

**Trans. by E.L. 260
Rev. 07/17/2026**

130 CMR 508.000: MASSHEALTH: MANAGED CARE REQUIREMENTS

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508.001: MassHealth Member Participation in Managed Care

(A) Mandatory Enrollment with a MassHealth Managed Care Provider. MassHealth members who are younger than 65 years old must enroll in a MassHealth managed care provider available for their coverage type. Members described in 130 CMR 508.001(B) or who are excluded from participation in a MassHealth managed care provider under 130 CMR 508.002(A) are not required to enroll with a MassHealth managed care provider.

(B) Voluntary Enrollment in a MassHealth Managed Care Provider. The following MassHealth members who are younger than 65 years old may, but are not required to, enroll with a MassHealth managed care provider available for their coverage type:

- (1) MassHealth members who are receiving services from DCF or DYS;
- (2) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program*. Such members may choose to receive all services on a fee-for-service basis;
- (3) MassHealth members who are enrolled in a home- and community-based services waiver. Such members may choose to receive all services on a fee-for-service basis; or
- (4) MassHealth members who are receiving Title IV-E adoption assistance as described at 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance*. Such members may choose to receive all services on a fee-for-service basis.

(C) Senior Care Options (SCO) Plan. MassHealth members who are 65 years or older may enroll in a SCO Plan under 130 CMR 508.008(A).

(D) One Care Plan. MassHealth members who are 21 through 64 years old at time of enrollment may enroll in a One Care Plan under 130 CMR 508.007(A).

(E) MassHealth Behavioral Health Contractor.

- (1) MassHealth members enrolled with a Primary Care ACO or in the PCC Plan must enroll with the MassHealth behavioral health contractor.
- (2) MassHealth Standard and CommonHealth members who are younger than 21 years old and who are excluded from participation with a MassHealth managed care provider under 130 CMR 508.002(A)(1) or (2) must enroll with the MassHealth behavioral health contractor.
- (3) MassHealth members who are receiving services from DCF or DYS and who do not choose to enroll with a MassHealth managed care provider must enroll with the MassHealth behavioral health contractor.
- (4) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program* and who do not choose to enroll with or a MassHealth managed care provider are enrolled with the MassHealth behavioral health contractor. Such members may choose to receive all services on a fee-for-service basis.
- (5) MassHealth members who are receiving Title IV-E adoption assistance as described at 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance* and who do not choose to enroll with a MassHealth managed care provider are enrolled with the MassHealth behavioral health contractor. Such members may choose to receive all services on a fee-for-service basis.

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508.002: MassHealth Members Excluded from Participation in Managed Care

(A) MassHealth Managed Care Provider. The following MassHealth members are excluded from participation with a MassHealth managed care provider.

- (1) a member who has Medicare;
- (2) a member who has access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*;
- (3) a member who is 65 years of age or older;
- (4) a member who is not eligible for benefits under Title XIX or XXI of the Social Security Act;
- (5) a member who is only eligible for benefits under Title XIX or XXI of the Social Security Act through Title XXI during the period from conception to the end of pregnancy;
- (6) a member in a nursing facility, chronic disease or rehabilitation hospital, intermediate care facility for individuals with intellectual disabilities (ICF/ID), or a state psychiatric hospital for other than a short-term rehabilitative stay;
- (7) a member who is eligible for emergency Medicaid benefits pursuant to Section 1903(v) of the Social Security Act;
- (8) a member who is eligible for Children's Medical Security Plan (CMSP);
- (9) a member who is eligible through the Emergency Aid to the Elderly, Disabled and Children (EAEDC) Program;
- (10) a member who is receiving hospice care through MassHealth on a fee-for-service basis, or who is terminally ill as documented by a medical prognosis of a life expectancy of six months or less; and
- (11) a member who has presumptive eligibility.

(B) SCO Plan. The following MassHealth members, 65 years of age and older, who are enrolled in Medicare Parts A and B and are eligible for Medicare Part D are excluded from participating in a SCO Plan.

- (1) a member who has access to other health insurance, with the exception of Medicare, that meets the basic-benefit level as defined in 130 CMR 501.001: Basic-benefit Level (BBL);
- (2) a member who does not live in the designated service area of a SCO Plan;
- (3) a member in an ICF/ID;
- (4) a member who is not eligible for MassHealth Standard;
- (5) a member who has presumptive eligibility;
- (6) a member who is enrolled in a home- and community-based services waiver, except the Home- and Community-Based Services Waiver–Frail Elder as described at 130 CMR 519.007(B): *Home- and Community-Based Services Waiver–Frail Elder*;
- (7) a member who is eligible through the Emergency Aid to the Elderly, Disabled and Children (EAEDC) Program;
- (8) a member who is a refugee described at 130 CMR 522.002: *Refugee Resettlement Program*;
- (9) a member who is not eligible for benefits under Title XIX or XXI of the Social Security Act;
- (10) a member who is only eligible for benefits under Title XIX or XXI of the Social Security Act through Title XXI during the period from conception to the end of pregnancy;

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- (11) a member who is eligible for emergency Medicaid benefits pursuant to Section 1903(v) of the Social Security Act; and
- (12) a member who is subject to a six-month deductible period under 130 CMR 520.028: *Eligibility for a Deductible*.

(C) One Care Plan. The following MassHealth members who are 21 through 64 years old at time of enrollment and who are enrolled in Medicare Parts A and B and are eligible for Medicare Part D are excluded from participation in a One Care Plan.

- (1) a member who has other health insurance, with the exception of Medicare, that meets the basic-benefit level as defined in 130 CMR 501.001: Basic-benefit Level (BBL);
- (2) a member who does not live in the designated service area of a One Care Plan;
- (3) a member in an ICF/ID;
- (4) a member who is not eligible for MassHealth Standard or CommonHealth;
- (5) a member who has presumptive eligibility;
- (6) a member who is enrolled in a home- and community-based services waiver;
- (7) a member who is eligible through the Emergency Aid to the Elderly, Disabled and Children (EAEDC) Program;
- (8) a member who is a refugee described at 130 CMR 522.002: *Refugee Resettlement Program*;
- (9) a member who is not eligible for benefits under Title XIX or XXI of the Social Security Act;
- (10) a member who is only eligible for benefits under Title XIX or XXI of the Social Security Act through Title XXI during the period from conception to the end of pregnancy;
- (11) a member who is eligible for emergency Medicaid benefits pursuant to Section 1903(v) of the Social Security Act; and
- (12) a member who is subject to a six-month deductible period under 130 CMR 520.028: *Eligibility for a Deductible*.

508.003 Enrollment with a MassHealth Managed Care Provider

(A) Member Selection.

- (1) In accordance with 130 CMR 508.004 through 508.006, members required or permitted to select a MassHealth managed care provider may select any MassHealth managed care provider from the MassHealth agency's list of MassHealth managed care providers for the member's coverage type in the member's service area, if the provider is able to accept new members.
- (2) A member who seeks to enroll with a managed care provider outside of the member's service area must submit a request in writing to the MassHealth agency on forms provided by the MassHealth agency. The MassHealth agency may grant such a request if they determine that:
 - (a) The out-of-area MassHealth managed care provider is in a service area contiguous to the member's service area; or
 - (b) The MassHealth agency determines either of the following:
 - 1. the member seeks a specific provider who is in the network of the out-of-area MassHealth managed care provider, such requested provider is not in the network of a MassHealth managed care provider in the member's service area, and the travel

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time or distance to such requested provider is equal to or less than the travel time to, as determined by the MassHealth agency, a comparable provider in the network of a MassHealth managed care provider in the member's service area, or

2. the medical benefit of receiving care from a MassHealth managed care provider in the member's service area is substantially outweighed, as determined by the MassHealth agency, by the medical benefit of receiving care from the out-of-area MassHealth managed care provider requested by the member.

(B) Member Assignment to a MassHealth Managed Care Provider. If a member does not choose a MassHealth managed care provider within the time specified by the MassHealth agency in a notice to the member or in other circumstances determined appropriate by the MassHealth agency and consistent with applicable laws, the MassHealth agency assigns the member to an available MassHealth managed care provider.

(1) The MassHealth agency assigns a member to a MassHealth managed care provider only if the MassHealth managed care provider is:

- (a) available for the member's coverage type;
- (b) in the member's service area as described in 130 CMR 508.004(A)(1), 130 CMR 508.005(A)(1), 508.006(A)(1)(a), 508.006(B)(1)(a), as applicable;
- (c) physically accessible to the member, if the member is disabled;
- (d) suitable for the member's age and sex (for example, the member is the appropriate age for a pediatrician); and
- (e) located in an area to which the member has available and affordable transportation.

(2) If the MassHealth agency determines that no MassHealth managed care provider meeting the criteria of 130 CMR 508.003(B)(1) is available in the member's service area:

- (a) The member may
 - 1. choose not to enroll with a MassHealth managed care provider if such circumstances prevail; or
 - 2. select an available MassHealth managed care provider outside of the member's service area.
- (b) Any MassHealth Standard or CommonHealth member younger than 21 years old who is not enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.003(B)(2)(a)1. must obtain any behavioral health services through the MassHealth behavioral health contractor. All other services for which the member is eligible may be obtained through any qualified participating MassHealth provider.
- (c) If, after a determination by the MassHealth agency under 130 CMR 508.003(B)(2), the MassHealth agency determines that a MassHealth managed care provider meeting the criteria of 130 CMR 508.003(B)(1) has become available, the member must enroll with such a provider, unless the member is otherwise enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.003(B)(2)(a)2.

(3) Notification. The MassHealth agency will notify a member in writing of the name and applicable contact information of the member's MCO, Accountable Care Partnership Plan, Primary Care ACO, or PCC, and the effective date of the member's enrollment with the MassHealth managed care provider.

(C) Member Choice to Transfer or Disenroll from a MassHealth Managed Care Provider. Members enrolled with a MassHealth managed care provider may transfer to another available

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MassHealth managed care provider by providing the MassHealth agency with an oral or written request as provided in 130 CMR 508.003(C).

(1) Members enrolled with an MCO, Accountable Care Partnership Plan, or Primary Care ACO may transfer to another available MassHealth managed care provider for any reason during a plan selection period.

(a) For members newly enrolled with an MCO, Accountable Care Partnership Plan, or Primary Care ACO, except for members reenrolled in accordance with 130 CMR 508.003(E), the plan selection period occurs during the first 90 days of the member's enrollment, or notification of the member's enrollment, whichever is later, with the MCO, Accountable Care Partnership Plan, or Primary Care ACO.

(b) For all other members, the plan selection period will be a 90-day period that occurs annually.

(c) The MassHealth agency may designate additional plan selection periods at its discretion.

(2) Except as set forth in 130 CMR 508.003(C)(3), a member enrolled with an MCO, Accountable Care Partnership Plan, or Primary Care ACO must remain enrolled with the MCO, Accountable Care Partnership Plan, or Primary Care ACO for the fixed enrollment period. For all members, the fixed enrollment period is the period of time when a member is not in a plan selection period. The MassHealth agency will notify members in writing of their disenrollment rights at least annually.

(a) Members enrolled in an MCO, Accountable Care Partnership Plan, or Primary Care ACO pursuant to 130 CMR 508.001(B)(1) or who is below one year in age do not have a fixed enrollment period.

(b) Members voluntarily enrolled in an MCO, Accountable Care Partnership Plan, or Primary Care ACO pursuant to 130 CMR 508.001(B)(2) through (4) may disenroll from their MCO, Accountable Care Partnership Plan, or Primary Care ACO at any time. Such members may be enrolled with the behavioral health contractor pursuant to 130 CMR 508.001(E). Members voluntarily enrolled in an MCO, Accountable Care Partnership Plan, or Primary Care ACO pursuant to 130 CMR 508.001(B)(2) through (4) may transfer to another MassHealth managed care provider only in accordance with this 130 CMR 508.003(C).

(3) During fixed enrollment, a member may only request a transfer out of the member's current MCO, Accountable Care Partnership Plan, or Primary Care ACO for the reasons listed in this 130 CMR 508.003(C)(3).

(a) The following reasons defined as cause for disenrollment in 42 CFR 438.56(d)(2):

1. the member moves such that the member's MCO, Accountable Care Partnership Plan, or Primary Care ACO is not available in the member's new service area;
2. the MCO, Accountable Care Partnership Plan, or Primary Care ACO does not, because of moral or religious objections, cover the service the member seeks;
3. the member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or
4. other reasons, including but not limited to, poor quality of care, lack of access to services covered, or lack of access to providers experienced in dealing with the

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member's health-care needs.

- (b) the MCO or Accountable Care Partnership Plan is no longer contracted with the MassHealth agency to cover the member's service area, or a PCP that participates in the member's Primary Care ACO is not available in the member's service area;
 - (c) the member adequately demonstrates to the MassHealth agency that the MCO, Accountable Care Partnership Plan, or Primary Care ACO has not provided access to providers that meet the member's health care needs over time, even after member's request for assistance;
 - (d) the member is homeless, the MassHealth agency's records indicate the member is homeless, and the MCO, Accountable Care Partnership Plan, or Primary Care ACO cannot accommodate the geographic needs of the member;
 - (e) the member adequately demonstrates to the MassHealth agency that the MCO, Accountable Care Partnership Plan, or Primary Care ACO substantially violated a material provision of its contract with MassHealth agency;
 - (f) the MassHealth agency imposes a sanction on the MCO, Accountable Care Partnership Plan, or Primary Care ACO that specifically allows for members to disenroll from the MCO, Accountable Care Partnership Plan, or Primary Care ACO without cause;
 - (g) the member adequately demonstrates to the MassHealth agency that the MCO, Accountable Care Partnership Plan, or Primary Care ACO is not meeting the member's language, communication, or other accessibility needs or preferences;
 - (h) the member adequately demonstrates to the MassHealth agency that the member's key network providers, including PCPs, specialists, or behavioral health providers, leave the MCO, Accountable Care Partnership Plan, or Primary Care ACO network; or
 - (i) the member's service area is Oak Bluffs or Nantucket.
- (4) Members enrolled in the PCC Plan may transfer from the PCC Plan to another available MassHealth managed care provider at any time.
- (5) The MassHealth agency will determine if the requirements needed for a member transfer pursuant to 130 CMR 508.003(C)(1) through (4) have been met within 30 days of MassHealth's receipt of the request. The MassHealth agency's determination is a ground for appeal in accordance with 130 CMR 610.032(A).
- (a) If the MassHealth agency fails to make a determination within 30 days of MassHealth's receipt of the request, the request will be considered approved.
 - (b) The effective date for a member transfer will be within 30 days of MassHealth's receipt of the request.

(D) Other Disenrollment of Member from a MassHealth Managed Care Provider.

- (1) The MassHealth agency may disenroll a member from an MCO, Accountable Care Partnership Plan, or Primary Care ACO at the MCO's, Accountable Care Partnership Plan's, or Primary Care ACO's request, if the MCO, Accountable Care Partnership Plan, or Primary Care ACO demonstrates to the MassHealth agency's satisfaction that the MCO, Accountable Care Partnership Plan, or Primary Care ACO has made reasonable efforts to provide medically necessary services to the member through available primary care providers or other relevant network providers and, despite such efforts, the continued enrollment of the member with the MCO, Accountable Care Partnership Plan, or Primary Care ACO seriously impairs the MCO's, Accountable Care Partnership Plan's, or Primary Care ACO's ability to furnish services to either this particular member or other members.

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- (2) The MassHealth agency may disenroll a member from a PCC's panel or a Primary Care ACO's Participating PCP's panel, at the PCC's or PCP's request, if the PCC or PCP demonstrates to the MassHealth agency's satisfaction that
- (a) there is a pattern of noncompliant or disruptive behavior by the member that is not the result of the member's special needs;
 - (b) the continued enrollment of the member with the provider seriously impairs the provider's ability to furnish services to either this particular member or other members; or
 - (c) the PCC or PCP is unable to meet the medical needs of the member.
- (3) If the MassHealth agency approves a request for disenrollment under this 130 CMR 508.003(D)(1), (2)(a), or (2)(b), it will state the good cause basis for disenrollment in a notice to the member in accordance with 130 CMR 610.032(A)(10).

(E) Reenrollment. Any member enrolled with a MassHealth managed care provider who loses and then regains managed care eligibility may be automatically reenrolled with the MassHealth managed care provider with which the member was most recently enrolled, if such MassHealth managed care provider is available for the member's coverage type and service area.

- (1) A member enrolled with an MCO, Accountable Care Partnership Plan, or Primary Care ACO who loses managed care eligibility during a plan selection period will receive a new plan selection period upon regaining eligibility.
- (2) A member enrolled with an MCO, Accountable Care Partnership Plan, or Primary Care ACO who loses managed care eligibility during the fixed enrollment period will not receive a new plan selection period upon regaining managed care eligibility; provided, however, that if a member's loss of managed care eligibility causes the member to miss part or all of the member's annual plan selection period, the member will receive a new plan selection period upon regaining managed care eligibility.

508.004: Managed Care Organizations (MCOs)

(A) Enrollment in an MCO.

- (1) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member's obligation to select a MassHealth managed care provider within the time period specified by the MassHealth agency. The MassHealth agency makes available to the member a list of the MCOs in the member's service area. The list of MCOs that the MassHealth agency will make available to members will include those MCOs that contract with the MassHealth agency to serve the coverage type for which the member is eligible and provide services within the member's service area. The member's service area is determined by the MassHealth agency based on zip codes or geographic area. Service area listings may be obtained from the MassHealth agency.
- (2) MassHealth members are assigned to MCOs, may transfer from MCOs, may be disenrolled from MCOs, and may be re-enrolled in MCOs as described in 130 CMR 508.003(B) through 130 CMR 508.003(E).

(B) Obtaining Services when Enrolled in an MCO.

- (1) Primary Care Services. When the member selects or is assigned to an MCO, that MCO will deliver the member's primary care, determine if the member needs medical or other

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specialty care from other providers, and determine referral requirements for such necessary medical services.

(2) Other Medical Services. All medical services to members enrolled in an MCO (except those services not covered under the MassHealth contract with the MCO, family planning services, and emergency services) are subject to the authorization and referral requirements of the MCO. MassHealth members enrolled in an MCO may receive family planning services from any MassHealth family planning provider and do not need an authorization or referral in order to receive such services. Members enrolled with an MCO should contact their MCO for information about covered services, authorization requirements, and referral requirements.

(3) Behavioral Health Services. Members who enroll in an MCO receive behavioral health services through that MCO. All behavioral health services to members enrolled in an MCO, except those services not covered under the MassHealth contract with the MCO, are subject to the authorization and referral requirements of the MCO. Members enrolled with an MCO should contact their MCO for information about covered services, authorization requirements, and referral requirements.

(4) Native Americans and Alaska Natives. Individuals who are Native Americans (within the meaning of “Indians” as defined at 42 U.S.C. 1396u-2) or Alaska Natives who participate in managed care under MassHealth may choose to receive covered services from an Indian health-care provider. Such Indian health care providers may participate in MassHealth subject to applicable provisions of 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) Copayments. Members who are enrolled in MCOs must make copayments in accordance with the MCO’s MassHealth copayment policy. Those MCO copayment policies must

(1) be approved by MassHealth; and

(2) be consistent with applicable copayment requirements set forth in 130 CMR 450.000: *Administrative and Billing Regulations*, 130 CMR 506.000: *MassHealth: Financial Requirements*, and 130 CMR 520.000: *MassHealth: Financial Eligibility*.

508.005: MassHealth Primary Care Clinician Plan (PCC Plan)

(A) Enrollment in the PCC Plan.

(1) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member’s obligation to select a MassHealth managed care provider within the time period specified by the MassHealth agency. To enroll in the PCC Plan, the member must select the PCC Plan and an available primary care clinician (PCC). The MassHealth agency makes available to the member a list of the PCCs in the member’s service area. The member’s service area is determined by the MassHealth agency based on zip codes or geographic area. Service area listings may be obtained from the MassHealth agency. The list of PCCs that the MassHealth agency will make available to members may include those approved as a PCC by MassHealth in accordance with 130 CMR 450.118: *Primary Care Clinician (PCC) Plan* and who practices within the member’s service area.

(2) MassHealth members are assigned to the PCC Plan, may transfer from the PCC Plan, may be disenrolled from a PCC’s panel, and may be re-enrolled in the PCC Plan as described in 130 CMR 508.003(B) through 130 CMR 508.003(E).

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(B) Obtaining Services when Enrolled with the PCC Plan.

(1) Primary Care. When the member selects or is assigned to the PCC Plan, the member's selected or assigned PCC will deliver the member's primary care, determine if the member needs medical or other specialty care from other providers, and make referrals for such necessary medical services.

(2) Other Medical Services. All medical services, except those services listed in 130 CMR 450.118(J): *Referral for Services*, require a referral or authorization from the member's PCC. MassHealth members enrolled in the PCC Plan may receive those services listed in 130 CMR 450.118(J), for which they are otherwise eligible, without a referral from their PCC.

(3) Behavioral Health Services. All members enrolled with the PCC Plan receive behavioral health (mental health and substance use disorder) services, except those services not covered under the MassHealth contract with the behavioral health contractor, through the MassHealth behavioral health contractor. Such behavioral health services, except for emergency services, may be obtained only from a provider that has entered into an agreement with the MassHealth behavioral health contractor. The MassHealth behavioral health contractor is responsible for authorizing or denying behavioral health services based on the member's medical need for those services.

(4) Emergency Services. Members enrolled with the PCC Plan may obtain emergency services, including emergency behavioral health services, from any qualified participating MassHealth provider as well as any provider that has entered into an agreement with the MassHealth behavioral health contractor.

(5) Native Americans and Alaska Natives. Individuals who are Native Americans (within the meaning of "Indians" as defined at 42 U.S.C. 1396u-2) or Alaska Natives may choose to receive covered services from an Indian health care provider. Such Indian health-care providers may participate in MassHealth subject to applicable provisions of 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) Copayments. Members who are enrolled in the PCC Plan must make copayments in accordance with MassHealth copayment requirements set forth in 130 CMR 450.000, 130 CMR 506.000, and 130 CMR 520.000.

508.006: Accountable Care Organizations (ACOs)

(A) Accountable Care Partnership Plans.

(1) Enrollment in an Accountable Care Partnership Plan.

(a) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member's obligation to select a MassHealth managed care provider within the time period specified by the MassHealth agency. The MassHealth agency makes available to the member a list of Accountable Care Partnership Plans in the member's service area. The list of Accountable Care Partnership Plans that the MassHealth agency will make available to members will include those Accountable Care Partnership Plans that contract with the MassHealth agency to serve the coverage type for which the member is eligible and provide services within the member's service area. The member's service area is determined by the MassHealth agency based on zip codes or geographic area. Service area listings may be obtained from the MassHealth agency.

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- (b) MassHealth members are assigned to Accountable Care Partnership Plans, may transfer from Accountable Care Partnership Plans, may be disenrolled from Accountable Care Partnership Plans, and may be re-enrolled in Accountable Care Partnership Plans as described in 130 CMR 508.003(B) through 130 CMR 508.003(E).
- (2) Obtaining Services when Enrolled in an Accountable Care Partnership Plan.
- (a) Primary Care Services. When the member selects or is assigned to an Accountable Care Partnership Plan, that Accountable Care Partnership Plan will deliver the member's primary care, determine if the member needs medical or other specialty care from other providers, and determine referral requirements for such necessary medical services.
- (b) Other Medical Services. All medical services to members enrolled in an Accountable Care Partnership Plan (except those services not covered under the MassHealth contract with the Accountable Care Partnership Plan, family planning services, and emergency services) are subject to the authorization and referral requirements of the Accountable Care Partnership Plan. MassHealth members enrolled in an Accountable Care Partnership Plan may receive family planning services from any MassHealth family planning provider and do not need an authorization or referral in order to receive such services. Members enrolled with an Accountable Care Partnership Plan should contact their Accountable Care Partnership Plan for information about covered services, authorization requirements, and referral requirements.
- (c) Behavioral Health Services. Members who enroll in an Accountable Care Partnership Plan receive behavioral health services through that Accountable Care Partnership Plan. All behavioral health services to members enrolled in an Accountable Care Partnership Plan, except those services not covered under the MassHealth contract with the Accountable Care Partnership Plan, are subject to the authorization requirements and referral requirements of the Accountable Care Partnership Plan. Members enrolled with an Accountable Care Partnership Plan should contact their Accountable Care Partnership Plan for information about covered services, authorization requirements, and referral requirements.
- (d) Native Americans and Alaska Natives. Individuals who are Native Americans (within the meaning of "Indians" as defined at 42 U.S.C. 1396u-2) or Alaska Natives who participate in managed care under MassHealth may choose to receive covered services from an Indian health-care provider. Such Indian health care providers may participate in MassHealth subject to applicable provisions of 130 CMR 450.000: *Administrative and Billing Regulations*.
- (3) Copayments. Members who are enrolled in an Accountable Care Partnership Plan must make copayments in accordance with the Accountable Care Partnership Plan's MassHealth copayment policy. Those Accountable Care Partnership Plan copayment policies must
- (a) be approved by MassHealth; and
- (b) be consistent with applicable copayment requirements set forth in 130 CMR 450.000, 130 CMR 506.000, and 130 CMR 520.000.
- (B) Primary Care ACOs.
- (1) Enrollment in a Primary Care ACO.
- (a) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member's obligation to select a MassHealth managed care provider within the period specified by the MassHealth

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agency. To enroll in a Primary Care ACO, the member must select a Primary Care ACO and an available PCP that participates with the Primary Care ACO the member has selected. The MassHealth agency makes available to the member a list of PCPs that are participating with each Primary Care ACO. The list of PCPs that the MassHealth agency will make available to members may include those approved as a PCP in accordance with 130 CMR 450.119: *Primary Care ACOs* and who practices within the member's service area.

(b) MassHealth members are assigned to Primary Care ACOs, may transfer from Primary Care ACOs, may be disenrolled from Primary Care ACOs, and may be re-enrolled in Primary Care ACOs as described in 130 CMR 508.003(B) through 130 CMR 508.003(E).

(2) Obtaining Services when Enrolled in a Primary Care ACO.

(a) Primary Care. When the member selects or is assigned to a Primary Care ACO, the member's selected or assigned PCP will deliver the member's primary care, determine if the member needs medical or other specialty care from other providers, and make referrals for such necessary medical services.

(b) Other Medical Services (excluding Behavioral Health). All medical services, except those services listed in 130 CMR 450.119: *Primary Care ACOs* and those provided by providers in a Primary Care ACO's referral circle, require a referral or authorization from the member's primary care provider. MassHealth members enrolled in a Primary Care ACO may receive those services listed in 130 CMR 450.119, for which they are otherwise eligible, without a referral from their PCP.

(c) Behavioral Health Services. All members enrolled with a Primary Care ACO receive behavioral health (mental health and substance use disorder) services, except those services not covered under the MassHealth contract with the behavioral health contractor, through the MassHealth behavioral health contractor as follows:

1. Nonemergency Behavioral Health Services. Behavioral health services, except for emergency services, may be obtained only from a provider that has entered into an agreement with the MassHealth behavioral health contractor. The MassHealth behavioral health contractor is responsible for authorizing or denying behavioral health services based on the member's medical need for those services.

2. Emergency Behavioral Health Services. Members may obtain emergency behavioral health services from any qualified participating MassHealth provider as well as any provider that has entered into an agreement with the MassHealth behavioral health contractor.

(d) Native Americans and Alaska Natives. Individuals who are Native Americans (within the meaning of "Indians" as defined at 42 U.S.C. 1396u-2) or Alaska Natives may choose to receive covered services from an Indian health care provider. Such Indian health-care providers may participate in MassHealth subject to applicable provisions of 130 CMR 450.000: *Administrative and Billing Regulations*.

(3) Copayments. Members enrolled in Primary Care ACOs must make copayments in accordance with MassHealth copayment requirements set forth in 130 CMR 450.000, 130 CMR 506.000, and 130 CMR 520.000.

508.007: One Care Plans

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(A) Enrollment Requirements. To voluntarily enroll in a One Care Plan, a MassHealth Standard or MassHealth CommonHealth member must meet all of the following criteria.

- (1) be 21 through 64 years old at the time of enrollment. If a member is enrolled in a One Care Plan and turns 65 years old and is eligible for MassHealth Standard or MassHealth CommonHealth, they may elect to remain in the One Care Plan beyond 65 years old.;
- (2) be eligible for MassHealth Standard as described in 130 CMR 519.001(B)(1) or 130 CMR 505.001(A)(1) or MassHealth CommonHealth as described in 130 CMR 519.001(B)(5) or 130 CMR 505.001(A)(2);
- (3) be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: Basic-Level Benefit (BLB);
- (4) live in a designated service area of a One Care Plan; and
- (5) not be subject to any of the exclusions defined in 130 CMR 508.002(C).

(B) Selection Procedure. The MassHealth agency will notify members of the availability of a One Care Plan in their service area and of the procedures for enrollment. An eligible member may voluntarily enroll in any One Care Plan in the member's service area. A service area is the specific geographical area of Massachusetts in which a One Care Plan agrees to serve in its contracts with the MassHealth agency and the Centers for Medicare & Medicaid Services. Service area listings may be obtained from the MassHealth agency or its designee. The list of One Care Plans that the MassHealth agency will make available to members will include those One Care Plans that contract with the MassHealth agency and provide services within the member's service area.

(C) Obtaining Services When Enrolled in a One Care Plan. When a member is enrolled in a One Care Plan in accordance with the requirements under 130 CMR 508.007, the One Care Plan will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, the One Care Plan is required to provide evidence of its coverage, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to specialty, behavioral health, and long-term services and supports.

(D) Disenrollment from a One Care Plan. Disenrollment requests will be effective the first day of the month following the month the request is received by the MassHealth agency or its designee.

(E) Discharge or Transfer. The MassHealth agency may discharge or transfer a member from a One Care Plan for good cause, including but not limited to cases where the One Care Plan demonstrates to the MassHealth agency's satisfaction a pattern of noncompliant or disruptive behavior by the member. In each case, notice to the member of the discharge or transfer will state the justification for the discharge or transfer.

(F) Other Programs. A member may not be enrolled in a One Care Plan and concurrently participate or be enrolled in any of the following programs or plans:

- (1) programs described at 130 CMR 519.007: *Individuals Who Would Be Institutionalized*;
- (2) Medicare demonstration program or Medicare Advantage plan, except for a Medicare Advantage Special Needs Plan for Dual Eligibles contracted as a One Care Plan;

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- (3) any Medicare Demonstrations wherein concurrent participation in a One Care Plan is prohibited;
- (4) Employer Group Waiver Plans or other employer-sponsored plans; or
- (5) plans receiving a retiree drug subsidy.

(G) Copayments. Members who are enrolled in a One Care Plan must make copayments in accordance with the One Care Plan's MassHealth copayment policy. Those One Care Plan copayment policies must

- (1) be approved by MassHealth; and
- (2) be consistent with applicable copayment requirements set forth in 130 CMR 450.000, 130 CMR 506.000, and 130 CMR 520.000.

508.008: Senior Care Options (SCO) Plans

(A) Enrollment Requirements. In order to voluntarily enroll in a SCO Plan, a MassHealth Standard member must meet all the following criteria:

- (1) be 65 years of age or older;
- (2) be eligible for MassHealth Standard as defined in 130 CMR 519.001(B)(1);
- (3) be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001;
- (4) live in a designated service area of a SCO Plan; and
- (5) not be subject to any of the exclusions defined in 130 CMR 508.002(B).

(B) Selection Procedure. The MassHealth agency will notify members of the availability of a SCO Plan in their service area and of the procedures for enrollment. An eligible member may voluntarily enroll in any SCO Plan in the member's service area. A service area is the specific geographical area of Massachusetts in which a SCO Plan agrees to serve its contract with the MassHealth agency and the Centers for Medicare & Medicaid Services. Service area listings may be obtained from the MassHealth agency or its designee. The list of SCO Plans that the MassHealth agency will make available to members will include those SCO Plans that contract with the MassHealth agency and provide services within the member's service area.

(C) Obtaining Services When Enrolled in a SCO Plan. When a member chooses to enroll in a SCO Plan in accordance with the requirements under 130 CMR 508.008, the SCO Plan will deliver the member's primary care and will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, each SCO Plan is required to provide evidence of its coverage, including a complete list of participating providers, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to covered services such as specialty, behavioral health, and long-term-care services.

(D) Disenrollment from a SCO Plan. Disenrollment requests will be effective the first day of the month following the month the request is received by the MassHealth agency or its designee.

(E) Discharge or Transfer. The MassHealth agency may discharge or transfer a member from a SCO Plan for good cause, including but not limited to cases where the SCO Plan demonstrates to

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the MassHealth agency's satisfaction a pattern of noncompliant or disruptive behavior by the member. In each case, notice to the member of the discharge or transfer will state the justification for the discharge or transfer.

(F) Other Programs. A member may not be enrolled in a SCO Plan and concurrently participate or be enrolled in any of the following programs or plans:

- (1) programs described at 130 CMR 519.007: *Individuals Who Would Be Institutionalized*; except the Home- and Community-based Services Waiver–Frail Elder described in 130 CMR 519.007(B): *Home- and Community-based Services Waiver–Frail Elder*;
- (2) Medicare demonstration program or Medicare Advantage plan, except for a Medicare Advantage Special Needs Plan for Dual Eligibles contracted as a SCO Plan;
- (3) any Medicare Demonstrations wherein concurrent participation in a SCO Plan is prohibited;
- (4) Employer Group Waiver Plans or other employer-sponsored plans; or
- (5) plans receiving a retiree drug subsidy.

(G) Copayments. Members who are enrolled in a SCO Plan must make copayments in accordance with the SCO's MassHealth copayment policy. Those SCO Plan copayment policies must

- (1) be approved by MassHealth; and
- (2) be consistent with applicable copayment requirements set forth in 130 CMR 450.000, 130 CMR 506.000, and 130 CMR 520.000.

508.009: Behavioral Health Contractor

The following applies to MassHealth members who are not in the PCC Plan or a Primary Care ACO and who receive behavioral health services through MassHealth's behavioral health contractor. (See 130 CMR 508.001(E).)

(A) Nonemergency Behavioral Health Services. Behavioral health services, except for emergency services and those services not covered under the MassHealth contract with the behavioral health contractor, may be obtained only from a provider that has entered into an agreement with the MassHealth behavioral health contractor. The MassHealth behavioral health contractor is responsible for authorizing or denying behavioral health services based on the member's medical need for those services.

(B) Emergency Behavioral Health Services. Members may obtain emergency behavioral health services from any qualified participating MassHealth provider as well as any provider that has entered into an agreement with the MassHealth behavioral health contractor.

(C) Copayments. Members who are enrolled in the MassHealth behavioral health contractor must make copayments in accordance with the MassHealth behavioral health contractor's MassHealth copayment policy. Those MassHealth behavioral health contractor copayment policies must

- (1) be approved by MassHealth; and
- (2) be consistent with applicable copayment requirements set forth in 130 CMR 450.000, 130

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CMR 506.000, and 130 CMR 520.000.

508.010: Right to a Fair Hearing

Members are entitled to a fair hearing under 130 CMR 610.000: *MassHealth: Fair Hearing Rules* to appeal for the reasons described in 130 CMR 610.032: *Grounds for Appeal*.

508.011: Timely Notice of Appealable Actions

(A) Whenever an MCO, Accountable Care Partnership Plan, SCO Plan, One Care Plan, or the behavioral health contractor reaches a decision that constitutes an appealable action, as described in 130 CMR 610.032(B), it must send a notice to the member within the following time frames that describes its decision and its internal appeal procedures:

- (1) for a standard service authorization decision to deny or provide limited authorization for a requested service, no later than seven days following receipt of the request for service, unless the time frame is extended up to 14 additional days because the member or a provider requested the extension or the MCO, Accountable Care Partnership Plan, SCO Plan, and One Care Plan, or behavioral health contractor can demonstrate a need for additional information and how the extension is in the member's interest;
- (2) for an expedited service decision to deny or provide limited authorization for a requested service, where a provider requests, or an MCO, Accountable Care Partnership Plan, SCO Plan, One Care Plan, or behavioral health contractor determines, that following the standard time frame in 130 CMR 508.011(A) could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, no later than three business days after receipt of the request for service, unless the time frame is extended up to 14 additional calendar days because the member requested the extension or the MCO, Accountable Care Partnership Plan, SCO Plan, One Care Plan, or behavioral health contractor can demonstrate a need for additional information and how the extension is in the member's interest;
- (3) for termination, suspension, or reduction of a previous authorization for a service, at least ten days before the action, except as provided in 42 CFR 431.213; and
- (4) for denial of payment where coverage of the requested service is at issue, on the day of the payment denial, except that no notice is necessary for procedural denials, which include, but are not limited to, the following:
 - (a) failure to follow the MCO, Accountable Care Partnership Plan, SCO Plan, One Care Plan, or behavioral health contractor's prior authorization procedures;
 - (b) failure to follow referral rules; and
 - (c) failure to file a timely claim.

(B) Whenever an MCO, Accountable Care Partnership Plan, SCO Plan, One Care Plan, or the behavioral health contractor fails to reach a decision on a standard or expedited service authorization within the time frames described in 130 CMR 508.011(A)(1) and (2), whichever is applicable, it must send a notice to the member on the date that such time frame expires.

508.012: Time Limits for Resolving Internal Appeals

(A) MCOs, Accountable Care Partnership Plans, SCO Plans, One Care Plans, and the behavioral

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health contractor must resolve standard internal appeals within 30 days after receiving the appeal, including any extensions pursuant to 130 CMR 508.012(C).

(B) Where the provider requests an expedited appeal or the MCO, Accountable Care Partnership Plan, SCO Plan, One Care Plan, or behavioral health contractor determines (for a request from the member) that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO, Accountable Care Partnership Plan, SCO Plan, One Care Plan, or the behavioral health contractor must resolve the internal appeal on an expedited basis within 72 hours after receiving the appeal, unless the time frames are extended by up to 14 days pursuant to 130 CMR 508.012(C), in which event the MCO, Accountable Care Partnership Plan, SCO Plan, One Care Plan, or behavioral health contractor must resolve the appeal within 17 days after receiving the appeal. If the MCO, Accountable Care Partnership Plan, SCO Plan, One Care Plan, or behavioral health contractor denies a member's request for expedited resolution of an internal appeal, the MCO, Accountable Care Partnership Plan, SCO Plan, One Care Plan, or behavioral health contractor must resolve the appeal in accordance with the time frames in 130 CMR 508.012(A) and must make reasonable efforts to give the member prompt, oral notice of the denial and follow up within two calendar days with a written notice. The MCO, Accountable Care Partnership Plan, SCO Plan, One Care Plan, or behavioral health contractor cannot deny a provider's request (on the member's behalf) that an internal appeal be expedited.

(C) MCOs, Accountable Care Partnership Plans, SCO Plans, One Care Plans, and the behavioral health contractor may extend the time frame for resolving internal appeals under the following circumstances, provided that, if the MCO, Accountable Care Partnership Plan, SCO Plan, One Care Plan, or the behavioral health contractor extends the time frame, it must give the member written notice of the reason for the extension:

- (1) the member requested the extension;
- (2) the MCO, Accountable Care Partnership Plan, SCO Plan or the behavioral health contractor showed (to the MassHealth agency's satisfaction) that there is a need for additional information and how the extension is in the member's interest; or
- (3) the One Care Plan showed (to the satisfaction of the MassHealth agency and the Centers for Medicare & Medicaid Services (CMS)) that there is a need for additional information and how the extension is in the member's interest.

508.013: Timely Notice of Internal Appeal Decisions

(A) MCOs, Accountable Care Partnership Plans, SCO Plans, One Care Plans, and the behavioral health contractor must provide notice of an internal appeal decision concerning an appealable action, as described in 130 CMR 610.032(B), within the timeframes described in 130 CMR 508.012.

(B) Notice from an MCO, an Accountable Care Partnership Plan, a SCO Plan, a One Care Plan, or the behavioral health contractor concerning an internal appeal must be in writing and, for an expedited internal appeal, reasonable efforts must be made to provide oral notice.

508.014: Severability

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The provisions of 130 CMR 508.000 are severable. If any provision of 130 CMR 508.000 or application of any provision to an applicable individual, entity, or circumstance is held invalid or unconstitutional, that holding will not be construed to affect the validity or constitutionality of any remaining provisions of 130 CMR 508.000 or application of those provisions to applicable individuals, entities, or circumstances.

REGULATORY AUTHORITY

130 CMR 508.000: M.G.L. c. 118E.

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