Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter ALL-189
January 2012

TO: All Providers Participating in MassHealth

FROM: Julian J. Harris, M.D., Medicaid Director

RE: All Provider Manuals (Change in Pharmacy Copayment Calendar-Year Maximum)

Effective January 1, 2012, MassHealth is revising the calendar-year copayment maximum for pharmacy services.

Starting in 2012, the pharmacy copayment cap will increase from $200 per calendar year to $250 per calendar year.

These emergency regulations are effective January 1, 2012.

MassHealth Web Site

This transmittal letter and attached pages are available on the MassHealth Web site at www.mass.gov/masshealth.

Questions

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 1-23 through 1-26

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(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 1-23 through 1-26 — transmitted by Transmittal Letter ALL-185

(M) Other Program Requirements. Payment for services provided to members enrolled with a MassHealth managed care provider is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(N) PCC Contracts. Providers that are PCCs are bound by and liable for compliance with the terms of the most recent PCC contract issued by the MassHealth agency, including amendments to the contract, as of the effective date specified in the PCC contract or amendment.

(130 CMR 450.119 through 450.123 Reserved)

450.124: Behavioral Health Services

(A) Behavioral Health Contractor. Except as provided in 130 CMR 450.124(B) and (C), all behavioral health (mental health and substance abuse) services will be authorized, provided, and paid solely by the MassHealth agency's behavioral health contractor (the Contractor). Payment for such services will be subject to the terms of the Contractor's provider contracts including, but not limited to, provisions governing service authorization and billing requirements. Any provider seeking a contract with the Contractor should contact the Contractor directly.

(B) Emergency Services. Emergency services may be provided by any provider regardless of whether that provider has entered into an agreement with the Contractor. However, all providers of emergency services (except those provided to exempt members pursuant to 130 CMR 450.124(C)) may claim payment for such services solely from the Contractor and such payment will be subject to the Contractor's billing requirements.

(C) Services to Exempt Members. Services provided to the following MassHealth members are not subject to 130 CMR 450.124:

(1) members who are enrolled in a MassHealth-contracted MCO; and
(2) members who are excluded from participating in managed care under 130 CMR 508.004.

(130 CMR 450.125 through 450.129 Reserved)

450.130: Copayments Required by the MassHealth Agency

(A) Copayment Requirement. The MassHealth agency requires its members to make the copayments described in 130 CMR 450.130(B) up to the calendar-year maximum described in 130 CMR 450.130(C), except as excluded in 130 CMR 450.130(D) and (E). Providers may collect copayments only in the amounts and for the services listed in 130 CMR 450.130(B). If the usual-and-customary fee is less than the copayment amount, the member must pay the amount of the service. Members who are enrolled in MassHealth MCOs must make copayments in accordance with the MCO's MassHealth copayment policy. Those MCO copayment policies must

(1) be approved by the MassHealth agency;
(2) exclude the persons and services listed in 130 CMR 450.130(D) and (E);
(3) not exceed the MassHealth copayment amounts set forth in 130 CMR 450.130(B); and
(4) not exceed the calendar-year maximum set forth in 130 CMR 450.130(C). (See also 130 CMR 506.013 through 506.017, 508.016, and 520.036 through 520.040.)

(B) Services Subject to Copayments. MassHealth members are responsible for making the following copayments unless excluded in 130 CMR 450.130(D) or (E).

(1) Pharmacy Services. The copayment for pharmacy services is

(a) $1 for each prescription and refill for each generic drug and over-the-counter drug covered by MassHealth in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics; and

(b) $3.65 for each prescription and refill for all other generic and over-the-counter drugs, and all brand-name drugs covered by MassHealth.

(2) Nonpharmacy Services. The copayment for nonpharmacy services is $3 for an acute inpatient hospital stay.

(C) Calendar-Year Maximum. Members are responsible for the MassHealth copayments described in 130 CMR 450.130(B), up to the following calendar-year maximums:

(1) $250 for pharmacy services; and

(2) $36 for nonpharmacy services.

(D) Excluded Individuals.

(1) The following individuals do not have to pay the copayments described in 130 CMR 450.130(B):

(a) members under 19 years of age;

(b) members who are pregnant or 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);

(c) MassHealth Limited members;

(d) MassHealth Senior Buy-In members or MassHealth Standard members for drugs covered under Medicare Parts A and B only, when provided by a Medicare-certified provider;

(e) members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for the mentally retarded or who are admitted to a hospital from such a facility or hospital;

(f) members receiving hospice services;

(g) persons receiving medical services through the EAEDC Program pursuant to 130 CMR 450.106, if they do not receive MassHealth Basic, MassHealth Standard, or MassHealth Essential;

(h) independent foster care adolescents who were in the care and custody of the Department of Children and Families on their 18th birthday and who are eligible for MassHealth Standard until they reach age 21; and

(i) members who are American Indians or Alaska Natives who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or through referral, in accordance with federal law.

(2) Members who have accumulated copayment charges totaling the calendar-year maximum of $250 on pharmacy services do not have to pay further MassHealth copayments on pharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for pharmacy services.
(3) Members who have accumulated copayment charges totaling the calendar-year maximum of $36 on non-pharmacy services do not have to pay further MassHealth copayments on nonpharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for nonpharmacy services.
(4) Members who have other comprehensive medical insurance, including Medicare, do not have to pay MassHealth copayments on nonpharmacy services.
(5) Members who are inpatients in a hospital do not have to pay a separate copayment for pharmacy services provided as part of the hospital stay.

(E) Excluded Services. The following services are excluded from the copayment requirement described in 130 CMR 450.130(B):
(1) family-planning services and supplies such as oral contraceptives, contraceptive devices such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;
(2) nonpharmacy behavioral health services; and
(3) emergency services.

(F) Notice to Members about Exclusions from the Copayment Requirement. Pharmacies and hospitals must post a notice about MassHealth copayments in areas where copayments are collected. The notice must be visible to the public and easily readable and must specify the exclusions from the copayment requirement listed in 130 CMR 450.130(D) and (E), and instruct members to inform providers if members believe they are excluded from the copayment requirement.

(G) Collecting Copayments.
(1) A member must pay the copayment described in 130 CMR 450.130(B) at the time the service is provided unless the member is exempt under 130 CMR 450.130(D) or (E), claims that he or she is exempt from the copayment, or claims that he or she is unable to make the copayment at the time the service is provided. The member's inability to make the copayment at the time service is provided does not eliminate the member's liability for the copayment, and providers may bill the member for the copayment amount.
(2) The MassHealth agency 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(D) or (E). 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.

(H) Receipt. The provider must give the member a receipt identifying the provider, service, date of service, member, and amount paid.

(I) Recordkeeping. Providers must keep all records necessary to determine if a copayment was collected from a member for a service on a specific date.

(130 CMR 450.131 through 450.139 Reserved)

450.140: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction

(A) Legal Basis.

(1) In accordance with federal law at 42 U.S.C. 1396d(a)(4)(b) and (r) and 42 CFR 441.50, and notwithstanding any limitations implied or expressed elsewhere in MassHealth regulations or other publications, the MassHealth agency has established a program of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for MassHealth Standard and MassHealth CommonHealth members under age 21 years, including those who are parents.

(2) Any MassHealth provider may deliver EPSDT services. However, in delivering well-child care, providers must follow the EPSDT Medical Protocol and Periodicity Schedule.

(3) EPSDT screening services include among other things, health, vision, dental, hearing, behavioral health, developmental and immunization status screening services.

(4) The regulations governing the EPSDT program are set forth in 130 CMR 450.140 through 450.149.

(B) Program Objectives. The objectives of the EPSDT program are

(1) to provide comprehensive and continuous health care designed to prevent illness and disability;

(2) to foster early detection and prompt treatment of health problems before they become chronic or cause irreversible damage;

(3) to create an awareness of the availability and value of preventive well-child care services; and

(4) to create an awareness of the services available under the EPSDT program, and where and how to obtain those services.

450.141: EPSDT Services: Definitions

Dental Care — dental services customarily furnished by or through dental providers as defined in 130 CMR 420.000, to the extent the furnishing of those services is authorized by the MassHealth agency.

EPSDT Medical Protocol and Periodicity Schedule (the Medical Schedule) — a schedule (see Appendix W of all MassHealth provider manuals) developed and periodically updated by the MassHealth agency in consultation with recognized medical and dental organizations involved in child health care. The Medical Schedule consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be provided.

EPSDT Dental Protocol and Periodicity Schedule (the Dental Schedule) — a schedule (see Appendix W) developed and periodically updated by the MassHealth agency in consultation with recognized medical and dental organizations involved in child health care. The Dental Schedule consists of screening and treatment procedures arranged according to the intervals or age levels at which each procedure is to be provided.

Interperiodic Visit — the provision of screening procedures or treatment services at an age other than those indicated on the Medical or the Dental Schedule. Interperiodic visits may be: