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

MassHealth
Transmittal Letter ALL-203
September 2013

TO: All Providers Participating in MassHealth

FROM: Kristin L. Thorn, Acting Medicaid Director

RE: *All Provider Manuals* (Integrated Care Organizations)

The Executive Office of Health and Human Services (EOHHS) and Centers for Medicare & Medicaid Services (CMS) have contracted with One Care plans (also known as integrated care organizations or ICOs) using a blended global financial arrangement to provide integrated, comprehensive medical, behavioral-health care, and long-term services and supports for those who are eligible for both Medicare and Medicaid ("dually eligible members") and who meet the specific criteria set forth below. These regulations establish the coverage types eligible to enroll in a One Care plan and the service options for members enrolled in a One Care plan, consistent with the Duals Demonstration to Integrate Care for Dual Eligibles (Duals Demonstration).

The purpose of the Duals Demonstration is to improve quality of care and reduce health disparities, improve health and functional outcomes, and contain costs for dually eligible members who participate in the Duals Demonstration by enrolling in a One Care plan. One Care plans are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

In order to be eligible to enroll in a One Care plan, a MassHealth member must meet all of the following criteria:

- be aged 21 through 64 at the time of enrollment;
- be eligible for MassHealth Standard as defined in 130 CMR 450.105(A) or MassHealth CommonHealth as defined in 130 CMR 450.105(E);
- be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001; and
- live in a designated service area of a One Care plan.

In addition, Duals Demonstration enrollees eligible for MassHealth Standard may elect to remain in the Duals Demonstration after age 65.

One Care plans will employ or contract with a network of providers that will deliver team-based integrated medical and behavioral-health care and long-term services and supports and will coordinate care across providers. The Interdisciplinary Care Team, led by a care coordinator and, if appropriate, an independent living and long-term services and supports coordinator, will arrange for the availability of care and services by specialists, hospitals, and providers of long-term services and supports and other community supports. The One Care plan will be the direct payer for all covered services.

Enrollment in a One Care plan for eligible members will start on or after October 1, 2013.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website 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.

These regulations are effective October 1, 2013.

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

All Provider Manuals

Pages 1-1 through 1-12 and 1-17 through 1-18

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

All Provider Manuals

Pages 1-1 and 1-2 — transmitted by Transmittal Letter ALL-176
Pages 1-3 and 1-4 — transmitted by Transmittal Letter ALL-171
Pages 1-5 through 1-12 — transmitted by Transmittal Letter ALL-178
Pages 1-17 through 1-18 — transmitted by Transmittal Letter ALL-200

450.101: Definitions

A number of common words and expressions are specifically defined here. Whenever one of them is used in 130 CMR 450.000, or in a provider contract, it will have the meaning given in the definition, unless the context clearly requires a different meaning. When appropriate, definitions may include a reference to federal and state laws and regulations.

Administrative Action — a measure taken by the MassHealth agency to correct or prevent the recurrence of an unacceptable course of action by a provider, including but not limited to the imposition of an administrative fine or other sanction.

Applicant — a person who completes and submits an application for MassHealth, and is awaiting the decision of eligibility.

Audit — an examination by the MassHealth agency of a provider's practices by means of an on-site visit, a review of the MassHealth agency's claim and payment records, a review of a provider's financial, medical, and other records such as prior authorizations, invoices, and cost reports. The MassHealth agency conducts audits to ensure provider and member compliance with laws and regulations governing MassHealth.

Billing Agent — an entity that contracts with a provider to act as the provider's representative for the preparation and submission of claims.

Claim — a request by a provider for payment for a medical service or product, identified in a format approved by the MassHealth agency, that contains information including member information, date of service, and description of service provided.

Commissioner — the commissioner of the Division of Medical Assistance appointed pursuant to M.G.L. c. 118E, § 2.

Coverage Type — a scope of medical services, other benefits, or both that are available to members who meet specific eligibility criteria.

Day — a calendar day unless a business day is specified.

DHCFP — the Massachusetts Division of Health Care Finance and Policy.

Division — the Massachusetts Division of Medical Assistance organized under M.G.L. c. 118E, or its agent.

Duals Demonstration Dual Eligible Individual — for purposes of the Duals Demonstration Program, a MassHealth member must meet all of the following criteria:

(1) be aged 21 through 64 at the time of enrollment;
(2) be eligible for MassHealth Standard as defined in 130 CMR 450.105(A) or MassHealth CommonHealth as defined in 130 CMR 450.105(E);
(3) be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*; and
(4) live in a designated service area of an integrated care organization (ICO).

Duals Demonstration Program — the MassHealth state Demonstration to Integrate Care for Duals Demonstration Dual Eligible Individuals.

Eligibility Verification System (EVS) — the member eligibility verification system accessible to providers. EVS also may be referred to as the Recipient Eligibility Verification System (REVS).

Emergency Aid to the Elderly, Disabled and Children Program (EAEDC) — a cash assistance program administered by the Department of Transitional Assistance for certain residents of Massachusetts that also covers certain medical services. The medical services component of the program is administered by the MassHealth agency.

Emergency Medical Condition — a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Emergency Services — medical services that are provided by a provider that is qualified to provide such services, and are needed to evaluate or stabilize an emergency medical condition.

Final Disposition — a written response by a health insurer to a request for payment, such as a rejection notice, an explanation of benefits (EOB), or a similar letter or form, by which the insurer either denies coverage, or acknowledges coverage and indicates the amount that the health insurer will pay.

Group Practice — a legal entity that employs or contracts with individual practitioners who have arranged for the joint use of facilities, and for payment into a common account of proceeds from the delivery of medical services by individual practitioners within the group. A sole proprietorship is not a group practice. An entity that qualifies under the MassHealth agency's program regulations as another discreet provider type, such as a community health center, is not a group practice. A "participant" in a group practice is any owner, employee, contractor, or provider delivering services through the group practice.

Health Insurer — a private or public entity (including Medicare) that has issued a health insurance plan or policy under which it has agreed to pay for medical services provided to a member.

Individual Practitioners — physicians, dentists, psychologists, nurse practitioners, nurse midwives, and certain other licensed, registered, or certified medical practitioners.

Integrated Care Organization (ICO) — an organization with a comprehensive network of medical, behavioral-health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with the Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare & Medicaid Services (CMS) and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

Managed Care — a system of primary care and other medical services that are provided and coordinated by a MassHealth managed care provider in accordance with the provisions of 130 CMR 450.117 et seq. and 130 CMR 508.000: *MassHealth: Managed Care Requirements*.

Managed Care Organization (MCO) — any entity with which the MassHealth agency contracts to provide and coordinate care and certain other medical services to members on a capitated basis, including a senior care organization (SCO), an integrated care organization (ICO), or an entity that is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO), or that otherwise meets the State Plan definition of an HMO.

MassHealth — the medical assistance and benefit programs administered by the MassHealth agency pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

MassHealth Agency — the Executive Office of Health and Human Services in accordance with the provisions of M.G.L. c. 118E.

MassHealth Enrollment Center (MEC) — a regional office of MassHealth that determines MassHealth eligibility of individuals and families who do not receive cash assistance (TAFDC, EAEDC, SSI).

MassHealth Managed Care Provider — a Primary Care Clinician participating in the Primary Care Clinician Plan or a managed care organization that has contracted with the MassHealth agency to provide and coordinate primary care and certain other medical services to certain MassHealth members.

Medicaid — see "MassHealth."

Medical Services — medical or related care, including goods and services provided to members, the cost of which is paid or payable by the MassHealth agency.

Medicare — a federally administered health insurance program for persons eligible under the Health Insurance for the Aged Act, Title XVIII of the Social Security Act (42 U.S.C. 1395-1395pp).

Member — a person determined by the MassHealth agency to be eligible for MassHealth.

Multiple-Source Drug — a drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

Overpayment — a payment made by the MassHealth agency to or for the use of a provider to which the provider was not entitled under applicable federal and state laws and regulations.

Over-the-Counter-Drug — any drug for which no prescription is required by federal or state law. These drugs are sometimes referred to as nonlegend drugs.

Party in Interest — a person with an ownership or control interest.

Peer Review — an evaluation of the quality, necessity, and appropriateness of medical services provided by a provider, to determine compliance with professionally recognized standards of health care or compliance with laws, rules, and regulations under which MassHealth is administered.

Prescription Drug — any drug for which a prescription is required by applicable federal or state law or regulation, other than MassHealth regulations. These drugs are sometimes referred to as legend drugs.

Primary Care — the provision of coordinated, comprehensive medical services, on both a first-contact and a continuous basis, to members enrolled in managed care. Services include an initial medical history intake, medical diagnosis and treatment, communication of information about illness prevention, health maintenance, and referral services.

Primary Care Clinician (PCC) Plan — a managed care option administered by the MassHealth agency through which enrolled members receive primary care and certain other medical services.

Provider — an individual, group, facility, agency, institution, organization, or business that furnishes medical services and participates in MassHealth under a provider contract with the MassHealth agency. For purposes of applying 130 CMR 450.235 through 450.240, the term "provider" includes formerly participating providers.

Provider Contract (also referred to as “Provider Agreement”) — a contract between the MassHealth agency and a contractor for medical services.

Provider Type — a provider classification specifying and limiting the kinds of medical services for which the provider may be paid under MassHealth.

Provider under Common Ownership — two or more providers in which a person or corporation has or had, at any time, an ownership or control interest, whether concurrently, sequentially, or otherwise. See 130 CMR 450.221(A)(9)(a), (b), (c), or (f).

Sanction — an administrative penalty imposed by the MassHealth agency pursuant to M.G.L. c. 118E, §37 against a provider found to have violated MassHealth laws, regulations, or contract requirements. Sanctions include, but are not limited to, administrative fines, suspension, and termination from participation in MassHealth.

Senior Care Organization (SCO) — an organization that participates in MassHealth under a contract with the MassHealth agency and the Centers for Medicare & Medicaid Services (CMS) to provide a comprehensive network of medical, health-care, and social-service providers and that integrates components of care, either directly or through subcontracts. Senior care organizations are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

Statutory Prerequisite — any license, certificate, permit, or other requirement imposed by state or federal law or regulation as a precondition to the practice of any profession or to the operation of any business or institution in or by which medical services are provided. Statutory prerequisites include, but are not limited to, licenses required by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health, licenses and certificates issued by the

Massachusetts boards of registration, and certificates required by the Massachusetts Department of Public Safety.

Third Party — any individual, entity, or program other than MassHealth that is or may be liable to pay all or part of the costs for medical services.

Transitional Aid to Families with Dependent Children (TAFDC) — a federally funded program administered by the Massachusetts Department of Transitional Assistance that provides cash assistance to certain low-income families.

Urgent Care — medical services that are not primary care, and are needed to treat a medical condition that is not an emergency medical condition.

450.102: Purpose of 130 CMR 400.000 through 499.000

130 CMR 400.000 through 499.000 contain the MassHealth agency's 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 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 Executive Office of Health and Human Services (EOHHS).

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 agency's regulations and applicable federal laws and regulations, the MassHealth agency's 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), the MassHealth agency's regulations shall be construed so far as possible to make them consistent with the federal Health Insurance Portability and Accountability Act (HIPAA), including federal regulations promulgated thereunder. 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 agency 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: *MassHealth Standard* and 130 CMR 519.002: *MassHealth Standard*).

(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: *MassHealth: Managed Care Requirements*.)

(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: *Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization* 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) (i) MassHealth Standard members who participate in a senior care organization receive all behavioral-health services only through the senior care organization.
(ii) MassHealth Standard members who participate in an integrated care organization receive all behavioral-health services through the integrated 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: *Adoption Assistance and Foster Care Maintenance* 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): *Women with Breast or Cervical Cancer*, 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 (SCO) in accordance with the requirements under 130 CMR 508.008: *Voluntary Enrollment in Senior Care Organizations.* The MassHealth agency does not pay a provider other than a SCO for any services that are provided to the MassHealth member while the member is enrolled in a SCO.

(7) Integrated Care Organizations. MassHealth Standard members aged 21 through 64 who are enrolled in Medicare Parts A and B, are eligible for Medicare Part D, and have no access to other health insurance that meets the basic-benefit level defined in 130 CMR 501.001: *Definition of Terms* may voluntarily enroll in integrated care organization (ICO) in accordance with the requirements at 130 CMR 508.007: *Eligibility and Enrollment in an Integrated Care Organization*. While enrolled in an ICO, MassHealth members who turn 65 and are eligible for MassHealth Standard may remain in an ICO after age 65. The MassHealth agency does not pay a provider other than the ICO for any services that are provided by an ICO while the member is enrolled in the ICO, except for family planning services that were not provided or arranged for by the ICO. It is the responsibility of the provider of services to determine if a MassHealth member is enrolled in an ICO. Upon request, the ICO must inform providers and enrollees of ICO-covered benefits. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

(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: *MassHealth Basic*):

(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: *MassHealth Basic* 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.

(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: *MassHealth Buy-In*), 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: *Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization*.

(D) MassHealth Senior Buy-In.
(1) Covered Services. For MassHealth Senior Buy-In members (see 130 CMR 519.010: *MassHealth Senior Buy-In*), 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: *Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization*.

(E) MassHealth CommonHealth.
(1) Covered Services. The following services are covered for MassHealth CommonHealth members (see 130 CMR 505.004: *MassHealth CommonHealth* and 519.012: *MassHealth CommonHealth*).
(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: *MassHealth: Managed Care Requirements*.)

(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 choose 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.

(4) Integrated Care Organizations. MassHealth CommonHealth members aged 21 through 64 who are enrolled in Medicare Parts A and B, are eligible for Medicare Part D, and have no access to other health insurance that meets the basic-benefit level defined in 130 CMR 501.001: *Definition of Terms* may voluntarily enroll in an integrated care organization (ICO) in accordance with the requirements at 130 CMR 508.007: *Eligibility and Enrollment in an Integrated Care Organization*. The MassHealth agency does not pay a provider other than the ICO for any services that are provided by an ICO while the member is enrolled in the ICO, except for family planning services that were not provided or arranged for by the ICO. It is the responsibility of the provider of services to determine if a MassHealth member is enrolled in an ICO. Upon request, the ICO must inform providers and enrollees of ICO-covered benefits. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

(F) MassHealth Prenatal.

(1) Covered Services. For MassHealth Prenatal members (see 130 CMR 505.003: *MassHealth Prenatal*), 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: *Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization*.

(G) MassHealth Limited.

(1) Covered Services. For MassHealth Limited members (see 130 CMR 505.008: *Voluntary Enrollment in Senior Care Organizations* and 519.009: *MassHealth Limited*), 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*: Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization.*

(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): *Premium Assistance for Children*, (C): *Premium Assistance for Adults* or (D): *Premium Assistance for Persons Who Are HIV Positive*.

(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: *Dental Services*.

(c) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(D): *Premium Assistance for Persons Who Are HIV Positive*, 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): *Copays, Coinsurance, and Deductibles*, 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).

(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 Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization*. Members excluded from managed care under 130 CMR 508.004: *Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization* 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 (SCO) for MassHealth Standard members aged 65 and over, who voluntarily enroll in a SCO in accordance with the requirements under 130 CMR 508.008: *Voluntary Enrollment in Senior Care Organizations*.

(1) Members who participate in a SCO must select a primary care provider.

(2) Members who participate in a SCO obtain all covered services through the SCO.

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

(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: *Adoption Assistance and Foster Care Maintenance* 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.

(J) MassHealth-contracted MCOs, SCOs, and integrated care organizations (ICOs), and their contracted behavioral health management firms or third party administrators, if any, must comply with and implement relevant provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Federal Mental Health Parity Law), and its implementing regulations and federal guidance, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations.

(1) Annual Certification of Compliance with Federal Mental Health Parity Law: The above referenced managed care entities must review their administrative and other practices, including the administrative and other practices of any contracted behavioral health organizations or third party administrators, for the prior calendar year for compliance with the relevant provisions Federal Mental Health Parity Law, regulations and guidance.

(a) Managed care entities must submit a certification signed by the chief executive officer and chief medical officer stating that the managed care entity has completed a comprehensive review of the administrative practices of the managed care entity for the prior calendar year for compliance with the necessary provisions of State Mental Health Parity Laws and Federal Mental Health Parity Law.

(b) If the managed care entity determines that all administrative and other practices were in compliance with relevant requirements of the Federal Mental Health Parity Law during the calendar year, the certification will describe how its relevant administrative and other practices were in compliance with Federal Mental Health Parity Law.

(c) If the managed care entity determines that any administrative or other practices were not in compliance with relevant requirements of the Federal Mental Health Parity Law during the prior calendar year, the certification will describe how its relevant administrative and other practices were in compliance with Federal Mental Health Parity Law, will include a list of the practices not in compliance, and the steps the managed care entity has taken to bring these practices into compliance.

(2) These managed care entities and their contracted behavioral health management firms or third party administrators, if any, must provide medical necessity criteria for prior authorization upon the request of a MassHealth member, a MassHealth provider, or the MassHealth agency. This requirement may be fulfilled by publishing the criteria on the entity's website.

(3) A member enrolled in any of these managed care entities may file a grievance with MassHealth if the member believes that services are provided in a way that is not consistent with applicable Federal Mental Health Parity laws, regulations or federal guidance. Member grievances may be communicated for resolution verbally or in writing to MassHealth's customer services contractor. MassHealth will investigate and resolve the grievance with the managed care entity within 30 business days of the receipt of the grievance.

(4) These managed care entities and their contracted behavioral health management firms or third party administrators, if any, must include in member handbooks or other guidance provided to members a description of the Federal Mental Health Parity Law, the member's right to file a grievance with them, and the policies and procedures for the receipt and timely resolution of such grievances.

(K) MassHealth managed care options include an integrated care organization (ICO) for MassHealth Standard and CommonHealth members who also meet the requirements for eligibility set forth under 130 CMR 508.007: *Eligibility and Enrollment in an Integrated Care Organization*.

(1) Members who participate in an ICO must choose or be assigned a primary care provider.

(2) Members who participate in an ICO obtain all covered services through the ICO.

(3) Members who enroll in the Duals Demonstration Program may continue to receive services from their current providers who accept current Medicare or Medicaid fee-for-service provider rates during a continuity-of-care period. A continuity-of-care period is a period beginning on the date of enrollment into the Duals Demonstration Program and extends to either of the following:

(a) up to 90 days, unless the comprehensive assessment and the individualized-care plan are completed sooner and the enrollee agrees to the shorter time period; or

(b) until the comprehensive assessment and the individualized-care plan are complete.

(4) Members who are enrolled in an ICO are identified on EVS (see 130 CMR 450.107). For a MassHealth member enrolled with an ICO, EVS will identify the name and telephone number of the ICO. The MassHealth agency will not pay an entity other than an ICO for any services that are provided to the MassHealth member while the member is enrolled in an ICO, except for family planning services that were not provided or arranged for by the ICO.