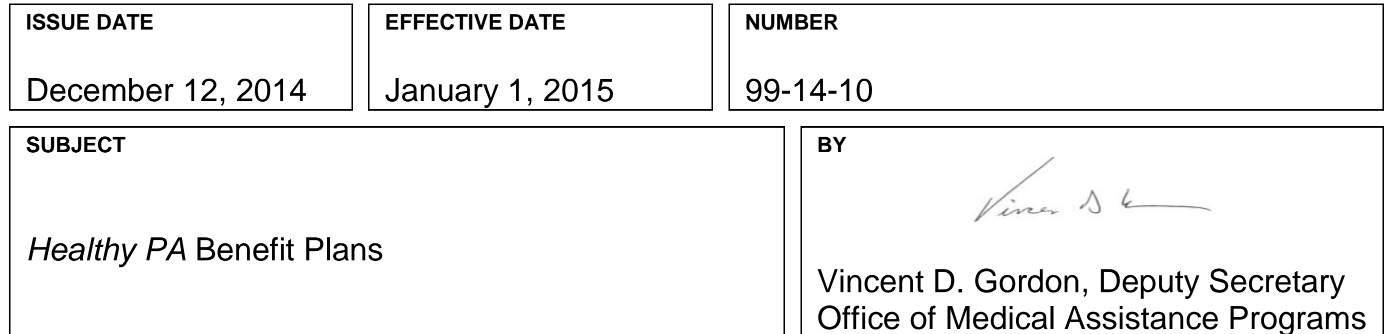
pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN



ISSUE DATE	EFFECTIVE DATE	NUMBER
December 12, 2014	January 1, 2015	99-14-10

SUBJECT	BY
Healthy PA Benefit Plans	Vincent D. Gordon, Deputy Secretary Office of Medical Assistance Programs

PURPOSE:

The purpose of this bulletin is to:

- advise providers of the new adult benefit plans and scope of benefits the Department of Human Services intends to implement on January 1, 2015, as part of *Healthy PA*;
- issue a Benefit Comparison chart; and
- inform providers of the criteria and procedures to request an exception to the limits under each benefit plan.

SCOPE:

This bulletin applies to all providers enrolled, or seeking to enroll, in the Medical Assistance (MA) Program to provide services in the fee-for-service, managed care, and Private Coverage Option (PCO) delivery systems.

BACKGROUND/DISCUSSION:

Healthy PA provides for access to quality, affordable healthcare for over 600,000 Pennsylvanians through the creation of a PCO that will promote healthy behaviors, improve health outcomes and increase personal responsibility. Individuals aged 19 through 64 years of age, with incomes up to 133% of the federal poverty level (FPL), may be determined newly eligible for coverage under *Healthy PA*. Under *Healthy PA*, these newly eligible adults are afforded access to benefits that match their health care needs.

As part of *Healthy PA*, the Department is also reforming the current Medicaid benefit structure by consolidating the existing 14 benefit packages into two adult benefit plans called *Healthy* and *Healthy Plus.* The *Healthy* plan, also known as the Low Risk plan, provides coverage for adults, ages 21 through 64, who do not have complex

medical or behavioral health care needs. *Healthy Plus*, known as the High Risk plan, provides coverage for adults who are determined to be “medically frail”, including individuals who have complex medical or behavioral health care needs, pregnant women, individuals on Social Security Income (SSI) and adults aged 65 and older. Under *Healthy PA*, there are no changes to benefits currently provided for beneficiaries under 21 years of age, and they will continue to receive all medically necessary services.

The benefit plans are consistent with national standards that include essential health benefits; mental health parity; and encouragement of preventive services. Beneficiaries will be assigned to either the *Healthy* or *Healthy Plus* plan based on existing claims data or health screening. The scope of benefits and applicable limits available under the *Healthy*, *Healthy Plus*, and PCO benefit plans is outlined in the attached Benefit Comparison chart (Attachment A).

Benefit Limit Exceptions

The Department will count the medical services received and submitted for payment in the PROMISe™ claims processing system towards the limits identified on the Benefit Plan Comparison chart.

If a beneficiary needs additional services beyond the identified benefit limit, the provider or beneficiary may request an exception to the benefit limit through the Department. In many cases, exceptions will be approved automatically in the PROMISe™ claims processing system. For those claims that are not automatically approved, the Department will manually review the Benefit Limit Exception (BLE) request as described in the Procedure section of this bulletin. BLE requests will not be granted under the PCO.

PROCEDURE:

Effective January 1, 2015, the Department will provide Medicaid services through the *Healthy, Healthy Plus,* and PCO benefit plans. Providers are advised to access the Eligibility Verification System (EVS) before rendering services to determine beneficiary eligibility and copayment responsibility.

Benefit Limit Exception Process

The Department will grant exceptions to the medical services benefit limits when one of the following criteria is met:

1. The Department determines the beneficiary has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the beneficiary.
2. The Department determines the beneficiary has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the beneficiary.
3. The Department determines that granting a specific exception is a cost effective alternative for the MA Program.
4. The Department determines that granting an exception is necessary in order to comply with Federal law.

Benefit limits do not apply to beneficiaries under 21 years of age or women who are pregnant, including throughout the postpartum period. The postpartum period begins on the last day of the pregnancy and ends on the last day of the month in which the 60-day period following termination of the pregnancy ends.

The Department will automatically approve an exception to the limit for certain conditions, diagnoses, and services that the Department has determined would meet certain benefit limit exception criteria. In these instances, the exception will be approved automatically if the PROMISe™ claims processing system determines that the benefit and the beneficiary's claims history show the indicated diagnosis or condition on one of the automatic benefit limit exception lists attached to this bulletin.

If the exception to the limit is not automatically approved, the provider may request a Benefit Limit Exception by:

- Calling the Provider Prior Authorization/Benefit Limit Exception line at 1-800-537-8862, or
- The beneficiary may call the Recipient Hotline at 1-800-537-8862, or
- Providers may mail or fax a written request to:

  Office of Medical Assistance Programs
  Fee for Service Programs Benefit Exception Review
  PO Box 8047
  Harrisburg, PA 17105-2675
  Fax: 717-265-8281 (APR-DRG , PSR)
  717-265-8286 (DME)

When requesting the Benefit Limit Exception, please provide the following information:

- The beneficiary's name, address, and telephone number
- The beneficiary's MA ID number

- The service for which the exception is being requested
- The reason the exception is needed
- Provider's name and telephone number

The Department will inform the provider in writing within 21 days of receiving the BLE request if the request is approved or denied.

Please note: All prior authorization and medical necessity review requirements continue to apply. Documentation of medical necessity for the service will be reviewed concurrent to consideration of the benefit limit exception.

Attached to this bulletin are the main conditions, services and items for which exceptions that will be granted automatically for inpatient hospital services APR-DRG (Attachment B), radiology and imaging (Attachment C), laboratory services (Attachment D), durable medical equipment (Attachment E) and medical supplies (Attachment F).

MA Managed Care Organizations (MCOs) or PCO organizations that contract with the Department have the option to impose the same or lesser limits. MA MCOs and PCO organizations that choose to impose the same or lesser limits will issue individual notices to their members and notify network providers at least 30 days in advance of the changes. Providers participating in an MA MCO or PCO organization should contact their respective plans for any coverage and payment related questions

For more information related to *Healthy PA*, providers may access the website at: http://www.healthypa.com. Providers are advised to frequently check the website for updates and announcements.

ATTACHMENTS:

Attachment A – Benefit Plan Comparison chart
Attachment B – Automatic Benefit Limit Exceptions for APR DRG
Attachment C – Automatic Benefit Limit Exceptions for Radiology and Imaging
Attachment D – Automatic Benefit Limit Exceptions for Laboratory Services
Attachment E – Automatic Benefit Limit Exceptions for Durable Medical Equipment
Attachment F – Automatic Benefit Limit Exceptions for Medical Supplies