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

MassHealth
Transmittal Letter ALL-216
October 2016

TO: All Providers Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: *All Provider Manuals* (Payment Reform Regulations)

As part of its delivery system reform efforts, MassHealth has revised its regulations at 130 CMR 450.000 to remove a number of services from the list of services exempt from the Primary Care Clinician (PCC) Plan referral requirement effective October 1, 2016. Presently, services rendered by a provider other than the member's assigned MassHealth PCC require a referral from the member's PCC unless the service(s) are exempted from the PCC Plan requirement.

The following services are no longer exempt from the PCC Plan referral requirement and, accordingly, were removed from 103 CMR 450.118(J)(5): *Exceptions to Services Requiring Referrals*:

- Chiropractor Services;
- Hearing Instrument Specialist Services;
- Medical Nutrition Therapy/Diabetes Self-Management Training;
- Orthotic Services;
- Prosthetic Services; and
- Imaging Services conducted at an Independent Diagnostic Testing Facility (IDTF).

MassHealth members who enroll in the PCC Plan can still obtain these services as long as a referral is provided by the member's assigned PCC. Providers who deliver these services to PCC Plan members should ensure that the member has obtained a referral from his or her assigned PCC for the service. Additional information can be found in All-Provider Bulletin 260.

130 CMR 450.118(J) was also amended to exempt certain services provided to members whose PCC participates in a MassHealth accountable care organization from the PCC Plan referral requirement, subject to bulletins and other issuances more particularly describing applicable referral requirements.

Modifications to 130 CMR 450.00 also include changes to 130 CMR 450.117(A): *Manage Care Participation* section, to introduce the Managed Care Plan Selection and Fixed Enrollment Periods for members enrolled in contracted managed care organizations (MCO). Details regarding these new rules are set forth in 130 CMR 508.000, *MassHealth Managed Care Requirements*. Modifications to 130 CMR 450.000 also include changes to update cross-references to 130 CMR 580.000, as amended.

These regulations are effective October 1, 2016.

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 the MassHealth Customer Service Center 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 1-7 through 1-14 and 1-21 through 1-30

OBSOLETE MATERIAL

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

All Provider Manuals

Pages 1-7 through 1-14 and 1-21 through 1-30 — transmitted by Transmittal Letter ALL-205

(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 and 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.)

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

(c) MassHealth Standard members who are excluded from participating in managed care under 130 CMR 508.002: *MassHealth Members Excluded from Participation in Managed Care* 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) 1. MassHealth Standard members who participate in a senior care organization receive all behavioral-health services only through the senior care organization.
2. 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 younger than 21 years old and who are excluded from participating in a MassHealth-contracted MCO under 130 CMR 508.002(A)(1) or (2) or the PCC Plan under 130 CMR 508.002(B)(1) or (2) must enroll with the MassHealth behavioral-health contractor.

(f) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program*, or who are enrolled in a home- and community-based services waiver 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.

(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(F): *Individuals 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 65 years of age and older may voluntarily enroll in a senior care organization (SCO) in accordance with the requirements under 130 CMR 508.008: *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 21 through 64 years of age who are enrolled in Medicare Parts A and B, are eligible for Medicare Part D, and have no 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: *Integrated Care Organizations*. While enrolled in an ICO, MassHealth members who turn 65 years of age and are eligible for MassHealth Standard may remain in an ICO after 65 years of age. 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 CarePlus.

(1) Covered Services. The following services are covered for MassHealth CarePlus members (*see* 130 CMR 505.008: *MassHealth CarePlus*.):

(a) abortion services;
(b) acute inpatient hospital services;
(c) ambulance services;
(d) ambulatory surgery services;
(e) audiologist services;
(f) behavioral health (mental health and substance abuse) services;
(g) chiropractor services;
(h) chronic disease and rehabilitation inpatient hospital 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) hospice services;
(p) laboratory services;
(q) nurse midwife services;
(r) nurse practitioner services;
(s) nursing facility services;
(t) orthotic services;
(u) outpatient hospital services;
(v) oxygen and respiratory therapy equipment;
(w) pharmacy services;
(x) physician services;
(y) podiatrist services;
(z) prosthetic services;
(aa) rehabilitation services;
(bb) renal dialysis services;
(cc) speech and hearing services;
(dd) therapy services: physical, occupational, and speech/language;
(ee) transportation services;
(ff) vision care; and
(gg) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth CarePlus members must enroll with a MassHealth managed care provider in accordance with 130 CMR 508.001: *MassHealth Member Participation in Managed Care*. (*See* also 130 CMR 450.117.)

(3) Managed Care Organizations. For MassHealth CarePlus members who are enrolled in a MassHealth-contracted 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(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.

(4) Behavioral-health Services.

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

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

(c) MassHealth CarePlus members who are excluded from participating in managed care under 130 CMR 508.002: *MassHealth Members Excluded from Participation in Managed Care* or who have not enrolled in an MCO or the PCC Plan may receive behavioral-health services from any participating MassHealth provider of such services.

(5) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for MassHealth CarePlus members, with the exception of members described at 130 CMR 505.002(F): *Individuals 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(B)(1) that are not available through the member's third-party health insurer.

(C) MassHealth Buy-In.

(1) For a MassHealth Buy-In member who is 65 years of age 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 508.002: *MassHealth Members Excluded from Participation in Managed Care*.

(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 508.002: *MassHealth Members Excluded from Participation in Managed Care*.

(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 and 508.000: *Managed Care Requirements*.)

(b) MassHealth CommonHealth members who are younger than 21 years old and who are excluded from participation in a MassHealth-contracted MCO under 130 CMR 508.002(A)(1) or (2) or in the PCC Plan under 130 CMR 508.002(B) (1) or (2) must enroll with the MassHealth behavioral-health contractor.

(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 21 through 64 years of age who are enrolled in Medicare Parts A and B, are eligible for Medicare Part D, and have no 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: *Integrated Care Organizations*. 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 Limited.

(1) Covered Services. For MassHealth Limited members (*see* 130 CMR 505.006: *MassHealth Limited* 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(F)(1).

(3) Managed Care Member Participation. MassHealth Limited members are excluded from participation in managed care pursuant to 130 CMR 508.002: *MassHealth Members Excluded from Participation in Managed Care*.

(G) 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) 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).

(b) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B): *Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household greater than 150 and less than or Equal to 300% of the Federal Poverty Level*, 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): *Eligibility Requirements for Adults and Young Adults Aged 19 and 20 Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 300% of the Federal Poverty Level*, the MassHealth agency issues a MassHealth card and provides

1. full payment of the member's private health-insurance premium; and
2. coverage of any services listed in 130 CMR 450.105(H) 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): *Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household greater than 150 and less than or equal to 300 Percent of the Federal Poverty Level*, the MassHealth agency pays providers directly, or reimburses the member, for

1. copayments, coinsurance, and deductibles relating to well-baby and well-child care; and
2. 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), (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.

(a) MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(E): *Eligibility Requirement for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or equal to 200 Percent of the Federal Poverty Level*, must enroll with a Primary Care Clinician (PCC) or a MassHealth-contracted managed care organization (MCO). (*See* 130 CMR 450.117.)

450.117: Managed Care Participation

(A) MassHealth members younger than 65 years old are required to enroll in the Primary Care Clinician (PCC) Plan or a MassHealth-contracted MCO available for their coverage type unless they are excluded from such participation under 130 CMR 450.117(E) through (I) or 508.002: *MassHealth Members Excluded from Participation in Managed Care* provided however, that MassHealth CarePlus members are required to enroll in such MassHealth managed care providers in accordance with 130 CMR 508.001: *MassHealth Member Participation in Managed Care.* Members excluded from managed care under 130 CMR 508.002: *MassHealth Members Excluded from Participation in Managed Care* receive MassHealth services for which they are eligible through any participating MassHealth provider. Members enrolled in a MassHealth-contracted MCO will have plan selection periods and fixed enrollment periods as set forth in 130 CMR 508.004(C): *Member Choice to Transfer or Disenroll from a MassHealth-contracted MCO* and 508.004(E): *Reenrollment*.

(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 65 years of age or older, who voluntarily enroll in a SCO in accordance with the requirements under 130 CMR 508.008: *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 younger than 21 years old and who are excluded from participation ina MassHealth-contracted MCO under 130 CMR 508.002(A)(1) or (2) or the PCC Plan under 130 CMR 508.002(B)(1) or (2) must enroll with the MassHealth behavioral-health contractor.

(F) MassHealth members who are enrolled in the Kaileigh Mulligan Program described at 130 CMR 519.007(A): *The Kaileigh Mulligan Program* or who are enrolled in a home- and community-based services waiver 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.

(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 a health care program, including contracted health services, operated by the Indian Health Service or by an Indian tribe, Tribal Organization, or Urban Indian Organization as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(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 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 affirmatively state that all 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 state that not all practices were in compliance with Federal Mental Health Parity Law, and 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) 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.

(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: *Integrated Care Organizations*.

(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.

450.118: Primary Care Clinician (PCC) Plan

(A) Role of Primary Care Clinician. The PCC is the principal source of care for members who are enrolled in the PCC Plan. All services for which such a member is eligible, except those listed in 130 CMR 450.118(J), are payable only when provided by the member's PCC, or when the PCC has referred the member to another MassHealth provider.

(B) Provider Eligibility. Providers who wish to enroll as PCCs must be participating providers in MassHealth, must complete a PCC provider application, which is subject to approval by the MassHealth agency, and must meet the requirements of the PCC provider contract. The following provider types may apply to the MassHealth agency to become PCCs:

(1) individual physicians who have current admitting privileges to at least one MassHealth-participating Massachusetts acute hospital in the physician's service area that participates in MassHealth or who meet 130 CMR 450.118(F)(1), and who are board-eligible or board-certified in family practice, pediatrics, internal medicine, obstetrics, gynecology, or obstetrics/gynecology, or who meet 130 CMR 450.118(F)(2);

(2) independent nurse practitioners who have a collaborative arrangement with a MassHealth-participating physician who meets the criteria of 130 CMR 450.118(B)(1) and who is in the nurse practitioner's service area;

(3) community health centers (freestanding or hospital-licensed) with at least one physician on staff who meets the criteria of 130 CMR 450.118(B)(1);

(4) acute hospital outpatient departments with at least one physician on staff who meets the criteria of 130 CMR 450.118(B)(1); and

(5) group practices with at least one physician or nurse practitioner who

(a) is enrolled and approved by the MassHealth agency as a participating provider in that group;

(b) meets the requirements of 130 CMR 450.118(B)(1) or (2); and

(c) has signed the PCC contract.

(C) Community Health Center Participation. When a community health center participates as a PCC, it must assign each enrollee to an individual practitioner who meets the requirements of 130 CMR 450.118(B)(1) or (2).

(D) Hospital Outpatient Department Participation. When a hospital outpatient department participates as a PCC, it must assign each enrollee to an attending physician who meets the requirements of 130 CMR 450.118(B)(1).

(E) Group Practice Participation. When a group practice participates as a PCC, the group practice

(1) may claim an enhanced fee only for services provided by those individual practitioners within the group who meet the requirements of 130 CMR 450.118(B)(1) or (2); and

(2) must assign each enrollee to an individual practitioner who meets the criteria under 130 CMR 450.118(B)(1) or (2).

(F) Waiver of Eligibility Requirements. The MassHealth agency may, if necessary to ensure adequate member access to services, and under the following circumstances, allow an individual physician to enroll as a PCC or as a physician in a group practice PCC notwithstanding the physician's inability to meet certain eligibility requirements set forth in 130 CMR 450.118(B)(1).

(1) Upon written request from a physician, the MassHealth agency may waive the requirement that an individual physician or a physician in a group practice have admitting privileges to at least one MassHealth-participating Massachusetts acute hospital, if the physician demonstrates to the MassHealth agency's satisfaction that the physician:

(a) practices in an area that is too distant to adequately respond to emergencies at the nearest acute hospital or where lack of admitting privileges is common for physicians practicing in that area;

(b) admits exclusively to acute hospitals that employ one or more physicians to care for their inpatient census, provided that the hospital's medical director agrees to admit and care for the physician's patients through the use of such physicians employed by the hospital; or

(c) establishes a collaborative relationship with a physician participating in MassHealth who has admitting privileges at the acute hospital closest to the requesting physician's office and who will assume responsibility for admitting the requesting physician's managed care members to that hospital when necessary.

(2) Upon written request from a physician, the MassHealth agency may waive the requirement that the individual physician or physician in a group practice is board-eligible or board-certified in family practice, pediatrics, internal medicine, obstetrics, gynecology, or obstetrics/gynecology, if the physician is board-eligible or board-certified in another medical specialty, and otherwise meets the requirements of 130 CMR 450.118.

(G) PCC Provider Qualifications Grandfathering Provision. Notwithstanding the generality of the provisions of 130 CMR 450.118, any provider who is continuously enrolled as a PCC before April 1, 2003, is subject to the PCC provider eligibility requirements in effect on and before March 31, 2003.

(H) Rate of Payment. The MassHealth agency pays PCCs an enhanced fee for primary care services, in accordance with the terms of the PCC provider contract.

(I) Termination.

(1) If the MassHealth agency determines that a PCC fails to fulfill any of the obligations stated in the MassHealth agency's regulations or PCC contract, the MassHealth agency may terminate the PCC contract in accordance with its terms. To the extent required by law, a pretermination hearing will be held in substantial conformity with the procedures set forth in 130 CMR 450.238 through 450.248.

(2) If the MassHealth agency determines that an individual practitioner within a PCC group practice fails to fulfill any of the obligations stated in the MassHealth agency's regulations or the PCC contract, the MassHealth agency may terminate the PCC contract pursuant to 130 CMR 450.118(I)(1), or require the group practice to stop assigning enrollees to such practitioner and to reassign existing enrollees to other practitioners in the group who meet the requirements of 130 CMR 450.118(B)(1) or (2).

(J) Referral for Services.

(1) Referral Requirement. All services provided by a clinician or provider other than the PCC Plan member's PCC require referral from the member's PCC in order to be payable, unless the service is exempted under 130 CMR 450.118(J)(5). This referral requirement also applies to services delivered by individual practitioners who are part of a group practice PCC and who have not been identified by the group practice as providers who may be assigned PCC Plan members under 130 CMR 450.118(E). In order to make a referral, PCCs must follow the processes described in the PCC provider contract.

(2) Time Frames for Referral. Whenever possible, the PCC should make the referral before the member's receipt of the service. However, the PCC may issue a referral retroactively if the PCC determines that the service was medically necessary at the time of receipt.

(3) Payment for Services Requiring Referral. The MassHealth agency pays a provider other than the member's PCC for services that require a PCC referral only when a referral has been submitted by the member's PCC.

(4) Services Requiring Referrals. See 130 CMR 450.105 for a list of the services covered for each MassHealth coverage type and applicable program regulations for descriptions of covered services and specific service limitations. Prior-authorization requirements are described in 130 CMR 450.303, 450.144(A)(2), and applicable program regulations and subregulatory publications. Payment for services is subject to all conditions and restrictions of MassHealth, including but not limited to, the scope of covered services for a member's coverage type, service limitations, and prior-authorization requirements.

(5) Exceptions to Services Requiring Referrals. Notwithstanding 130 CMR 450.118(J)(4), the following services provided by a clinician or other provider other than the member's PCC do not require a referral from the member's PCC in order to be payable:

(a) abortion services;
(b) annual gynecological exams;
(c) clinical laboratory services;
(d) diabetic supplies;
(e) durable medical equipment (items, supplies, and equipment) described in 130 CMR 409.000: *Durable Medical Equipment Services*;
(f) fiscal intermediary services as described in 130 CMR 422.419(B): *The Fiscal Intermediary;*
(g) fluoride varnish administered by a physician or other qualified medical professional;
(h) functional skills training provided by a MassHealth personal care management agency as described in 130 CMR 422.421(B): *Functional Skills Training*;
(i) HIV pre- and post-test counseling services;
(j) HIV testing;
(k) hospitalization

1. Elective Admissions. All elective admissions are exempt from the PCC referral requirement and are subject to the MassHealth agency's admission screening requirements at 130 CMR 450.208(A). The hospital must notify the member's PCC within 48 hours following an elective admission;
2. Nonelective Admissions. Nonelective admissions are exempt from the PCC referral requirement. The hospital must notify the member's PCC within 48 hours following a nonelective admission;

(l) obstetric services for pregnant and postpartum members provided up to to the end of the month in which the 60-day period following the termination of pregnancy ends;
(m) oxygen and respiratory therapy equipment;
(n) pharmacy services (prescription and over-the-counter drugs);
(o) radiology and other imaging services with the exception of magnetic resonance imaging (MRI) computed tomography (CT) scans, positron emission tomography (PET) scans, and imaging services conducted at an independent diagnostic testing facility (IDTF), which do require a referral;
(p) services delivered by a behavioral health (mental health and substance abuse) provider (including inpatient and outpatient psychiatric services);
(q) services delivered by a dentist;
(r) services delivered by a family planning service provider, for members of child-bearing age;
(s) services delivered by a hospice provider;
(t) services delivered by a limited service clinic;
(u) services delivered in a nursing facility;
(v) services delivered by an anesthesiologist;
(w) services delivered in an intermediate care facility for the mentally retarded (ICF-MR);
(x) services delivered to a homeless member outside of the PCC office pursuant to 130 CMR 450.118(K);
(y) services delivered to diagnose and treat sexually transmitted diseases;
(z) services delivered to treat an emergency condition;
(aa) services provided under a home- and community-based waiver;
(bb) sterilization services when performed for family planning services;
(cc) surgical pathology services;
(dd) tobacco-cessation counseling services;
(ee) transportation to covered care;
(ff) vision care in the following categories (*see* Subchapter 6 of the *Vision Care Manual*): visual analysis frames, single-vision prescriptions, bifocal prescriptions, and repairs; and
(gg) additional services provided to members whose PCC participates in an Accountable Care Organization (ACO) subject to bulletins and other issuances more particularly describing applicable referral requirements.

(K) Services to Homeless Members. To provide services to homeless members according to 130 CMR 450.118(J)(5)(cc), the provider must furnish written evidence of demonstrated experience in delivering medical care in a nonmedical setting, and request, in writing, designation from the MassHealth agency that the PCC is approved to provide services to homeless members. The MassHealth agency retains the right to approve or disapprove such a request or revoke an approval of such a request at any time.

(L) Recordkeeping and Reporting.

(1) PCC Recordkeeping Requirement. The PCC must document all referrals in the member's medical record by recording the following:

(a) the date of the referral;
(b) the name of the provider to whom the member was referred;
(c) the reason for the referral;
(d) number of visits authorized; and
(e) copies of the reports required by 130 CMR 450.118(L)(2).

(2) Reporting Requirements. The PCC who made the referral must obtain from the provider who furnished the service the results of the referred visit by telephone and in writing whenever legally possible.

(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 508.002: *MassHealth Members Excluded from Participation in Managed Care.*

(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 or quarterly maximums set forth in 130 CMR 450.130(C).
(*See* also 130 CMR 506.011 through 506.019, 508.004(F), 508.005(F), 508.007(G), 508.008(G), 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) Maximum Cost Sharing. Members are responsible for the MassHealth copayments described in 130 CMR 450.130(B), up to the following maximums:

(1) $250 for pharmacy services per calendar year;
(2) $36 for nonpharmacy services per calendar year; and
(3) five percent of the member's MAGI income of the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable, in a given calendar quarter, including both copayments and any applicable premium payments.

(D) Excluded Individuals.

(1) The following individuals do not have to pay the copayments described in 130 CMR 450.130(B):
(a) members younger than 21 years old;
(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;