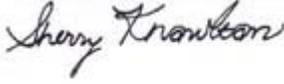


	<b>MEDICAL ASSISTANCE BULLETIN</b> <b>COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE</b>	
	<b>SUBJECT</b>  Basic Health Care For Adult General Assistance Recipients - <u>Felix et. al. v. Casey et. al.</u> Stipulation of Settlement	<b>BY</b>    Sherry Knowlton Deputy Secretary for Medical Assistance Programs
<b>NUMBER:</b>	99-93-05, 1101-93-03	
<b>ISSUE DATE:</b>	July 21, 1993	
<b>EFFECTIVE DATE:</b>	July 1, 1993	

**PURPOSE:**

The purpose of this bulletin is to:

1. Notify providers of increased coverage in pharmaceutical services under the General Assistance (GA) Basic Health Care Package, and dental services for all blue card and pink card adult recipients, effective July 1, 1993, as a result of the Felix v. Casey Stipulation of Settlement;
2. Inform providers that the terms of the Felix v. Casey Interim Agreement remain in effect through June 30, 1993;
3. Inform providers that effective July 1, 1993, services approved through the exception process are subject to the increased copayment rates; and
4. Inform providers that the limits and requirements on all other services implemented January 1, 1993, remain in effect with no changes.

**NOTE:** This bulletin references the following Medical Assistance bulletins, and obsoletes and replaces them effective July 1, 1993:

Basic Health Care for Adult General Assistance Recipients, MA Bulletin Number 99-92-07.

Interim agreement Felix et. al. v. Casey et. al., MA Bulletin Number 1101-93-02.

This bulletin also references, but does not obsolete HealthCare Benefit Package, MA Bulletin Number 99-93-02.

**SCOPE:**

This bulletin applies to all providers enrolled in the Medical Assistance Program.

**NOTE:** Not all changes affect all recipients. Please read this notice carefully.

**BACKGROUND:**

The Department amended 55 Pa. Code Chapter 1101 and implemented the GA Basic Health Care Package for GA recipients, age 21 to 65, whose medical assistance benefits are funded solely by state funds. The package included primary and preventive health care services and inpatient hospital care, placed additional limitations on some services, and increased the amounts of recipient copayments.

A class action suit, Felix v. Casey, was filed in Federal District Court in Philadelphia related to the GA Basic Health Care Package. The Department and plaintiffs signed an interim agreement effective January 7, 1993, which expanded the list of compensable drugs which do not require an exception for coverage, permitted recipients to use their three per month allotment of pharmacy vouchers anytime between January 1, 1993 and June 30, 1993, (total of 18 vouchers) and exempted from the increased copayment any service approved through the exception process.

The terms of the interim agreement remain in effect through June 30, 1993.

**DISCUSSION:**

**WHAT SERVICES WILL CHANGE EFFECTIVE JULY 1, 1993?**

Services for affected blue card GA recipients (HealthCare Package III) that will change effective July 1, 1993, are as follows:

- **Pharmaceuticals** – The Department will pay for all classes of legend drugs and insulin included on the Department's Drug Reference File, prescribed or ordered by a physician, not to exceed a maximum of six (6) prescriptions, including originals and refills, per calendar month.

All nonlegend or over-the-counter (OTC) products (except insulin) plus all pharmaceutical services and items listed in Pharmaceutical Services Regulations Section 1121.54 are noncompensable under the GA Basic Health Care Package.

Compensability of drugs can be verified through the Drug Verification System (DVS), 1-800-292-2820.

- **Dental** – All medically necessary dental services are reinstated but with new limits. Please refer to MA Bulletin Number 03-93-04, Dental Services for Adults, for details on compensable services and conditions for payment.

**WHAT SERVICES HAD NEW LIMITS EFFECTIVE JANUARY 1, 1993, WHICH REMAIN IN EFFECT JULY 1, 1993?**

Limits placed on services provided by the following enrolled providers to both blue card (HealthCare Benefits Package III) and green card (HealthCare Benefits Package V) GA recipients affected by the GA Basic Health Care Package which went into effect on January 1, 1993, will remain in effect after July 1, 1993:

- Practitioner's Office and Clinic Visits – Limited to a combined maximum of 18 visits per year.  
  
(Practitioners include: physicians, podiatrists, chiropractors, optometrists, and certified registered nurse practitioners.)  
  
(Clinics include: independent medical clinics, rural health clinics, general and rehabilitation hospital clinics, family planning clinics, and federally qualified health centers. Not included are visits to Emergency Rooms, Outpatient Drug and Alcohol Clinics, Outpatient Psychiatric Clinics, and Psychiatric Partial Hospitalization Facilities.)
- Home Health Agency Visits – Limited to a maximum of 30 visits per year.
- Freestanding Drug and Alcohol Rehabilitation Hospitals and Drug and Alcohol Detoxification/Rehabilitation Units of General Hospitals – Up to 30 days per year.
- Freestanding Medical Rehabilitation Hospitals and Medical Rehabilitation Units of General Hospitals – Up to 30 days per year.
- Emergency Room – Emergency services only.
- Ambulance – Emergency transportation only.

**NOTE:** For purposes of tallying annual limits, a year is defined as the State fiscal year, July 1 through June 30.

**WHAT SERVICES REMAINED THE SAME EFFECTIVE JANUARY 1, 1993 AND WILL CONTINUE UNCHANGED EFFECTIVE JULY 1, 1993?**

All GA recipients who are affected by the GA Basic Health Care Package, regardless of whether they are blue card (HealthCare Benefit Package III) or green card (HealthCare Benefit Package V) are eligible for the services provided by the following enrolled providers with no change to existing regulations and coverage limitations:

- Ambulatory Surgical Center
- Outpatient Drug and Alcohol Clinic

- Outpatient Psychiatric Clinic
- Inpatient Private and Public Psychiatric Hospital
- Psychiatric Partial Hospitalization
- Nursing Facility
- Hospice
- Laboratory and X-Ray
- Inpatient Hospital
- Short Procedure Unit
- Nurse Midwife
- Renal Dialysis Center
- Birth Center
- Intermediate Care Facility for the Mentally Retarded
- Funeral Director

An additional service included with no change in existing regulations and coverage limitations for blue card (HealthCare Benefit Package III) GA recipients only is as follows:

- Medical Supplies and Equipment

NOTE: GA recipients enrolled in an HMO or HealthPASS are entitled, at a minimum, to the range of services described above. HMO's or HealthPASS may choose to provide more services to GA recipients than those described in the GA Basic Health Care Package. Providers affiliated with an HMO or HealthPASS who provide services to medical assistance recipients should contact the plan directly with benefit and reimbursement questions.

**COPAYMENT:**

Affected blue card and green card GA recipients (HealthCare Benefit Packages III and V) are expected to pay the following copayment amounts for all services except emergencies:

- Prescriptions - \$2.00 per prescription and per refill for all drugs covered under this package.
- Inpatient hospital - \$6.00 per day of inpatient care, not to exceed \$42.00 per admission.
- Total component or technical component of diagnostic radiology, nuclear medicine, radiation therapy, medical diagnostic - \$2.00 per service.
- Outpatient psychotherapy - \$1.00 per unit of service.
- For all other outpatient services, the copayment amount is as follows:
  - If the medical assistance fee is \$2.00 - \$10.00, the copayment is \$1.00
  - If the medical assistance fee is \$10.01 - \$25.00, the copayment is \$2.00.
  - If the medical assistance fee is \$25.01 - \$50.00, the copayment is \$4.00.
  - If the medical assistance fee is \$50.01 or more, the copayment is \$6.00.

The cap on copayment is \$180 per six months.

Services excluded from the copayment requirement, listed in §1101.63(b)(2), continue to apply to GA recipients affected by the new copayment requirement with the exception of §1101.63(b)(2)(xv), specific drugs identified by the Department. These drugs will require a \$2.00 copayment per prescription and refill.

REMINDER: A provider may not deny services to any eligible medical assistance recipient because of the recipient's inability to pay the copayment. Whenever a recipient is liable for copayment but the provider is unable to collect it, the provider must enter Visit Code 11 in the visit code field of the invoice.

**WHICH GA RECIPIENTS ARE AFFECTED BY THE GA BASIC HEALTH CARE PACKAGE?**

GA recipients, age 21 to 65, whose medical assistance benefits are funded solely by state funds, with no federal financial participation, receive the Basic Health Care Package.

All recipients 21 years old or older with any combination of the following categories of assistance and program status codes are affected:

**CATEGORY**

**PROGRAM STATUS CODE(S)**

D, K, PD, PK, TD, TK, TR

00, 21, 22, 23

The provider can identify an affected GA recipient by looking at the category and program status code printed on the recipient's Medical Services Eligibility Card. The category field is identified by the heading "CAT"; the program status code is identified by the heading "PGM STATUS". Both fields are located in the upper right corner of the card.

<input type="checkbox"/> ACTED SERVICES WHEN INDICATED: <input type="checkbox"/> PHARMACY <input type="checkbox"/> PHYSICIANS <input type="checkbox"/> OTHER <input type="checkbox"/> CASE MGT THE SERVICES CHECKED ABOVE CAN BE FURNISHED ONLY BY THE PROVIDER BELOW.		VALID THROUGH 07/24/92	
		CASE NUMBER CD. RECORD NO. CAT CASE DIC 22 0000481 D * 6	
INSTRUCTIONS TO PROVIDER SERVICES WILL BE PROVIDED IN ACCORDANCE WITH THE DEPARTMENT OF PUBLIC WELFARE REGULATIONS AND HANDBOOK. THE PERSON SHOWN IN THE ADDRESS BLOCK MAY NOT ALWAYS BE ELIGIBLE. THIS PERSON IS ELIGIBLE ONLY IF SHOWN WITH A LINE NUMBER.	LINE NO. 01 02 **	NAME MARY JOHN *****	SOC-SEC-NO. S BIRTHDATE RESOURCES A 194-39-8677 F 05/19/48 B 161-31-7404 M 08/01/73 * * * * *
	SERIAL NO. 01000041		CASE NAME & ADDRESS MARY A DOE 114 SOUTH FRONT ST HARRISBURG PA 17104
DAUPHIN CAO 2432 N SEVENTH ST HARRISBURG PA 17110		CLIENT'S SIGNATURE 	

\* Example of Category on the Medical Services Eligibility Card.

\*\* Example of Program Status Code on the Medical Services Eligibility Card.

**WHICH GA RECIPIENTS ARE NOT AFFECTED BY THE GA BASIC HEALTH CARE PACKAGE?**

1. All GA recipients under age 21, regardless of their category and/or program status code or whether they are blue card or green card, will continue to receive all services covered under the Medical Assistance Program (HealthCare Benefit Package I). They are not affected by this package. The provider can determine if the GA recipient is under age 21 by reviewing the "BIRTHDATE" printed on the Medical Services Eligibility Card.

EXAMPLE: In the sample Medical Services Eligibility Card, the category is "D" and the program status code is "00". In line number 01, Mary A. Doe is over age 21. Therefore, Mary A. Doe's medical assistance benefits are affected by the change because of her category, program status code, and age (21 to 65). In line number 02, John B. Doe is under age 21. His medical assistance benefits are not affected by the change. Although the category is "D" and the program status code is "00", he continues to be eligible for all services covered under the Medical Assistance Program because of his age, which is under 21 years.

2. Blue card and green card GA recipients whose medical assistance benefits are eligible for federal financial participation will continue to receive the same services currently covered under the Medical Assistance Program (HealthCare Benefit Packages II and IV).

If a GA recipient has any combination of the categories and program status codes listed below; he/she is not affected by the GA Basic Health Care Package:

<b><u>CATEGORY</u></b>	<b><u>PROGRAM STATUS CODE(S)</u></b>
K, PD, PK, TD, TK, TR	01, 02, 05, 11, 15, 50, 51, 52

Persons assigned these categories and program status codes include pregnant women, migrants, refugees who have been in the United States eight months or less, persons who have been referred to the Disability Advocacy Program (DAP) or persons who have applied for Social Security or Supplemental Security Income (SSI) benefits.

If a GA recipient age 21 or older presents a valid medical services eligibility card with a category and program status code that indicate that the recipient is subject to the GA Basic Health Care Package, but the recipient claims or the recipient's circumstances indicate that the card is miscoded, the provider should refer the recipient back to the County Assistance Office caseworker. **Only the caseworker can authorize a correction to the card.** Until the category and/or program status code are changed, the recipient is subject to the GA Basic Health Care Package limits.

#### **INTERIM VOUCHER SYSTEM**

The provider will be able to determine if a recipient has reached his/her limit for practitioners' office/clinic visits or prescription drugs by means of a paper voucher system. The paper voucher system for prescription drugs will remain in effect until the Electronic Claims Management (ECM) System is in operation in all pharmacies statewide.

The Department will distribute the appropriate number of paper vouchers to the recipient. The recipient must present both the voucher and his/her current Medical Services Eligibility Card to the medical provider before obtaining services. The medical provider must check the identifying information on the voucher and the card to make certain they are both for the same person and are valid on the date of service. The voucher must then be signed and dated by the recipient or his/her authorized representative before service is provided.

If a recipient loses his/her vouchers, the provider should instruct him/her to contact the County Assistance Office to obtain replacement vouchers.

If a recipient says that he/she has used all of his/her vouchers, determine if the recipient is eligible for an exception to the limit, based on the exception criteria outlined in Medical Assistance Bulletin 1101-93-04. If the recipient appears to be eligible for an exception call 1-800-637-7840. If the recipient is not eligible for an exception, inform the recipient that the service will not be compensable under the Medical Assistance Program, and he/she is liable for payment.

**NOTE: For detailed information on the voucher system, please refer to Medical Assistance Bulletin 01-93-12, 04-93-04, 07-93-03, 10-93-04, 11-93-07, 15-93-02, 19-93-09, 26-93-04, 30-93-03, 49-93-04.**

#### **NEXT STEPS:**

Before providing a service to a GA recipient, be sure to:

1. Ask to see the recipient's Medical Services Eligibility Card. Check the "VALID THROUGH" date.
2. If the card is valid on the date of service, determine the age of the recipient needing service and if the service is compensable under the Medical Assistance Program.
  - a. If the recipient is under 21 years of age and the service is compensable, provide the service.
  - b. If the recipient is age 21 to 65, determine if the recipient is blue card or green card and if the service is compensable.
3. If the service is compensable, identify the recipient's category of assistance and program status code.
  - a. If the recipient is not affected by the GA Basic Health Care Package, provide the service.
  - b. If the recipient is subject to the Basic Health Care Package, and service is a compensable practitioner's office/clinic visit or a compensable prescription drug:

- Ask the recipient for his/her voucher for the service.
  - If the recipient states that he/she does not have a voucher because he/she has reached the limit, determine if the recipient is eligible for an exception to the limit. (Refer to [Medical Assistance Bulletin 1101-93-04](#) for information on the exception process.)
  - If the recipient appears to be eligible for an exception, call 1-800-637-7840.
  - If the recipient has reached the limit and is not eligible for an exception, inform the recipient that the service will not be compensable under the Medical Assistance Program.
4. If the service is not compensable for any reason, inform the recipient before the service is provided that it is not covered under the Medical Assistance Program and the recipient will be responsible for payment.

**COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:**

Call the appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at [www.dpw.state.pa.us/omap](http://www.dpw.state.pa.us/omap).