RULES AND REGULATIONS

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CH. 140]

Special MA Eligibility Provisions

The Department of Public Welfare (Department), under sections 201(2) and 403(b) of the Public Welfare Code (62 P. S. §§ 201(2) and 403(b)) and section 1902(a)(10)(A)(ii)(XVIII) of the Social Security Act (42 U.S.C.A. § 1396a(a)(10)(A)(ii)(XVIII)) (Title XIX), regarding state plans for medical assistance, adds Chapter 140, Subchapter E (relating to the categorically needy breast and cervical cancer prevention and treatment program for qualified women). Notice of proposed rulemaking was published at 34 Pa.B. 6335 (November 27, 2004).

Purpose of Final-Form Rulemaking

The purpose of this final-form rulemaking is to take advantage of a Federal option in the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Pub. L. No. 106-354, 104 Stat. 409) (BCCPT Act), which amended section 1902(a)(10)(A)(ii)(XVIII) of the Social Security Act. The BCCPT Act permits states to provide Medical Assistance to women under 65 years of age who have been screened for breast or cervical cancer through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Individuals must be diagnosed and found to need treatment for either breast or cervical cancer or a precancerous condition of the breast or cervix. Coverage is limited to women who are "uninsured," which is defined in § 140.702 (relating to definitions) as lacking "creditable coverage" as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) (section 2701(c) of the Public Health Service Act (42 U.S.C.A. § 300gg(c)(1)), regarding increased portability through limitation on preexisting condition exclusions.

Consistent with the BCCPT Act, providers and facilities funded in full or in part by the CDC are authorized to screen women only. Breast cancer is the most common form of cancer diagnosed among women in this Commonwealth and the second most common cause of cancer deaths for women in this Commonwealth (www.health.state.pa.us/stats). Cervical cancer, while less common than breast cancer, is one of the most successfully treatable cancers, if detected at an early stage (www.health.state.pa.us/stats).

The BCCPT Act amended Title XIX of the Social Security Act. The Commonwealth has elected this option and published a notice of intent at 32 Pa.B. 115 (January 5, 2002) to implement the Breast and Cervical Cancer Prevention and Treatment Program (BCCPT Program). The Commonwealth's State Plan Amendment to provide Medical Assistance under the BCCPT Program to uninsured women screened and diagnosed with breast or cervical cancer, or a precancerous condition of the breast or cervix, was approved on February 15, 2002, by the Centers for Medicare and Medicaid Services. The Department of Health (DOH) is the designated screening entity for the BCCPT Program.

Under Federal law, the DOH must agree that low-income women will be given priority in the provision of services. See 42 U.S.C.A. § 300n(a), regarding additional required agreements. Under its grant agreement with the NBCCEDP, the DOH HealthyWoman Project provides breast and cervical cancer screening for uninsured women who are under 65 years of age and have a household income below 250% of the Federal Poverty Income Guidelines (FPIG). Prior to the implementation of the BCCPT Program on January 1, 2002, there were no consistent avenues available to fund the ongoing treatment needs of low-income, uninsured women who were screened and diagnosed with breast or cervical cancer.

Affected Individuals and Organizations

The final-form rulemaking affects and benefits women under 65 years of age who are uninsured, who have been screened for breast or cervical cancer through the CDC NBCCEDP and have been diagnosed and found to need treatment for either breast or cervical cancer, or a precancerous condition of the breast or cervix.

There are approximately 11,600 women diagnosed with breast and cervical cancer each year in this Commonwealth (www.health.state.pa.us/stats). Census data was used to estimate the total number of the 11,600 women who are under 65 years of age and have income levels between 100% and 250% of the FPIG. The result of this analysis indicated that there are an additional 1,109 women who may be eligible for Medical Assistance each year under this option.

Accomplishments and Benefits

The final-form rulemaking will take advantage of a Federal option in the BCCPT Act that permits states to provide Medical Assistance to uninsured women under 65 years of age who have been screened for breast or cervical cancer through the CDC NBCCEDP and diagnosed and found to need treatment for either breast or cervical cancer, or a precancerous condition of the breast or cervix.

There has been no consistent avenue available to fund ongoing treatment needs of low-income, uninsured women diagnosed with breast or cervical cancer, or a precancerous condition of the breast or cervix. As a result, many women may have gone without necessary treatment that may prevent or cure their illness. This option will provide low-income, uninsured women with Medical Assistance that will enable them to seek necessary treatment, thereby decreasing the incidence of uncompensated care and this Commonwealth's cancer mortality rate.

There may be a reduction in premature mortality rates from breast and cervical cancer as a result of screening, early diagnosis and treatment. Health care providers may see a reduction in the incidence of uncompensated care for uninsured women who require treatment for breast and cervical cancer.

Fiscal Impact

The Insurance Department might realize a savings since some women determined eligible for the BCCPT Program might have been otherwise eligible for medical coverage under the adult Basic Program administered by the Insurance Department and funded by tobacco settlement funds.

Private hospitals and physicians who treat uninsured women with breast or cervical cancer, or a precancerous condition of the breast or cervix, may be compensated for services rendered.

Low-income (under 250% FPIG), uninsured women who may have otherwise incurred personal debt will realize a savings.

Paperwork Requirements

New application forms were created exclusively for use with the BCCPT Program: the PA 600B—for applications; the PA 600BP—for partial redeterminations; and the PA 600BR—for annual redeterminations. These forms have been in use since the beginning of the BCCPT Program. Each form provides instructions for use by the applicant or recipient and provider. The Department has not received adverse comments regarding these forms.

The BCCPT Program application, form PA 600B, is a two-part application used by the HealthyWoman Project and the County Assistance Office (CAO) to determine eligibility for the BCCPT Program. Part A of the application is completed at the DOH HealthyWoman Project screening site and contains demographic and income information, consent for release of information and BCCPT Program rights and responsibilities. Part B of the application is completed by the applicant, the medical provider and the CAO. Use of a single form to document demographic information needed by both programs for an eligibility determination will reduce additional paperwork for providers, applicants and the Department.

The BCCPT Program Partial Renewal, form PA 600BP, is completed at a partial redetermination of eligibility for women whose treatment for breast or cervical cancer is expected to last less than 12 months. The recipient, the medical provider and the CAO complete this form.

The BCCPT Program Annual Renewal, form PA 600BR, is completed every 12 months when continued eligibility for the BCCPT Program is redetermined. The recipient, the medical provider, the Office of Medical Assistance Programs and the CAO complete this form.

Additional information regarding the Commonwealth's BCCPT Program is in MA Bulletins 99-01-02 and 99-02-06 and Chapter 317 of the Medicaid Eligibility Handbook available on the Department's website (www.dpw.state.pa.us).

The Department includes eligibility information about the DOH HealthyWoman Program on the Department's website. A link to learn more about the DOH HealthyWoman Project, including the 250% income eligibility limit which is updated annually on the DOH website, is included on the Department's website.

Public Comment

Written comments, suggestions and objections regarding the proposed rulemaking were requested within a 30-day period following publication of proposed rulemaking. The Department received letters from the Independent Regulatory Review Commission (IRRC) and two commentators: the Pennsylvania Health Law Project (PHLP) and Community Legal Services, Inc. (CLS). In addition to providing comments on the proposed rulemaking, the PHLP stated that the BCCPT Program has been invaluable to eligible women in providing coverage for needed treatment of breast or cervical cancer, or a precancerous condition of the breast or cervix. The CLS thanked the Department for adopting the BCCPT Program.

The Department has carefully reviewed and considered each suggestion and comment and thanks the commentators.

Discussion of Comments and Major Changes

Following is a summary of the comments received within the public comment period following publication of the proposed rulemaking and the Department's response to those comments.

General—Regulations

One commentator remarked that limiting the BCCPT Program to women unconstitutionally excludes men with breast cancer.

Response

The BCCPT Act covers individuals who have been screened under the CDC breast and cervical cancer early detection program established under Title XV of the Public Health Service Act (42 U.S.C.A. §§ 300k—300n-5), which specifies "women." See 42 U.S.C.A. § 1396a(aa)(3). The Department must provide Medical Assistance in accordance with the BCCPT Act.

General—Regulations

One commentator believed that limiting the program to women who are screened through the HealthyWoman Project sites creates unnecessary obstacles to accessing the BCCPT Program.

Response

The BCCPT Act specifies eligible women must be screened through the CDC NBCCEDP. CDC NBCCEDP identified the HealthyWoman Project as the accepted healthcare provider.

General—Preamble

One commentator recommended referencing sources of information such as Medical Assistance Bulletins 99-01-12 and 99-02-06 and Operations Memorandum OPS011208 in the preamble.

Response

The Department agrees in part. Information included in the Operations Memorandum has been incorporated into Chapter 317 of the Medicaid Eligibility Handbook, which is available on the Department's website (www.dpw.state.pa.us). Some information included in the nonregulatory documents has been incorporated into the final-form rulemaking. For example, the definition of "treatment for breast and cervical cancer" is included in § 140.702.

§ 140.602. Definitions. (redesignated as § 140.702)

§ 140.621(2)(ii). Conditions of Eligibility. (redesignated as § 140.721(2)(ii))

§ 140.633(1). Verification requirements. (redesignated as § 140.733(i))

One commentator expressed concern with the Department's use of the term "need treatment." In addition, IRRC stated that the term should be edited for clarity. The PHLP commented that "need treatment" should be more clearly defined and it is unclear if this phrase includes taking medication designed to prevent the recurrence of cancer. The PHLP also stated that the regulation may result in different interpretations by different providers, and that "[t]he lack of clear definition has been problematic for consumers trying to access coverage through the BCCPT."

IRRC noted that MA Bulletin 99-01-12, effective January 1, 2002, includes a definition for "treatment for breast or cervical cancer" and recommends that the Department include this definition in the final-form rulemaking.

Response

The Department concurs with the commentator and IRRC and revised the regulation accordingly to include a definition for "treatment for breast or cervical cancer" in § 140.702. The definition includes medical services to prevent recurrence.

§ 140.621. Conditions of eligibility. (redesignated as § 140.721)

IRRC and one commentator stated that the reference to Chapter 149 (relating to citizenship and alienage) in § 140.621(1)(iii) (redesignated as § 140.721(1)(iii)) should be edited for clarity and replaced with a reference to Chapter 150 (relating to citizenship and alienage provisions for categorically needy NMP-MA and MNO-MA).

Response

The Department agrees that Chapter 149 is an incorrect reference and replaced the reference with a reference to Chapter 150.

§ 140.621(2)(iii). Conditions of eligibility. (redesignated as § 140.721(2)(iii))

One commentator suggested that stating that women must be "uninsured" to be eligible misleads the reader. This commentator recommended that language in the regulations pertaining to being "uninsured" as a condition of eligibility should be changed to "having no creditable coverage" and all uses of the word "uninsured" should be deleted.

Response

The Department agrees in part. The BCCPT Act requires that, to be eligible, women "are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act (42 U.S.C.A. § 300gg(c)(1)." The term "uninsured" is defined in § 140.702 as "Having no creditable coverage as the term is defined under the Health Insurance Portability and Accountability Act (HIPAA) (Section 2701(c) of the Public Health Service Act (42 U.S.C.A. § 300gg(c)(1))." Because "uninsured" has been defined in the regulations to mean "having no creditable coverage," it has not been deleted from the final-form rulemaking.

§ 140.621(2)(iv). Conditions of eligibility. (redesignated as § 140.721(2)(iv))

One commentator commented that the regulations should provide an exception that would allow BCCPT Program eligibility for women that were eligible for Medical Assistance for Workers with Disabilities (MAWD). The commentator suggested that the regulation should be changed to limit eligibility to women who are "ineligible for any other categorically needy Medicaid program, except those charging monthly premiums, such as MAWD."

Response

The Department disagrees. The Commonwealth provides coverage under 1902(a)(10)(a)(ii)(XVIII) of the Social Security Act, which specifies that women must not be otherwise covered under creditable coverage, as defined in HIPAA (section 2701(c) of the Public Health Service Act).

§ 140.631. Income eligibility limitations. (redesignated as § 140.731)

IRRC and one commentator recommended that this section should be edited for clarity. The commentator remarked that this section should reference the regulations or guidelines, or both, that describe the income eligibility requirements for the CDC NBCCEDP and the HealthyWoman Project. IRRC remarked that clarity would be improved by specifically identifying or including a cross-reference to where the income limits necessary to be eligible for screening by CDC NBCCEDP can be found and how an individual's income is determined.

Response

The Department disagrees with this request to include CDC NBCCEDP and the HealthyWoman Project income eligibility requirements and guidelines within the regulation. A woman who is income-eligible for CDC NBCCEDP meets the income requirements for the BCCPT Program. The Department does not do a separate determination of income eligibility. However, the DOH's income eligibility requirements can be found on the Department's website at www.health.state.pa.us.

§ 140.633(a)(2). Verification requirements. (redesignated as § 140.733(a)(2))

One commentator stated that this section should read "[v]erification that the woman is a United States citizen, a qualified alien, or otherwise PRUCOL as defined in Chapter 150. An applicant applying for BCCPT for an emergency medical condition is not required to verify alien status."

Response

The Department disagrees with the suggested revision. Emergency Medical Assistance and BCCPT are separate programs. Verification that an applicant is a United States citizen or a qualified alien is required for the BCCPT Program as for any other category of Medical Assistance. "Permanently Residing Under Color of Law (PRUCOL)" is an obsolete term. An individual who is ineligible for BCCPT because of alien status and who has an emergency medical condition may qualify for Medical Assistance for that medical emergency in accordance with § 150.11 (relating to aliens eligible for emergency medical services).

Information regarding the coverage of emergency medical conditions for undocumented aliens was not included in the regulations because it is outside the scope of Chapter 140 (relating to special MA eligibility provisions).

§ 140.641. Complete redetermination. (redesignated as § 140.741)

One commentator suggested this section should be edited for clarity and for use of consistent language.

Response

The Department agrees with the commentator's suggestion. In § 140.741, the words "for qualified women" have been deleted. The term "Categorically Needy" has been replaced with "for all enrolled women." In addition, § 140.742 (relating to partial redetermination) has been revised for clarity and consistency with § 140.741.

§ 140.641(b). Complete redetermination. (redesignated as § 140.741(b))

§ 140.642(b). Partial redetermination. (redesignated as § 140.742(b))

One commentator advised that the reference to Chapter 133 (relating to redetermining eligibility) in these sections is confusing and should be edited for clarity.

Response

The Department concurs and added a cross-reference to a specific citation in Chapter 133.

§ 140.661. Eligibility begin date. (redesignated as § 140.761)

One commentator stated that this section should reference the section on retroactive eligibility by adding the following sentence to the end of this section: "However,

retroactive coverage for services may be available as allowed for by the provisions under § 140.671 dealing with Retroactive Eligibility."

Response

The Department adopted this recommendation and a reference to retroactive eligibility has been added to this section.

§ 140.681. Reporting of changes. (redesignated as § 140.781)

IRRC and one commentator commented that this section should be edited for clarity to include, or should reference provisions that include, what changes in circumstances need to be reported and to whom the changes should be reported.

Response

The Department agrees and revised the text to provide that the recipient shall report changes to the Department that would affect eligibility as set forth in § 140.721 (relating to conditions of eligibility).

§ 140.691. Appeal and fair hearing. (redesignated as § 140.791)

One commentator stated that this section should be revised to add language to explain to which eligibility and service denials the appeal and fair hearing rights do and do not apply. Also, the commentator stated that additional guidance should be added regarding whether and how a woman can appeal HealthyWoman Project eligibility determinations.

Response

The Department disagrees that the HealthyWoman Project appeal and fair hearing information should be added to this regulation. Section 140.791 provides that the appeal and fair hearing rights under Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings) apply to eligibility determinations of the Department. This includes eligibility under the BCCPT Program. Appeals of service denials are beyond the scope of this final-form rulemaking.

Regulatory Review Act

Under section 5.1(a) of the Regulatory Review Act (71 P. S. § 745.5a(a)), on February 16, 2007, the Department submitted a copy of this final-form rulemaking to IRRC and to the Chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare. In compliance with the Regulatory Review Act the Department also provided the Committees and IRRC with copies of all public comments received, as well as other documentation.

In preparing the final-form rulemaking, the Department reviewed and considered comments received from the Committees, IRRC and the public. In addition to submitting the final-form rulemaking, the Department provided IRRC and the Committees with a copy of a Regulatory Analysis Form prepared by the Department. A copy of this form is available to the public upon request.

In accordance with section 5.1(j.1) and (j.2) of the Regulatory Review Act, on March 15, 2007, this final-form rulemaking was deemed approved by the Committees. IRRC met on March 15, 2007, and approved the final-form rulemaking.

Findings

The Department finds that:

(a) The public notice of intention to adopt the administrative regulations by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and the regulations promulgated thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(b) The adoption of this final-form rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the Public Welfare Code (62 P. S. §§ 101—1412).

Order

The Department, acting under the authority of sections 201(2) and 403(b) of the Public Welfare Code and Title XIX of the Social Security Act, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapter 140, are amended by adding §§ 140.701, 140.702, 140.721, 140.731—140.733, 140.741, 140.742, 140.751, 140.761, 140.771, 140.781 and 140.791 to read as set forth in Annex A.

(b) The Secretary of the Department shall submit this order and Annex A to the Offices of General Counsel and Attorney General for approval as to legality and form as required by law.

(c) The Secretary of the Department shall certify and deposit this order and Annex A with the Legislative Reference Bureau as required by law.

(d) This order shall take effect upon publication in the *Pennsylvania Bulletin* retroactive to January 1, 2002.

ESTELLE B. RICHMAN,
Secretary

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission, relating to this document, see 37 Pa.B. 1463 (March 31, 2007).)

(*Editor's Note*: At 34 Pa.B. 6335, these regulations were originally proposed in Subchapter D, §§ 140.601, 140.602, 140.621, 140.631—140.633, 140.641, 140.642, 140.651, 140.652, 140.671, 140.681 and 140.691. The final-form regulations now appear in Subchapter E.)

Fiscal Note: 14-490. (1) General Fund;

	MA Inpatient	*MA Outpatient*
(2) Implementing Year 2006-07 is	$998,000	$4,022,000
(3) 1st Succeeding Year 2007-08 is	$1,260,000	$5,296,000
2nd Succeeding Year 2008-09 is	$1,430,000	$6,273,000
3rd Succeeding Year 2009-10 is	$1,546,000	$7,081,000
4th Succeeding Year 2010-11 is	$1,672,000	$7,992,000
5th Succeeding Year 2011-12 is	$1,809,000	$9,021,000
	MA Inpatient	*MA Outpatient*
(4) 2005-06 Program—	$474,693,000	$945,950,000
2004-05 Program—	$531,875,000	$842,991,000
2003-04 Program—	$411,042,000	$677,979,000

(7) MA Inpatient and MA Outpatient; (8) recommends adoption. Funds have been included in the budget to cover these increases.

Annex A

TITLE 55. PUBLIC WELFARE

PART II. PUBLIC ASSISTANCE MANUAL

Subpart C. ELIGIBILITY REQUIREMENTS

CHAPTER 140. SPECIAL MA ELIGIBILITY PROVISIONS

Subchapter E. THE CATEGORICALLY NEEDY BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT PROGRAM FOR QUALIFIED WOMEN

GENERAL PROVISIONS

ELIGIBILITY

INCOME, RESOURCES AND VERIFICATION

REDETERMINATION

BENEFIT COVERAGE

REPORTING

RIGHT TO APPEAL AND FAIR HEARING

GENERAL PROVISIONS

§ 140.701. Policy on Medical Assistance for women with breast or cervical cancer.

The Department provides full MA benefits to uninsured women under 65 years of age who have been screened and diagnosed with breast or cervical cancer, or a precancerous condition of the breast or cervix, who are eligible under the Commonwealth's categorically needy BCCPT Program.

§ 140.702. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

BCCPT Program—Breast and Cervical Cancer Prevention and Treatment Program—A Federally-funded option that provides full MA benefits to uninsured women under 65 years of age who have been screened and diagnosed and are in need of treatment for breast or cervical cancer, or a precancerous condition of the breast or cervix. These women have been identified through an entity funded in full or in part by CDC.

CDC—Centers for Disease Control and Prevention—The lead Federal agency for protecting the health and safety of people at home and abroad by applying disease prevention and control.

NBCCEDP—National Breast and Cervical Cancer Early Detection Program—A program established by Congress under the Breast and Cervical Cancer Mortality Act of 1990 (Pub. L. No. 101-354, 104 Stat. 409) which authorizes the CDC to promote breast and cervical cancer screening and to pay for screening services for eligible individuals.

Treatment for breast and cervical cancer—Medical services, which are, or are reasonably expected to provide one of the following:

(i) Ameliorate the direct effects of breast or cervical cancer.

(ii) Aid in the clinical characterization of breast or cervical cancer, including testing for the effectiveness of curative treatment but excluding screening for recurrence or new primary cancers.

(iii) Prevent the recurrence of breast or cervical cancer.

Uninsured—Having no "creditable coverage" as the term is defined under the Health Insurance Portability and Accountability Act (HIPAA) (Section 2701(c) of the Public Health Service Act (42 U.S.C.A. § 300gg(c)(1)).

ELIGIBILITY

§ 140.721. Conditions of eligibility.

Eligibility for MA under the BCCPT Program is based on the requirements in the following chapters:

(1) A woman shall meet the following eligibility requirements:

(i) Chapter 125 (relating to application process).

(ii) Chapter 148 (relating to MA residence provisions for categorically needy NMP-MA and MNO-MA).

(iii) Chapter 150 (relating to citizenship and alienage provisions for categorically needy NMP-MA and MNO-MA).

(iv) Chapter 155 (relating to enumeration).

(v) Chapter 255 (relating to restitution).

(vi) Chapter 257 (relating to reimbursement).

(2) Under the BCCPT Program, a woman shall be:

(i) Under 65 years of age.

(ii) Screened under the CDC's NBCCEDP and diagnosed with either breast or cervical cancer, or a precancerous condition of the breast or cervix, and need treatment for either breast or cervical cancer, or a precancerous condition of the breast or cervix.

(iii) Uninsured.

(iv) Otherwise ineligible for categorically needy Medicaid as defined in § 1101.21 (relating to definitions).

INCOME, RESOURCES AND VERIFICATION

§ 140.731. Income eligibility limitations.

There are no income limits when determining eligibility under the BCCPT Program. An individual who meets the income limits to be eligible for screening by the CDC's NBCCEDP is income-eligible for the BCCPT Program.

§ 140.732. Resource eligibility limitations.

There are no resource limits when determining eligibility under the BCCPT Program.

§ 140.733. Verification requirements.

(a) Under the BCCPT Program, the following verification is required:

(1) Verification that the woman was screened for breast or cervical cancer, or a precancerous condition of the breast or cervix, by a provider or facility funded in full or in part by the CDC under its NBCCEDP, and diagnosed

and found to need treatment for either breast or cervical cancer, or a precancerous condition of the breast or cervix. Verification of the continued need for treatment must be provided at each partial and complete redetermination.

(2) Verification that the woman is a United States citizen or qualified alien as the term is defined in 8 U.S.C.A. § 1641(b) (relating to definitions).

(3) Verification that the woman is under 65 years of age.

(4) Verification that the woman is a resident of this Commonwealth.

(5) Verification that the woman is uninsured.

(b) The verification specified in subsection (a) must be provided on a form established by the Department.

REDETERMINATION

§ 140.741. Complete redetermination.

(a) A complete redetermination is required at least every 12 months for women who continue to require treatment for either breast or cervical cancer, or a precancerous condition of the breast or cervix.

(b) For the BCCPT Program, the eligibility factors in § 133.84(c) (relating to MA redetermining eligibility procedures) apply.

§ 140.742. Partial redetermination.

(a) A partial redetermination is required at the end of the initial period of treatment for a woman whose initial period of treatment is expected to last less than 12 months. The initial period of treatment is based on the diagnosing or treating physician's attestation regarding the woman's diagnosis.

(b) For the BCCPT Program, the partial redetermination eligibility factors in § 133.84(d) (relating to MA redetermining eligibility procedures) apply.

BENEFIT COVERAGE

§ 140.751. Benefit coverage.

The Department will provide full MA coverage for a woman determined eligible under the BCCPT Program.

§ 140.761. Eligibility begin date.

The eligibility begin date is the date the woman is diagnosed with breast or cervical cancer, or a precancerous condition of the breast or cervix, but not prior to January 1, 2002. Retroactive BCCPT Program benefits are available under § 140.771 (relating to retroactive eligibility).

§ 140.771. Retroactive eligibility.

The earliest possible date for retroactive BCCPT Program benefits to begin is the first day of the third month preceding the month of application, but not prior to January 1, 2002. The period of eligibility for retroactive BCCPT Program benefits begins the first day of the month in which the first medical service was incurred if the applicant was otherwise eligible during that month.

REPORTING

§ 140.781. Reporting of changes.

The recipient shall report changes that would affect eligibility for the BCCPT Program under § 140.721 (relating to conditions of eligibility) to the Department within 10 days from the date of the change.

RIGHT TO APPEAL AND FAIR HEARING

§ 140.791. Appeal and fair hearing.

The applicant or recipient is entitled to the appeal and fair hearing rights under Chapter 275 (relating to appeal and fair hearing and administrative disqualification hearings).

[Pa.B. Doc. No. 07-837. Filed for public inspection May 11, 2007, 9:00 a.m.]

DEPARTMENT OF PUBLIC WELFARE
[55 PA. CODE CH. 1249]
Home Health Agency Services

The Department of Public Welfare (Department), under sections 403, 443.2(2) and 509 of the Public Welfare Code (62 P. S. §§ 403, 443.2(2) and 509), amends Chapter 1249 (relating to home health agency services) to read as set forth in Annex A. Notice of proposed rulemaking was published at 34 Pa.B. 6544 (December 11, 2004).

Purpose of the Final-Form Rulemaking

The purpose of this final-form rulemaking is to remove the requirement that a recipient be homebound to qualify for Home Health Agency (HHA) services and to remove the limits for HHA visits from the regulation.

The final-form rulemaking is needed to conform the regulations to the Department's direction of emphasizing home- and community-based services, when appropriate, rather than more restrictive and expensive alternatives such as nursing home care, as well as to comply with a Federal directive clarifying Federal regulations regarding the Medicaid home health benefit. Based upon *Olmstead v. L.C.*, 527 U. S. 581 (1999), the Health Care Financing Administration, now the Centers for Medicare and Medicaid Services, clarified its position that requiring that a person be "homebound" to qualify for Medicaid HHA services violates Federal regulatory requirements in 42 CFR 440.230(c) and 440.240(b) (relating to sufficiency of amount, duration, and scope; and comparability of services for groups). As a result, the Department is removing the requirement that individuals be homebound to receive HHA services.

In addition, the Department is removing HHA service limits from the regulations and placing them on the Medical Assistance (MA) Program Fee Schedule to make those limits consistent with limits on other MA services. The Department is not changing the existing limits.

Affected Individuals and Organizations

The amendments to Chapter 1249 will have a positive effect on physicians and HHAs enrolled in the MA Program as well as MA recipients of HHA services. The final-form rulemaking permits the attending physician to prescribe medically necessary HHA services to MA recipients who are not homebound if the HHA service would avoid or delay the need for treatment in a hospital or other institutional setting for the condition being treated or if the MA recipient has an illness, injury or mental health condition that justifies providing the service in the home instead of a physician's office, clinic or other outpatient setting. The removal of the homebound requirement does not preclude recipients who are homebound from receiving HHA services.

The removal of the limits on HHA visits from the regulations formalizes a process whereby recipients with

a medically necessary and appropriate need for continued care in excess of the Fee Schedule limitations can apply for a program exception as authorized in § 1150.63 (relating to waivers). It will no longer be necessary to seek a waiver of the regulation from the Secretary of the Department for payment for HHA visits that exceed the service limits.

Accomplishments and Benefits

The final-form rulemaking benefits MA recipients because it will enable the MA Program to prior authorize medically necessary HHA services for recipients who are not homebound but who are in need of medical care that can be provided more cost effectively in their own homes, rather than in a hospital, long-term care facility or other institutional setting. In addition, MA recipients of HHA services and their physicians will benefit from the final-form rulemaking because the amendments to § 1249.59 (relating to limitations on payment) permit the attending physician to prescribe and the MA recipient to receive medically necessary HHA visits beyond the existing service limits, if approved through a program exception.

Fiscal Impact

It is anticipated that the final-form rulemaking will result in no additional cost to the Department. Allowing providers to prescribe medically necessary HHA services for MA recipients who are not homebound and those MA recipients to receive medically necessary HHA services will result in more MA recipients qualifying for HHA services, but additional costs associated with increased HHA services utilization will be offset by decreased utilization of hospital and other institutional services. The Department anticipates no fiscal impact on the private sector or the general public as a result of this final-form rulemaking.

Paperwork Requirements

No additional reporting, paperwork or recordkeeping is required to comply with the final-form rulemaking.

Public Comment

Written comments, suggestions and objections regarding the proposed rulemaking were requested within a 30-day period following publication of the proposed rulemaking. No public comments were received within the 30-day time frame; however, the Department received two comments from the Independent Regulatory Review Commission (IRRC). The Department also received comments from the Disabilities Law Project (DLP) and Pennsylvania Protection and Advocacy (PP&A) after the 30-day comment period closed.

Discussion of Comments and Major Changes

Following is a summary of the comments received following publication of the proposed rulemaking and the Department's response to those comments. A summary of major changes from the proposed rulemaking is also included.

General Provisions

§ 1249.2a. Clarification of conditions under which MA recipients may be considered homebound—statement of policy.

Comment

IRRC stated that it understood that the Department will be rescinding § 1249.2a and replacing it with a statement of policy that is consistent with the changes to this regulation. IRRC recommended that the Department publish this final-form rulemaking and the updated statement of policy concurrently to avoid inconsistencies in Chapter 1249.

Response

Because MA recipients must no longer be homebound to receive HHA services, a statement of policy clarifying when a recipient may be considered homebound is no longer necessary. Therefore, the Department will be rescinding the statement of policy and will not replace it with another statement of policy.

Payment for Home Health Services

§ 1249.52. Payment conditions for various services.

Comment

IRRC commented that it understood that MA recipients who reside or are eligible to reside in a nursing home, rehabilitative facility or a mental institution qualify for HHA services and therefore recommended that the term "hospitalization" in proposed § 1249.52(a)(2)(i) be replaced with a broader term that encompasses all institutional care settings.

DLP and PP&A commented that Federal Medicaid regulations prohibit a state from requiring that a person be in or qualify for institutional care to receive HHA services and recommended that proposed § 1249.52 (a)(2)(i) be deleted.

Response

The Department disagrees with IRRC's statement that eligibility for HHA services depends on whether an MA recipient resides or is eligible to reside in a nursing home, rehabilitative facility or mental institution. The Department agrees with DLP and PP&A that eligibility for HHA services may not be based on whether the recipient has received or is eligible to receive care in an institutional setting. Eligibility is based on an MA recipient's health care benefits package, irrespective of whether the recipient has been or may be institutionalized.

The intent of the Department's initial statement in § 1249.52(a)(2)(i) ("The only alternative to home health agency services is hospitalization") was to explain one of the conditions that the Department would have considered in determining the medical necessity of HHA services, not to establish eligibility for the services. The Department agrees that this section requires clarification and that the alternatives to HHA services need to be expanded beyond hospitalization. The section has been rewritten as follows: "The specific HHA services would avoid or delay the need for treatment in a hospital or other institutional setting for the condition being treated."

Comment

DLP and PP&A expressed concern that proposed § 1249.52(a)(2)(ii) continued to require a person to have a physical or mental condition that justifies that the service must be provided in the home rather than in an outpatient clinic, which they believe is another way of requiring that recipients of HHA services be homebound. DLP and PP&A also commented that because occupational, physical and speech therapies are not covered for adult MA recipients in an outpatient setting, adult MA recipients can receive these services outside of an institution only through HHA visits. Therefore, requiring that a recipient must have a condition that justifies receiving the therapy in the home will effectively prevent adult MA recipients who are not homebound from receiving medically necessary therapies.

Response

The Department disagrees with DLP and PP&A's comment that occupational, physical and speech therapies are not covered for adult MA recipients in outpatient settings other than through HHA. The Department covers medically necessary occupational, physical and speech therapies for adult MA recipients in outpatient clinics as well as through HHA.

Nonetheless, the Department agrees with DLP and PP&A that the language of the regulation needs to be revised so that it is clear that an MA recipient does not have to be homebound to qualify for HHA services. In addition, the requirement for documentation in the medical record has been deleted from this subparagraph and added to the introductory sentence in § 1249.52(a). As a result, the Department revised § 1249.52(a)(2)(ii) as follows: "The recipient has an illness, injury or mental health condition that justifies providing the service at the recipient's residence instead of a physician's office, clinic or other outpatient setting."

Comment

DLP and PP&A recommended that the Department remove all references to the homebound requirement from Medical Assistance Bulletin 23-94-04, Procedures for Prior Authorization of Home Health Services, issued June 10, 1994, and effective July 5, 1994.

Response

The Department agrees and will rescind MA Bulletin 23-94-04 and issue an updated bulletin removing the requirement that a recipient be homebound to qualify for HHA services.

Discussion of Additional Changes

In addition to the changes explained previously, after additional internal review and in preparation for final-form rulemaking, the Department made the following changes:

§ 1249.42. Ongoing responsibilities of providers.

After additional internal review of proposed § 1249.42(1)(ii), the Department realized that the proposed language inadvertently did not require an initial assessment of need for HHA services. Accordingly, § 1249.42(1)(ii) has been revised to remove the word "continued" to make clear that the need for HHA services must be assessed and documented both initially and on a continuing basis.

§ 1249.59. Limitations on payment.

After additional internal review of proposed § 1249.59, the Department realized that the proposed language did not make it possible to request services above the service limits through a program exception. Accordingly, § 1249.59(2) and (4) (redesignated as paragraph (3)) have been revised to remove the limits on HHA visits and place them on the Fee Schedule.

As a result of the revision to § 1249.59(2), proposed § 1249.52(6) is unnecessary and has been deleted. Proposed paragraph (7) has been redesignated as paragraph (6).

In addition to the changes discussed previously, the Department made several technical revisions in preparing the final-form rulemaking, including correcting typographical errors and revising language to enhance clarity.

Regulatory Review Act

Under section 5.1(a) of the Regulatory Review Act (71 P. S. § 745.5a(a)), on February 16, 2007, the Department submitted a copy of this final-form rulemaking to IRRC and to the Chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare. In compliance with the Regulatory Review Act, the Department also provided the Committees and IRRC with copies of all public comments received, as well as other documentation.

In preparing the final-form rulemaking, the Department reviewed and considered comments received from the Committees, IRRC and the public. In addition to submitting the final-form rulemaking, the Department provided IRRC and the Committees with a copy of a Regulatory Analysis Form prepared by the Department. A copy of this form is available to the public upon request.

In accordance with section 5.1(j.1) and (j.2) of the Regulatory Review Act, on March 15, 2007, this final-form rulemaking was deemed approved by the Committees. IRRC met on March 15, 2007, and approved the final-form rulemaking.

Findings

The Department finds that:

(a) Public notice of intention to adopt the administrative regulation by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and the regulations promulgated thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(b) The adoption of this final-form rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the Public Welfare Code (62 P. S. §§ 101—1412).

Order

The Department, acting under sections 403, 443.2(2) and 509 of the Public Welfare Code, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapter 1249, are amended by amending §§ 1249.2, 1249.42, 1249.52, 1249.57 and 1249.59 to read as set forth in Annex A.

(b) The Secretary of the Department shall submit this order and Annex A to the Offices of General Counsel and Attorney General for approval as to legality and form as required by law.

(c) The Secretary of the Department shall certify and deposit this order and Annex A with the Legislative Reference Bureau as required by law.

(d) This order shall take effect upon final publication in the *Pennsylvania Bulletin*.

ESTELLE B. RICHMAN,
Secretary

(*Editor's Note*: For a statement of policy relating to this final-form rulemaking, see 37 Pa.B. 2215 (May 12, 2007).)

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission, relating to this document, see 37 Pa.B. 1463 (March 31, 2007).)

Fiscal Note: Fiscal Note 14-491 remains valid for the final adoption of the subject regulations.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1249. HOME HEALTH AGENCY SERVICES

GENERAL PROVISIONS

§ 1249.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Home health agency—A public or private agency or organization, or part of an agency or organization that is licensed by the Commonwealth and certified for participation in Medicare. The agency shall be staffed and equipped to provide skilled nursing care and at least one therapeutic service—physical therapy, occupational therapy or speech pathology—or home health aides to a disabled, aged, injured or sick recipient on a part-time or intermittent basis in his residence.

Home health services—Nursing services, home health aide services, physical therapy, occupational therapy or speech pathology and audiology services provided by a home health agency and medical supplies, equipment and appliances suitable for use in the home. For the purpose of this chapter, medical supplies, equipment and appliances do not include dentures, prosthetic devices, orthoses or eyeglasses.

Residence—A place where the recipient makes his home.

(i) The term includes a personal care home, a hospice, a relative's home or a friend's home.

(ii) The term does not include a hospital, skilled nursing facility or intermediate care facility.

Usual charge—A home health agency's most frequent charge to the general public within the same calendar month.

Visit—A personal contact in the recipient's residence made for the purpose of providing a covered service by a health care worker on the staff of the home health agency or by others under contract or arrangement with the home health agency.

PROVIDER PARTICIPATION

§ 1249.42. Ongoing responsibilities of providers.

Ongoing responsibilities of providers are established in Chapter 1101 (relating to general provisions). The home health agency shall:

(1) Have written policies concerning the acceptance of recipients and the feasibility of meeting the recipient's needs in the home care setting, which include, but are not limited to:

(i) An evaluation visit in the recipient's residence to consider the physical facilities available, attitudes of family members and the availability of family members to help in the care of the patient.

(ii) Assessment and documentation of the need for home health agency services.

(2) Establish a plan of care for the recipient that does the following:

(i) Specifies the types of services required.

(ii) Provides long range projection of likely changes in the recipient's condition.

(iii) Includes the diagnosis and a description of the recipient's functional limitations.

(iv) Includes the type and frequency of nursing services, rehabilitation and therapy services and home health aide services needed.

(v) Includes drugs, medications, special diets, activities permitted and the medical supplies, equipment and appliances necessary for the recipient's use.

PAYMENT FOR HOME HEALTH SERVICES

§ 1249.52. Payment conditions for various services.

(a) Home health agencies are reimbursed for services furnished to MA recipients within the MA Program Fee Schedule limits if the following conditions are met and documented in the recipient's medical record:

(1) The services are ordered by and included in the plan of treatment established by the recipient's attending physician.

(2) The attending physician certifies that the recipient requires care in the home and one of the following conditions exist:

(i) The specific home health services would avoid or delay the need for treatment in a hospital or other institutional setting for the condition being treated.

(ii) The recipient has an illness, injury or mental health condition that justifies providing the services at the recipient's residence instead of a physician's office, clinic or other outpatient setting.

(3) The attending physician certifies that the recipient requires the skilled services of a nurse, physical therapist, occupational therapist or speech therapist or the services of a home health aide.

(4) A change in the treatment plan is made in writing and signed by the physician, or if given orally, is put in writing and signed by the health care professional receiving the oral order on behalf of the agency. The order shall be countersigned by the physician within 30 days of the physician's order. The following health care professionals may receive oral orders from the physician:

(i) Registered nurses.

(ii) Licensed practical nurses.

(iii) Physical therapists, occupational therapists and speech therapists. These health care professionals may only receive oral orders that pertain to these specialties.

(5) The plan is reviewed by the attending physician, in consultation with agency professional personnel at least every 60 days. The review of the recipient's plan must contain the signature of the attending physician and the date the review was performed.

(6) The Department has prior authorized the services.

(b) Home health agencies are reimbursed for the following services furnished to MA recipients:

(1) Skilled nursing care.

(2) Home health aide services.

(3) Physical and occupational therapy.

(4) Speech pathology and audiology services.

(5) Medical/surgical supplies listed in the MA Program Fee Schedule.

§ 1249.57. Payment conditions for maternal/child services.

(a) *Maternal/child services.* Home health agencies are reimbursed for maternal/child services if the following conditions are met:

(1) The service is prescribed by the recipient's attending physician.

(2) The services are reasonable and necessary to the treatment of the pregnancy, illness or injury. To be considered reasonable and necessary, the services furnished must be consistent with:

(i) The recipient's particular medical needs as ordered by the recipient's attending physician.

(ii) Accepted standards of medical practice.

(b) *Postpartum and child services.* When the mother no longer requires postpartum visits for medical reasons, but the child continues to need medical services, payment will be made for the additional visits for care of the child only if the services are ordered by the attending physician and are part of a written plan of care written specifically for the child.

§ 1249.59. Limitations on payment.

The following limits apply to payment for covered services:

(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 to the same recipient on the same day but only for separate care.

(2) After the first 28 days of unlimited home health care, payment is limited to the number of home visits specified on the MA Program Fee Schedule. A new period of unlimited care begins following hospitalization, the onset of a new primary diagnosis or the exacerbation of an existing diagnosis which causes a change in the recipient's condition and requires a change in the plan of treatment, subject to § 1249.52(a)(4) (relating to payment conditions for various services).

(3) For prenatal and postpartum care, the following limits apply:

(i) Payment for prenatal care is limited to the number of visits specified on the MA Program Fee Schedule. Complications of pregnancy are not counted as prenatal care but are classified for invoicing purposes as acute illness.

(ii) Payment for a postpartum visit includes payment for care provided the newborn child.

(4) Payment for hypodermic or intramuscular therapy provided during a home visit is included in the visit fee. If this service is provided during a recipient's visit to the home health agency, the agency will be paid at the rate specified in the MA Program Fee Schedule.

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