
York	67	20	17	3,943	85.0%	30	27	3,847	90.0%
My TOTALS		1,778	1,364	837,627	76.7%	1,560	1,300	550,829	83.3%
TOTALS FROMS PMS REPORT		1,778	1,364	837,627		1,560	1,300	550,829	
Difference		0	0	0		0	0	0	