Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
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Boston, MA 02111
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MASSHEALTH
TRANSMITTAL LETTER ALL-110
December 2002

TO: All Providers Participating in MassHealth

FROM: Wendy E. Warring, Commissioner

RE: *All Provider Manuals* (Changes to Pharmacy Copayments)

The Division has revised its administrative and billing regulations at 130 CMR 450.000.

The Massachusetts Legislature increased pharmacy copayments for MassHealth members from 50 cents per prescription to $2 per prescription. This copayment increase applies to drugs covered by MassHealth (whether legend or non legend), including the original prescription and all refills.

The following continue to be excluded from the copayment requirement:

- MassHealth members who have not reached their 19th birthday;
- MassHealth members who are pregnant;
- MassHealth members who are in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends;
- MassHealth Limited members;
- MassHealth Senior Buy-In members or MassHealth Standard members for Medicare-covered drugs only, when furnished by a Medicare-certified provider;
- MassHealth members who are inpatients in hospitals, nursing facilities, chronic-disease or rehabilitation hospitals, and intermediate-care facilities for the mentally retarded;
- family-planning services and supplies such as oral contraceptives, contraceptive devices such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;
- emergency services;
- hospice-care services; and
- persons receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106, if they do not receive MassHealth Basic or MassHealth Standard.

MassHealth members who are enrolled in MassHealth managed-care organizations (MCOs) must follow the MassHealth copayment policy of their MCO. Those MCO copayment policies must be approved by the Division, must exclude the persons and services listed above, and may not exceed MassHealth copayment amounts.

These regulations apply to claims processed for dates of service on or after January 1, 2003.

These regulations are effective January 1, 2003.

NEW MATERIAL

(The pages listed here contain new or revised language.)

All Provider Manuals

Pages i, 1-27, and 1-28

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

All Provider Manuals

Page i — transmitted by Transmittal Letter ALL-99

Pages 1-27 and 1-28 — transmitted by Transmittal Letter ALL-98

1. INTRODUCTION

(C) Verifying Member Eligibility for Services. Providers must access the Division's Recipient Eligibility Verification System (REVS) before providing services to verify a member's eligibility for MassHealth (see 130 CMR 450.107). If the member is an inpatient in a chronic-disease or rehabilitation hospital that has a managed-care contract with the Division, REVS will issue a message notifying the provider to contact the chronic-disease or rehabilitation hospital before providing services.

450.130: Copayments Required by the Division

(A) The Division requires MassHealth members who are not enrolled in MCOs to make the copayments described in 130 CMR 450.130(B) for drugs obtained from the dispensing pharmacy and for nonemergency services provided in a hospital emergency department, except as excluded in 130 CMR 450.130(C). Providers may collect copayments only in the amounts and for the services listed in 130 CMR 450.130(B). MassHealth members who are enrolled in MassHealth MCOs must make copayments in accordance with the MCO's MassHealth copayment policy. Those MCO copayment policies must be approved by the Division, must exclude the services and persons listed in 130 CMR 450.130(C), and may not exceed the MassHealth copayment amounts set forth in 130 CMR 450.130(B). (See also 130 CMR 508.016 through 508.019.) If the usual and customary fee is less than the copayment amount, the member must pay the amount of the service.

(B) Copayments consist of the following:
(1) $2 for each prescription for drugs covered by MassHealth (whether legend or nonlegend), including the original prescription and all refills; and
(2) $3 for nonemergency services covered by MassHealth provided in a hospital emergency department. (See 130 CMR 450.118 for a discussion of payment for hospital emergency department services for members who are enrolled with a MassHealth managed-care provider.)

(C) The following are excluded from the copayment requirement described in 130 CMR 450.130(B):
(1) MassHealth members who have not reached their 19th birthday;
(2) MassHealth members who are pregnant;
(3) MassHealth members who are in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15, she is exempt from the copayment requirement until August 1);
(4) MassHealth Limited members;
(5) MassHealth Senior Buy-In members or MassHealth Standard members for Medicare-covered drugs only, when furnished by a Medicare-certified provider;
(6) MassHealth members who are inpatients in hospitals, nursing facilities, chronic-disease or rehabilitation hospitals, and intermediate-care facilities for the mentally retarded;
(7) family-planning services and supplies such as oral contraceptives, contraceptive devices such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;
(8) emergency services;
(9) hospice-care services; and
(10) persons receiving medical services through the EAEDC Program pursuant to 130 CMR 450.106, if they do not receive MassHealth Basic or MassHealth Standard.

(D) Pharmacies and hospital emergency departments must post a notice in a conspicuous area that specifies the exclusions from the copayment requirement listed in 130 CMR 450.130(C), and that instructs members to inform providers if members believe they are excluded from the copayment requirement.

(E) A member must pay the copayment described in 130 CMR 450.130(B) at the time service is provided unless exempted by 130 CMR 450.130(C) or unless the member claims inability to make the copayment at the time service is provided. The member's inability to make the copayment at the time service is provided does not alleviate the member's liability for the copayment, and providers may bill the member for the copayment amount. The Division will deduct the amount of the copayment from the amount paid to the provider (whether or not the provider collects the copayment from the member), unless the member or service is exempt according to 130 CMR 450.130(C). Providers should not deduct the copayment amount from the amount claimed. Providers may not refuse services to any members who are unable to pay the copayment at the time service is provided.

(130 CMR 450.131 through 450.139 Reserved)