



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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Boston, MA 02111
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MASSHEALTH
TRANSMITTAL LETTER ALL-132
June 2005

TO: All Providers Participating in MassHealth
FROM: Beth Waldman, Medicaid Director *BW*
RE: *All Provider Manuals* (Revisions to Regulations)

The regulations about MassHealth-contracted managed care entities are being revised with some clarifying language. The revisions include changes that:

- expressly prohibit enrollment discrimination by MassHealth-contracted managed care entities; and
- require MassHealth-contracted managed care entities to communicate information to MassHealth members about advance directives.

These regulations are effective July 1, 2005.

NEW MATERIAL

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

All Provider Manuals

Pages 1-15, 1-16, 2-1, and 2-2

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 1-15 and 1-16 — transmitted by Transmittal Letter ALL-118

Pages 2-1 and 2-2 — transmitted by Transmittal Letter ALL-113

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(B) Responsibilities of Acute Hospitals. Acute outpatient and inpatient hospitals are obligated under M.G.L. c. 118G, § 13 to provide medically necessary services to recipients of the EAEDC Program. EAEDC recipients are entitled to receive the services described in 130 CMR 410.000 and 415.000 to the same extent that such services are provided to MassHealth members under M.G.L. c. 118E.

(C) Prior Authorization. Any covered services that require prior authorization in the MassHealth regulations (130 CMR 400.000 through 499.000) require prior authorization for the EAEDC Program.

450.107: Eligible Members and the MassHealth Card

(A) Eligibility Determination. MassHealth eligibility is determined in accordance with 130 CMR 501.000 et seq. Eligibility for the EAEDC Program is determined pursuant to 106 CMR 319.000 through 321.000, 701.000 through 701.600, 705.000 through 705.950, and 706.000 through 706.800.

(B) Recipient Eligibility Verification System. The MassHealth agency uses the Recipient Eligibility Verification System (REVS) for day-specific eligibility verification, and to communicate a member's MassHealth eligibility, coverage type, managed care status, restrictions, and other insurance information to health-care providers.

(C) MassHealth Card. The MassHealth agency issues a plastic identification card for most MassHealth members. The MassHealth card contains information necessary to access REVS. Members for whom the MassHealth agency pays health-insurance premiums only may not have a MassHealth card.

(D) Temporary MassHealth Eligibility Card. When necessary, the MassHealth agency or the Department of Transitional Assistance will issue a temporary MassHealth card to the cardholder for use until a plastic MassHealth card is issued. The temporary MassHealth card shows dates of eligibility, service restrictions, and other insurance information. If a discrepancy occurs between information given on a temporary MassHealth card and by REVS, the information on the temporary card prevails. To be paid for a covered service that was provided based on information given on a temporary card, a provider must produce a copy of the temporary card, and have otherwise met all other prerequisites for payment.

(E) Time-Limited Eligibility. The MassHealth agency may determine certain individuals to be eligible for MassHealth Standard or MassHealth Family Assistance coverage for a limited period of time if, on the basis of preliminary information, the individual appears to meet the applicable requirements. Coverage for members with time-limited eligibility begins 10 days before the date on which the MassHealth agency receives the Medical Benefit Request (MBR). The MassHealth agency may determine time-limited eligibility for:

- (1) MassHealth Standard or MassHealth Family Assistance for children under age 19; and
- (2) MassHealth Family Assistance for persons who claim to have a positive human immunodeficiency virus (HIV) status.

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450.108: Selective Contracting

(A) Use of Selective Contracts. The MassHealth agency may provide some services through selective contracts where such contracts are permitted by federal and state law.

(B) Termination of Provider Contracts. The MassHealth agency may terminate, in whole or in part, existing provider contracts where selective contracts are in effect. In the event of any such termination, the MassHealth agency notifies the affected providers in writing, at least 30 days prior to termination. Such termination does not affect payments to providers for services provided prior to the date of termination.

450.109: Out-of-State Services

(A) MassHealth covers services provided in another state to a MassHealth member, subject to all applicable limitations, including service coverage, prior authorization, and provider enrollment, only in the following circumstances:

- (1) medical services are needed because of a medical emergency;
- (2) medical services are needed and the member's health would be endangered if the member were required to travel to Massachusetts; or
- (3) it is the general practice for members in a particular locality to use medical resources in another state.

(B) MassHealth does not cover services provided outside the United States and its territories.

(130 CMR 450.110 and 450.111 Reserved)

450.112: Advance Directives

(A) Provider Participation. All hospitals, nursing facilities, MCOs, home health agencies, personal care agencies, hospices, and the MassHealth behavioral health contractor must:

- (1) provide to all adults aged 18 or over, who are receiving medical care from the provider, the following written information concerning their rights, which information must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change to:
 - (a) make decisions concerning their medical care;
 - (b) accept or refuse medical or surgical treatment; and
 - (c) formulate advance directives (for example, living wills or durable powers of attorney for health care, or health-care proxy designations);
- (2) provide written information to all adults about the provider's policies concerning implementation of these rights;
- (3) document in the patient's medical record whether the patient has executed an advance directive;
- (4) not condition the provision of care or otherwise discriminate against a patient based on whether that patient has executed an advance directive;
- (5) ensure compliance with requirements of state law concerning advance directives; and
- (6) educate staff and the community on advance directives.

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450.200: Conflict Between Regulations and Contracts

If the MassHealth regulations about payment methods and conditions of provider participation conflict with a provider contract, such contract will supersede the regulation, unless the contract expressly states otherwise.

450.201: Choice of Provider

Pursuant to federal regulations set forth in 42 CFR 431.51, members have the right to choose providers from whom they may obtain medical services with certain exceptions that are specified in the MassHealth regulations, including, but not limited to, 130 CMR 450.117(B) and 450.316. However, a member's right to choose a provider does not permit or require payment by the MassHealth agency to any person or institution not eligible for such payment under the MassHealth regulations in effect at the time a medical service is provided.

450.202: Nondiscrimination

(A) M.G.L. c. 151B, § 4, clause 10 prohibits discrimination against any individual who is a recipient of federal, state, or local public assistance, including MassHealth, because the individual is such a recipient or because of any requirement of such an assistance program. Accordingly, except as specifically permitted or required by regulations relative to institutional providers, no provider may deny any medical service to a member eligible for such service unless the provider would, at the same time and under similar circumstances, deny the same service to a patient who is not a MassHealth member (for example, no new patients are being accepted, or the provider does not provide the desired service to any patient). A provider may not specify a particular setting for the provision of services to a member that is not also specified for nonmembers in similar circumstances.

(B) No provider may engage in any practice, with respect to any member, that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 CFR Part 80 (relative to discrimination on account of race, color, or national origin), 45 CFR Part 84 (relative to discrimination against handicapped persons), and 45 CFR Part 90 (relative to age discrimination).

(C) Pursuant 42 U.S.C. § 1396u-2 and 42 CFR 438.6(d), MCOs, PCCs, and the behavioral health contractor may not unlawfully discriminate and will not use any policy or practice that has the effect of unlawfully discriminating against a MassHealth member eligible to enroll in the contractor's MassHealth plan on the basis of health status, need for health-care services, race, color, or national origin. MCOs, PCCs, and the behavioral health contractor will accept for enrollment and reenrollment all members referred by the MassHealth agency in the order in which they are referred without restriction, provided that PCCs will accept members for enrollment and reenrollment up to the limits for PCC panel capacity set under the contract between EOHHS and PCCs.

(D) Violations of 130 CMR 450.202(A), (B), and (C) may result in administrative action, referral to the Massachusetts Commission Against Discrimination, or referral to the U.S. Department of Health and Human Services, or any combination of these.

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450.203: Payment in Full

(A) Federal and state laws require that participation in MassHealth be limited to providers who agree to accept, as payment in full, the amounts paid in accordance with the applicable fees and rates or amounts established under a provider contract or regulations applicable to MassHealth payment (see 42 CFR 447.15, M.G.L. c. 118E, § 36, and M.G.L. c. 118G, § 7). No provider may solicit, charge, receive, or accept any money, gift, or other consideration from a member, or from any other person, for any item or medical service for which payment is available under MassHealth, in addition to, instead of, or as an advance or deposit against the amounts paid or payable by the MassHealth agency for such item or service, except to the extent that the MassHealth regulations specifically require or permit contribution or supplementation by the member or by a health insurer.

(B) If the provider receives payment from a member for any service payable under MassHealth without knowing that the member was a MassHealth member at the time the service was provided, the provider must, upon learning that the individual is a MassHealth member, immediately return all sums solicited, charged, received, or accepted with respect to such service.

450.204: Medical Necessity

The MassHealth agency will not pay a provider for services that are not medically necessary and may impose sanctions on a provider for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary.

(A) A service is "medically necessary" if:

(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and

(2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007.

(B) Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records, available to the MassHealth agency upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)

(C) A provider's opinion or clinical determination that a service is not medically necessary does not constitute an action by the MassHealth agency.

(D) Additional requirements about the medical necessity of acute inpatient hospital admissions are contained in 130 CMR 415.414.