	MEDICAL ASSISTANCE BULLETIN **COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE**		
	NUMBER: 99-96-05	**ISSUE DATE**: June 14, 1996	**EFFECTIVE DATE**: June 17, 1996
SUBJECT: Implentation of Act No. 1996-35		**BY:** Darlene C. Collins **Darlene C. Collins, M.Ed., M.P.H.** **Deputy Secretary for Medical Assistance Programs**	

PURPOSE:

The purpose of this bulletin is to notify enrolled providers of the Department's implementation plan for changes to the Medical Assistance Program resulting from Act No. 1996-35.

SCOPE:

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

BACKGROUND:

Act No. 1996-35, amending the Public Welfare Code, was signed into law on May 16, 1996. Certain provisions of the law will be implemented on June 17, 1996. Changes that affect the Medical Assistance Program are as follows:

1. Establishes new and revised eligibility criteria for General Assistance (GA) (cash assistance) and General Assistance Related Medical Assistance, both Medically Needy Only (GA MNO) (medical assistance only) and Categorically Needy (GA NMP) (same medical assistance benefit package as a GA cash recipient).

2. Combines the retroactive/continuing period of eligibility for all medically needy only recipients to no more than a six consecutive calendar month period.

3. Requires all GA and GA related categories of medical assistance recipients to pay a $150 deductible per fiscal year for compensable ambulatory surgical center services and inpatient and outpatient hospital services, except for laboratory and X-ray services, effective October 1, 1996. (Providers will be notified of the implementation of this change in a Medical Assistance Bulletin to be issued at a later date.)

4. Requires that any managed care organization under contract with the Department of Public Welfare must contract on an equal basis with any pharmacy that is qualified to participate in the Medical Assistance Program if the pharmacy agrees to the payment rates and terms established by the managed care organization and adheres to its quality standards. (Managed care organizations have already been notified of the implementation of this change.)

DISCUSSION:

IMPLEMENTATION FOR NEW APPLICANTS

The changes in medical assistance eligibility will apply to all applicants who apply for medical assistance on or after June 17, 1996. Applications signed and dated prior to June 17, 1996 will be processed using the current regulations in effect prior to June 17, 1996.

Applications signed and dated on or after June 17, 1996 will be processed using the new regulations. If the applicant does not meet the new eligibility criteria, he/she will not be authorized medical assistance benefits.

EXAMPLE: A person is admitted to the hospital on June 15, 1996 and signs and dates an application for benefits on that date. The local county assistance office (CAO) will determine eligibility for GA related medical assistance using the current eligibility criteria.

If the person is admitted to the hospital on June 15, 1996, but does not sign and date an application until June 17, 1996, the CAO will process the application using the new eligibility criteria.

NOTE: Providers should continue to process applications according to the current procedures. Benefits will not be authorized until the CAO conducts a face-to-face interview with the applicant and verifies all information on the application.

IMPLEMENTATION FOR CURRENT RECIPIENTS

GA RELATED MEDICALLY NEEDY ONLY MEDICAL ASSISTANCE RECIPIENTS

The CAOs have received instructions to accomplish the implementation of the new eligibility criteria for current GA MNO recipients using individual case reviews over the next several months. Recipients will be systematically reviewed on a case-by-case basis to determine if the person meets the new GA MNO eligibility criteria. If the person meets the eligibility criteria, GA MNO benefits will continue under Health Care Benefits Package 5; if the person does not meet eligibility criteria, GA MNO benefits will be discontinued.

REMINDER: Since some recipients will lose eligibility on or after June 17, 1996, it is critical that providers check the Eligibility Verification System (EVS) each time a service is rendered. **DO NOT ASSUME THAT A PERSON REMAINS ELIGIBLE BECAUSE HE/SHE HAS AN ACCESS CARD.**

PAYMENT FOR SERVICES UNDER FEE-FOR-SERVICE AND LANCASTER COMMUNITY HEALTH PLAN (LCHP)

Inpatient Hospital Services

If a recipient loses eligibility for GA related medical assistance benefits while in the hospital, the Department will follow the same procedures that currently apply when any recipient becomes ineligible. If eligibility ends during and inpatient stay, the Department will reimburse the inpatient facility for the entire stay. Payment to practitioners is based on eligibility on the date of service.

Outpatient Services

Payment for outpatient services is based on eligibility on the date of service and in the case of LCHP an appropriate referral is required.

Prior Authorization/Approval of Services

Recipients who received any type of prior approval for a particular service must be eligible on the date the service is provided. Prior approval does not supersede eligibility.

DISENROLLMENT FROM MANAGED CARE WHEN ELIGIBLE

Recipients enrolled in managed care plans who lose eligibility during the calendar month will continue to receive services under the plan for the remainder of the calendar month.

The EVS response will refer the provider to the appropriate managed care plan for additional information. IT IS CRITICAL THAT PROVIDERS CHECK THE EVS SYSTEM EACH TIME MANAGED CARE SERVICES ARE PROVIDED. DO NOT ASSUME THAT A PERSON REMAINS ELIGIBLE FOR MANAGED CARE SERVICES BECAUSE HE/SHE WAS ELIGIBLE DURNIG THE PREVIOUS CALENDAR MONTH.

Providers affiliated with a managed care plan who provide services to medical assistance recipients should contact the plan directly with benefit and reimbursement questions.

SPECIAL REQUEST FOR PERSONS RECEIVING BEHAVIORAL HEALTH SERVICES

If a recipient who is currently receiving behavioral health services loses eligibility for medical assistance benefits as a result of Act 1996-35, he/she should be referred to the local county mental health agency or county drug and alcohol program for continuation of service(s).

REMINDER: It is critical that providers check the Eligibility Verification System (EVS) each time service is rendered

to be certain that a recipient is eligible on the date of service.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
The appropriate toll-free inquiry line for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.