Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Transmittal Letter ALL-178
June 2010

TO: All Providers Participating in MassHealth

FROM: Terence G. Dougherty, Medicaid Director

RE: *All Provider Manuals* (Managed Care Requirements)

MassHealth is revising the regulations about managed care. The revisions

- allow MassHealth Essential, Basic, and Standard members who have breast or cervical cancer and MassHealth Family Assistance members who are HIV positive to enroll in a managed care organization (MCO) or in the Primary Care Clinician (PCC) Plan if they meet other managed care eligibility requirements. Historically, such members could enroll only in the PCC Plan;
- require MassHealth CommonHealth members who are eligible for managed care to receive services through either an MCO or the PCC Plan. Historically, such members could choose to receive all services on a fee-for-service basis; and
- allow MassHealth members who are Native Americans or Alaskan Natives who are enrolled in an MCO to choose to receive services through an Indian provider, even if that provider is not part of the managed care network.

These regulations are effective July 1, 2010.

If you have any questions about the information in this transmittal letter please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

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

All Provider Manuals

Pages 1-5 through 1-18

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(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 1-5 and 1-6 — transmitted by Transmittal Letter ALL-113
Pages 1-7 and 1-8 — transmitted by Transmittal Letter ALL-170
Pages 1-9 and 1-10 — transmitted by Transmittal Letter ALL-149
Pages 1-11 through 1-18 — transmitted by Transmittal Letter ALL-176

450.102: Purpose of 130 CMR 400.000 through 499.000

130 CMR 400.000 through 499.000 contain the MassHealth regulations specific to provider participation in, and the medical services and benefits available under, MassHealth and the Emergency Aid to the Elderly, Disabled and Children Program. 130 CMR 450.000 et seq. applies to all MassHealth providers and services. The MassHealth agency also promulgates other regulations, and publishes other documents affecting these programs, including other chapters in Title 130 CMR, statements of policy and procedure, conditions of participation, guidelines, billing instructions, provider bulletins, and other documents referenced in 130 CMR. In addition, the regulations in 130 CMR frequently refer to federal regulations, to regulations of the Massachusetts Department of Public Health and other agencies, and to rates and fee schedules established by the Massachusetts Division of Health Care Finance and Policy (DHCFP).

450.103: Promulgation of Regulations

(A) All regulations of the MassHealth agency are promulgated in accordance with M.G.L. c. 30A. In the event of any conflict between MassHealth regulations and applicable federal laws and regulations, MassHealth regulations shall be construed so far as possible to make them consistent with such federal laws and regulations.

(B) Without limiting the generality of 130 CMR 450.103(A), MassHealth regulations shall be construed so far as possible to make them consistent with the federal Health Insurance Portability and Accountability Act, including federal regulations promulgated thereunder (HIPAA). To implement and comply with HIPAA, the MassHealth agency, from time to time, may issue billing instructions, provider bulletins, companion guides, or other materials, which shall be effective and controlling notwithstanding any MassHealth regulations to the contrary.

(130 CMR 450.104 Reserved)

450.105: Coverage Types

A member is eligible for services and benefits according to the member's coverage type. Each coverage type is described below. Payment for the covered services listed in 130 CMR 450.105 is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment. See individual program regulations for information on covered services and specific service limitations, including age restrictions applicable to certain services.

(A) MassHealth Standard.

(1) Covered Services. The following services are covered for MassHealth Standard members (see 130 CMR 505.002 and 130 CMR 519.002).

(a) abortion services;
(b) acute inpatient hospital services;
(c) adult day health services;
(d) adult foster care services;
(e) ambulance services;
(f) ambulatory surgery services;
(g) audiologist services;
(h) behavioral health (mental health and substance abuse) services;
(i) Chapter 766: home assessments and participation in team meetings;
(j) chiropractor services;
(k) chronic disease and rehabilitation inpatient hospital services;
(l) community health center services;
(m) day habilitation services;
(n) dental services;
(o) durable medical equipment and supplies;
(p) early intervention services;
(q) family planning services;
(r) hearing aid services;
(s) home health services;
(t) hospice services;
(u) laboratory services;
(v) nurse midwife services;
(w) nurse practitioner services;
(x) nursing facility services;
(y) orthotic services;
(z) outpatient hospital services;
(aa) oxygen and respiratory therapy equipment;
(bb) personal care services;
(cc) pharmacy services;
(dd) physician services;
(ee) podiatrist services;
(ff) private duty nursing services;
(gg) prosthetic services;
(hh) rehabilitation services;
(ii) renal dialysis services;
(jj) speech and hearing services;
(kk) therapy services: physical, occupational, and speech/language;
(ll) transportation services;
(mm) vision care; and
(nn) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth Standard members must enroll with a MassHealth managed care provider unless excluded from participation in managed care. (See 130 CMR 450.117 et seq. and 130 CMR 508.000.)

(3) Managed Care Organizations. For MassHealth Standard members who are enrolled in a MassHealth MCO, the following rules apply.

(a) The MassHealth agency does not pay a provider other than the MCO for any services that are covered by the MassHealth agency's contract with the MCO, except for family planning services that were not provided or arranged for by the MCO. It is the responsibility of the provider to verify the scope of services covered by the MassHealth agency's contract with the MCO.

(b) The MassHealth agency pays providers other than the MCO for those services listed in 130 CMR 450.105(A)(1) that are not covered by the MassHealth agency's contract with the MCO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(4) Behavioral-Health Services.

(a) MassHealth Standard members enrolled in the PCC Plan receive behavioral-health services only through the MassHealth behavioral-health contractor. (See 130 CMR 450.124 et seq.)

(b) MassHealth Standard members enrolled in an MCO receive behavioral-health services only through the MCO. (See 130 CMR 450.117 et seq.)

(c) MassHealth Standard members who are excluded from participating in managed care under 130 CMR 508.004 or who have not enrolled in an MCO or with the MassHealth behavioral-health contractor may receive behavioral-health services from any participating MassHealth provider of such services.

(d) MassHealth Standard members who participate in a senior care organization receive all behavioral-health services only through the senior care organization.

(e) MassHealth Standard members who are under the age of 21 and who are excluded from participating in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(A) or (B) must enroll with the MassHealth behavioral-health contractor.

(f) MassHealth Standard members who are under the age of 21 and who are excluded from participating in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(I), (J), or (K) are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(g) MassHealth members who are receiving services from the Department of Children and Families (DCF) or the Department of Youth Services (DYS) may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO must enroll with the MassHealth behavioral-health contractor.

(h) MassHealth members who receive Title IV-E adoption assistance described in 130 CMR 522.003 may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(5) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for MassHealth Standard members, with the exception of members described at 130 CMR 505.002(H), if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency pays a provider only for those services listed in 130 CMR 450.105(A)(1) that are not available through the member's third-party health insurer.

(6) Senior Care Organizations. MassHealth Standard members aged 65 and over may voluntarily enroll in a senior care organization in accordance with the requirements under 130 CMR 508.008. The MassHealth agency does not pay a provider other than a senior care organization for any services that are provided to the MassHealth member while the member is enrolled in a senior care organization.

(B) MassHealth Basic. Basic members receive services through either the purchase of medical benefits or premium assistance.

(1) Covered Services. The following services are covered for MassHealth Basic members (see 130 CMR 505.006):

(a) abortion services;
(b) acute inpatient hospital services;
(c) ambulance services (emergency only);
(d) ambulatory surgery services;
(e) audiologist services;
(f) behavioral-health (mental health and substance abuse) services;
(g) Chapter 766: home assessments and participation in team meetings;
(h) chiropractor services;
(i) community health center services;
(j) dental services;
(k) durable medical equipment and supplies;
(l) family planning services;
(m) hearing aid services;
(n) home health services;
(o) laboratory services;
(p) nurse midwife services;
(q) nurse practitioner services;
(r) orthotic services;
(s) outpatient hospital services;
(t) oxygen and respiratory therapy equipment;
(u) pharmacy services;
(v) physician services;
(w) podiatrist services;
(x) prosthetic services;
(y) rehabilitation services (except in inpatient hospital settings);
(z) renal dialysis services;
(aa) speech and hearing services;
(bb) therapy services: physical, occupational, and speech/language;
(cc) vision care; and
(dd) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth Basic members for whom eligibility is determined under 130 CMR 505.006 must participate in managed care as described in 130 CMR 450.117. These members are eligible to receive services listed in 130 CMR 450.105(B)(1) only after enrolling with a MassHealth managed care provider in accordance with 130 CMR 508.002(I).

(3) Premium Assistance. For adults who meet the eligibility requirements of MassHealth Basic, but who have health insurance, the MassHealth agency pays part or all of the member's health insurance premium. The amount of the payment is based on the MassHealth agency's determination of cost effectiveness. The MassHealth agency does not pay for any other benefits for these members.

(4) Managed Care Organizations. For MassHealth Basic members who are enrolled in MassHealth MCOs, the following rules apply.

(a) The MassHealth agency does not pay a provider other than the MCO for any services that are covered by the MassHealth agency's contract with the MCO, except for family planning services that were not provided or arranged for by the MCO. It is the responsibility of the provider to verify the scope of services covered by the MassHealth agency's contract with the MCO.

(b) The MassHealth agency pays providers other than the MCO for those services listed in 130 CMR 450.105(B)(1) that are not covered by the MassHealth agency's contract with the MCO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(5) Behavioral-Health Services.

(a) MassHealth Basic members enrolled in the PCC Plan receive behavioral-health services only through the MassHealth behavioral-health contractor. (See 130 CMR 450.124 et seq.)

(b) MassHealth Basic members enrolled in an MCO receive behavioral-health services only through the MCO. (See 130 CMR 450.117 et seq.)

(C) MassHealth Buy-In.

(1) For a MassHealth Buy-In member who is aged 65 or older or is institutionalized (see 130 CMR 519.011), the MassHealth agency pays all of the member's Medicare Part B premium. The MassHealth agency does not pay for any other benefit for these members.

(2) MassHealth Buy-In members are responsible for payment of copayments, coinsurance, and deductibles. MassHealth Buy-In members are also responsible for payment for any services that are not covered by the member's insurance.

(3) The MassHealth agency does not pay providers directly for any services provided to any MassHealth Buy-In member, and therefore does not issue a MassHealth card to MassHealth Buy-In members.

(4) MassHealth Buy-In members are excluded from participation in any of the MassHealth agency's managed care options pursuant to 130 CMR 508.004.

(D) MassHealth Senior Buy-In.

(1) Covered Services. For MassHealth Senior Buy-In members (see 130 CMR 519.010), the MassHealth agency pays the member's Medicare Part B premiums, and where applicable, Medicare Part A premiums. The MassHealth agency also pays for coinsurance and deductibles under Medicare Parts A and B.

(2) Managed Care Member Participation. MassHealth Senior Buy-In members are excluded from participation in managed care pursuant to 130 CMR 508.004.

(E) MassHealth CommonHealth.

(1) Covered Services. The following services are covered for MassHealth CommonHealth members (see 130 CMR 505.004 and 519.012).

(a) abortion services;

(b) acute inpatient hospital services;

(c) adult day health services;

(d) adult foster care services;
(e) ambulance services;
(f) ambulatory surgery services;
(g) audiologist services;
(h) behavioral-health (mental health and substance abuse) services;
(i) Chapter 766: home assessments and participation in team meetings;
(j) chiropractor services
(k) chronic disease and rehabilitation inpatient hospital services;
(l) community health center services;
(m) day habilitation services;
(n) dental services;
(o) durable medical equipment and supplies;
(p) early intervention services;
(q) family planning services;
(r) hearing aid services;
(s) home health services;
(t) hospice services;
(u) laboratory services;
(v) nurse midwife services;
(w) nurse practitioner services;
(x) nursing facility services;
(y) orthotic services;
(z) outpatient hospital services;
(aa) oxygen and respiratory therapy equipment;
(bb) personal care services;
(cc) pharmacy services;
(dd) physician services;
(ee) podiatrist services;
(ff) private duty nursing services;
(gg) prosthetic services;
(hh) rehabilitation services;
(ii) renal dialysis services;
(jj) speech and hearing services;
(kk) therapy services: physical, occupational, and speech/language;
(ll) transportation services;
(mm) vision care; and
(nn) X-ray/radiology services.

(2) Managed Care Member Participation.

(a) MassHealth CommonHealth members must enroll with a MassHealth managed care provider unless excluded from participation in managed care. (See 130 CMR 450.117 et seq. and 508.000.)

(b) MassHealth CommonHealth members who are under the age of 21 and who are excluded from participation in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(A) or (B) must enroll with the MassHealth behavioral-health contractor.

(c) MassHealth CommonHealth members who are under the age of 21 and who are excluded from participation in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(I), (J), or (K) may choose to enroll with the MassHealth behavioral-health contractor. Such members may chose to receive all services on a fee-for-service basis.

(3) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for any MassHealth CommonHealth member if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency pays a provider only for those services listed in 130 CMR 450.105(E)(1) that are not available through the member's third-party health insurer.

(F) MassHealth Prenatal.

(1) Covered Services. For MassHealth Prenatal members (see 130 CMR 505.003), the MassHealth agency pays only for ambulatory prenatal care provided by a MassHealth provider.

(2) Managed Care Member Participation. MassHealth Prenatal members are excluded from participation in managed care pursuant to 130 CMR 508.004.

(G) MassHealth Limited.

(1) Covered Services. For MassHealth Limited members (see 130 CMR 505.008 and 519.009), the MassHealth agency pays only for the treatment of a medical condition (including labor and delivery) that manifests itself by acute symptoms of sufficient severity that the absence of immediate medical attention reasonably could be expected to result in

(a) placing the member's health in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

(2) Organ Transplants. Pursuant to 42 U.S.C. 1396b(v)(2), the MassHealth agency does not pay for an organ-transplant procedure, or for care and services related to that procedure, for MassHealth Limited members, regardless of whether such procedure would otherwise meet the requirements of 130 CMR 450.105(G)(1).

(3) Managed Care Member Participation. MassHealth Limited members are excluded from participation in managed care pursuant to 130 CMR 508.004.

(H) MassHealth Family Assistance.

(1) Premium Assistance. The MassHealth agency provides benefits for MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B), (C), or (D).

(a) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B)(4) and (C), the only benefit the MassHealth agency provides is partial payment of the member's employer-sponsored health insurance, except as provided in 130 CMR 450.105(H)(1)(b) and (H)(2).

(b) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B)(4), the MassHealth agency provides dental services as described in 130 CMR 420.000.

(c) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(D), the MassHealth agency issues a MassHealth card and provides

(i) full payment of the member's private health-insurance premium; and

(ii) coverage of any services listed in 130 CMR 450.105(H)(3) not covered by the member's private health insurance. Coverage includes payment of copayments, coinsurance, and deductibles required by the member's private health insurance.

(2) Payment of Copayments, Coinsurance, and Deductibles for Certain Children Who Receive Premium Assistance.

(a) For children who meet the requirements of 130 CMR 505.005(B)(6), the MassHealth agency pays providers directly, or reimburses the member, for

(i) copayments, coinsurance, and deductibles relating to well-baby and well-child care; and

(ii) copayments, coinsurance, and deductibles for services covered under the member's employer-sponsored health insurance once the member's family has incurred and paid copayments, coinsurance, and deductibles for eligible members that equal or exceed five percent of the family group's annual gross income.

(b) Providers should check the Eligibility Verification System (EVS) to determine whether the MassHealth agency will pay a provider directly for a copayment, coinsurance, or deductible for a specific MassHealth Family Assistance member.

(3) Covered Services for Members Who Are Not Receiving Premium Assistance. For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B)(3), (E), (F), or (G), the following services are covered:

(a) abortion services;
(b) acute inpatient hospital services;
(c) ambulance services (emergency only);
(d) ambulatory surgery services;
(e) audiologist services;
(f) behavioral-health (mental health and substance abuse) services;
(g) Chapter 766: home assessments and participation in team meetings;
(h) chiropractor services;
(i) chronic disease and rehabilitation inpatient hospital services;
(j) community health center services;
(k) dental services;
(l) durable medical equipment and supplies;
(m) early intervention services;
(n) family planning services;
(o) hearing aid services;
(p) home health services;
(q) hospice services;
(r) laboratory services;
(s) nurse midwife services;
(t) nurse practitioner services;
(u) orthotic services;
(v) outpatient hospital services;
(w) oxygen and respiratory therapy equipment;
(x) pharmacy services;
(y) physician services;
(z) podiatrist services;
(aa) prosthetic services;
(bb) rehabilitation services;
(cc) renal dialysis services;
(dd) speech and hearing services;
(ee) therapy services: physical, occupational, and speech/language;
(ff) vision care; and
(gg) X-ray/radiology services.

(4) Managed Care Participation. MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(E) or (F) must enroll with a Primary Care Clinician (PCC) or a MassHealth-contracted managed care organization (MCO). (See 130 CMR 450.117).

(5) Managed Care Organizations. For MassHealth Family Assistance members who are enrolled in a MassHealth MCO, the following rules apply.

(a) The MassHealth agency does not pay a provider other than the MCO for any services that are covered by the MassHealth agency's contract with the MCO, except for family planning services that were not provided or arranged for by the MCO. It is the responsibility of the provider to verify the scope of services covered by the MassHealth agency's contract with the MCO.

(b) The MassHealth agency pays providers other than the MCO for those services listed in 130 CMR 450.105(H)(3) that are not covered by the MassHealth agency's contract with the MCO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(6) Behavioral-Health Services.

(a) MassHealth Family Assistance members enrolled in the PCC Plan receive behavioral-health services only through the MassHealth behavioral-health contractor. (See 130 CMR 450.124 et seq.)

(b) MassHealth Family Assistance members enrolled in an MCO receive behavioral-health services only through the MCO. (See 130 CMR 450.117 et seq.)

(c) MassHealth Family Assistance members who are not receiving premium assistance, and have not enrolled in an MCO or been enrolled with the MassHealth behavioral-health contractor may receive behavioral-health services from any participating MassHealth provider of such services.

(I) MassHealth Essential. MassHealth Essential members receive services through either the purchase of medical benefits or premium assistance.

(1) Covered Services. The following services are covered for MassHealth Essential members (see 130 CMR 505.007 and 519.013):

(a) abortion services;
(b) acute inpatient hospital services;
(c) ambulance services (emergency only);
(d) ambulatory surgery services;
(e) behavioral-health (mental health and substance abuse) services;
(f) community health center services;
(g) dental services;
(h) durable medical equipment and supplies;
(i) family planning services;
(j) laboratory services;
(k) nurse practitioner services;
(l) outpatient hospital services;
(m) oxygen and respiratory therapy equipment;
(n) pharmacy services;
(o) physician services;
(p) podiatrist services;
(q) prosthetic services;
(r) rehabilitation services (except in inpatient hospital settings);
(s) renal dialysis services;
(t) speech and hearing services;
(u) therapy services: physical, occupational, and speech/language;

(v) vision care services provided by a licensed doctor of optometry, including eye exams and supplementary testing services, but not including the provision or dispensing of ophthalmic materials such as eyeglasses, contact lenses, or other visual aids; and
(w) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth Essential members for whom eligibility is determined under 130 CMR 505.007 must enroll with a MassHealth managed care provider unless excluded from participation in managed care. (See 130 CMR 450.117 and 508.000.) These members are eligible to receive services listed in 130 CMR 450.105(I)(1) only after enrolling with a MassHealth managed care provider in accordance with 130 CMR 508.002(I)(2), except as described in 130 CMR 505.007(E).

(3) Behavioral-Health Services.

(a) MassHealth Essential members enrolled in the PCC Plan receive behavioral-health services only through the MassHealth behavioral-health contractor. (See 130 CMR 450.124.)

(b) MassHealth Essential members enrolled in an MCO receive behavioral-health services only through the MCO. (See 130 CMR 450.117.)

(4) Premium Assistance. For adults who meet the eligibility requirements for MassHealth Essential but have health insurance, the MassHealth agency pays part or all of the member's health insurance premium. The amount of the payment for premium assistance is based on the MassHealth agency's determination of cost effectiveness. The MassHealth agency does not pay for any other benefits for these members, except as described in 130 CMR 505.007(E). Premium assistance members are excluded from participation in managed care in accordance with 130 CMR 508.004(B).

(J) Children's Medical Security Plan. Children determined to be eligible for the Children's Medical Security Plan (CMSP) receive benefits described in 130 CMR 522.004(G).

450.106: Emergency Aid to the Elderly, Disabled and Children Program

(A) Covered Services. The following services are covered for EAEDC recipients:
(1) physician services specified in 130 CMR 433.000;
(2) community health center services specified in 130 CMR 405.000;
(3) prescription drugs (those drugs that require a prescription under federal or state law) specified in 130 CMR 406.000;
(4) insulins (the only over-the-counter drugs that are covered) and diabetic supplies;
(5) infusion (intravenous) therapy, including chemotherapy, pain management, antibiotics, chelation, and cardiac management;
(6) oxygen and respiratory therapy services specified in 130 CMR 427.000;
(7) substance abuse treatment services as specified in 130 CMR 418.000 if provided in public detoxification and outpatient substance abuse treatment centers; and
(8) diagnostics and testing (such as laboratory, radiology, magnetic resonance imaging, or psychological testing) necessary for the determination or redetermination of eligibility for the EAEDC Program, upon referral from a physician or a community health center.

(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) Eligibility Verification System. The MassHealth agency uses the Eligibility Verification System (EVS) 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 EVS. 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 issues 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 EVS, 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.

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.

(B) When Providers Must Give Written Information to Adults.

(1) A hospital must give written information at the time of the person's admission as an inpatient.

(2) A nursing facility must give information at the time of the person's admission as a resident.

(3) A provider of home health care or personal care services must give information to the person before services are provided.

(4) A hospice program must give information to the person before services are provided.

(5) An MCO must give information at the time the person enrolls or reenrolls with the MCO.

(C) Incapacitated Persons. If a person is admitted to a facility in an incapacitated state and is unable to receive information or articulate whether he or she has executed an advance directive, the facility must include materials about advance directives in the information to the families or to the legal representatives, surrogates, or other concerned persons of the incapacitated patient to the extent it does so in accordance with state law. This does not relieve the facility of its obligation to provide this information to the patient once the patient is no longer incapacitated.

(D) Previously Executed Advance Directives. When the patient or a relative, surrogate, or other concerned or related person presents the provider with a copy of the person's advance directive, the provider must comply with the advance directive, including recognition of the power of attorney, to the extent allowed under state law. Unless contrary to state law, if no one comes forward with a previously executed advance directive and the patient is incapacitated or otherwise unable to receive information or articulate whether he or she has executed an advance directive, the provider must note in the medical record that the person was not able to receive information and was unable to communicate whether an advance directive existed.

(E) Religious Objections. No private provider will be required to implement an advance directive if such action is contrary to the formally adopted policy of such provider that is expressly based on religious beliefs, provided

(1) the provider has informed the person or, if the person is incapacitated at the time of admission and unable to receive information due to the incapacitated condition or mental disorder, the person’s family or surrogate, of such policy prior to or upon admission, if reasonably possible; and

(2) the person is transferred to another equivalent facility that is reasonably accessible to the person's family and willing to honor the advance directive. If the provider or the health care agent is unable to arrange such a transfer, the provider must seek judicial guidance or honor the advance directive.

(130 CMR 450.113 through 450.116 Reserved)

450.117: Managed Care Participation

(A) MassHealth members under the age of 65 are required to enroll in the Primary Care Clinician (PCC) Plan or a MassHealth-contracted managed care organization (MCO) unless they are excluded from such participation under 130 CMR 450.117(E) through (I) or 508.004. Members excluded from managed care under 130 CMR 508.004 receive those MassHealth services for which they are eligible through any participating MassHealth provider.

(B) MassHealth managed care options provide for the management of medical care, including primary care, behavioral-health services, and other medical services.

(1) Members who enroll with a PCC obtain primary care through the PCC, and behavioral-health services through the MassHealth behavioral-health contractor.

(2) Members who enroll with an MCO obtain all medical services, including behavioral-health services, through the MCO, except those services not covered under the MassHealth contract with the MCO.

(C) Members who participate in managed care are identified on EVS (see 130 CMR 450.107). For members enrolled with a MassHealth managed care provider, this system will give the name and telephone number of the managed care provider (the PCC, the MCO, and the behavioral-health contractor, as applicable). The conditions under which the MassHealth agency pays other providers for services provided to MassHealth members enrolled with a MassHealth managed care provider are limited to those described in 130 CMR 450.105 and 450.118.

(D) MassHealth managed care options include a senior care organization for MassHealth Standard members aged 65 and over, who voluntarily enroll in a senior care organization in accordance with the requirements under 130 CMR 508.008.

(1) Members who participate in a senior care organization must select a primary care physician.

(2) Members who participate in a senior care organization obtain all covered services through the senior care organization.

(3) Members who are enrolled in a senior care organization are identified on EVS (see 130 CMR 450.107). For a MassHealth member enrolled with a senior care organization, EVS will identify the name and telephone number of the senior care organization. The MassHealth agency will not pay a provider other than a senior care organization for any services that are provided to the MassHealth member while the member is enrolled in a senior care organization.

(E) MassHealth Standard and CommonHealth members who are under the age of 21 and who are excluded from participation in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(A) or (B) must enroll with the MassHealth behavioral-health contractor.

(F) MassHealth Standard and CommonHealth members who are under the age of 21 and who are excluded from participation in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(I), (J), or (K) are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(G) MassHealth members who are receiving services from the Department of Children and Families (DCF) or the Department of Youth Services (DYS) may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO must enroll with the MassHealth behavioral-health contractor.

(H) MassHealth members who are receiving Title IV-E adoption assistance described in 130 CMR 522.003 may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(I) Individuals who are Native Americans (within the meaning of “Indians” as defined at 42 U.S.C. 1396u-2) or Alaska Natives and who participate in managed care under MassHealth may choose to receive covered services from an Indian health-care provider. All participating MCOs must provide payment for such covered services in accordance with the provisions of 42 U.S.C. 1396u-2(h) and comply with all other provisions of 42 U.S.C. 1396u-2(h). For the purposes of 130 CMR 450.117(I), the term Indian health-care provider means an Indian Health Program or an Urban Indian Organization.