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

MassHealth
Transmittal Letter ALL-226
September 2018

TO: All Providers Participating in MassHealth

FROM: Dan Tsai, Assistant Secretary for MassHealth

RE: All Provider Manuals (One Care and Medication Assisted Treatment (MAT) Changes)

The changes to the Administrative and Billing regulations allow disabled individuals enrolled in One Care who turn 65 and are eligible for CommonHealth to remain enrolled in One Care, pursuant to authority MassHealth received in the November 2016, 1115 waiver amendment. Previously, this option was available only to members who were eligible for MassHealth Standard. In addition, these amendments update language related to terminology for the Duals Demonstration, ICOs, and One Care to reflect, e.g., that ICOs are now referred to as "One Care plans."

In addition, the referral requirement for medication assisted treatment (MAT) for opioid use disorder has been removed for the PCC Plan and Primary Care ACO programs.

These regulations are effective September 21, 2018.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth-transmittal-letters.

To sign up to receive email alerts when MassHealth issues new transmittal letters and provider bulletins, send a blank email to join-masshealth-provider-pubs@listserv.state.ma.us. No text in the body or subject line is needed.

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, email 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 1-9, 1-10, and 1-25 through 1-34

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 1-9, 1-10, and 1-25 through 1-34 — transmitted by Transmittal Letter ALL-224

(d) MassHealth Standard members who are younger than 21 years old and who are excluded from participating with a MassHealth managed care provider under 130 CMR 508.002(A)(1) or (2) must enroll with the MassHealth behavioral health contractor.

(e) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program* may choose to enroll with a MassHealth managed care provider. Such members who do not choose to enroll with a MassHealth managed care provider are enrolled with the MassHealth behavioral health contractor. Such members may choose to receive all services on a fee-for-service basis.

(f) 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 with a MassHealth managed care provider. Such members who do not choose to enroll with a MassHealth managed care provider must enroll with the MassHealth behavioral health contractor.

(g) 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 with a MassHealth managed care provider. Such members who do not choose to enroll with a MassHealth managed care provider are enrolled with the MassHealth behavioral health contractor. Such members may choose to receive all services on a fee-for-service basis.

(h) MassHealth members who participate in one of the Money Follows the Person home- and community-based services waivers who are not enrolled with a MassHealth managed care provider or not otherwise enrolled with the behavioral health contractor must enroll with the behavioral health contractor.

(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 or 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 old and are eligible for MassHealth CommonHealth may remain in One Care after the age of 65. While enrolled in an ICO, MassHealth members who turn 65 years of age and are eligible for MassHealth

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 enrolled members of ICO-covered benefits. ICOs are responsible for providing enrolled members 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) ambulance services;
(c) ambulatory surgery services;
(d) audiologist services;
(e) behavioral health services;
(f) certified nurse midwife services;
(g) certified nurse practitioner services;
(h) certified registered nurse anesthetist services;
(i) chiropractor services;
(j) clinical nurse specialist services;
(k) community health center services;
(l) dental services;
(m) durable medical equipment and supplies;
(n) family planning services;
(o) hearing aid services;
(p) home health services;
(q) hospice services;
(r) inpatient hospital services;
(s) laboratory services;
(t) nursing facility services;
(u) orthotic services;
(v) outpatient hospital services;
(w) oxygen and respiratory therapy equipment;
(x) pharmacy services;
(y) physician services;
(z) physician assistant services;
(aa) podiatrist services;
(bb) prosthetic services;

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

(D) Hospital Outpatient Department Participation. When a hospital outpatient department participates as a PCC, it must assign each enrolled member to an attending physician who meets the requirements of 130 CMR 450.118(B)(1) or (2).

(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 enrolled member to an individual practitioner who meets the criteria under 130 CMR 450.118(B)(1), (2), or (6).

(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 enrolled members to such practitioner and to reassign existing enrolled members 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). In order to make a referral, PCCs must follow the processes described in the PCC provider contract and must include the individual national provider indentifier (NPI) number of an individual practitioner who meets the criteria of 130 CMR 450.118(B)(1), (2), or (6). Please refer to 130 CMR 450.231, *General Conditions of Payments*, for additional requirements regarding referrals.

(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 and includes the individual NPI number of an individual practitioner who meets the criteria of 130 CMR 450.118(B)(1), (2), or (6).

(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 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 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, and 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 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 or a certified registered nurse anesthetist;
(w) services delivered in an intermediate care facility for individuals with intellectual disabilities (ICF/ID);

(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) medication assisted treatment (MAT) for opioid use disorder.

(K) Services to Homeless Members. To provide services to homeless members according to 130 CMR 450.118(J)(5)(x), 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.

450.119: Primary Care ACOs

(A) (1) Role of Primary Care ACO. Each Primary Care ACO is contracted with the MassHealth agency to coordinate and manage care for enrolled members.

(2) Role of Primary Care ACO's participating Primary Care Provider (participating PCP). The participating PCPs are the principal source of care for members who are enrolled in a Primary Care ACO. All services for which such a member is eligible, except those listed in 130 CMR 450.119(I), are payable only when provided by the member's participating PCP, or when the participating PCP has referred the member to another MassHealth provider.

(3) Role of Primary Care ACO's Referral Circle. Each Primary Care ACO may establish a referral circle of providers pursuant to its contract with the MassHealth agency.

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

(1) individual physicians who have current admitting privileges to at least one MassHealth-participating Massachusetts acute hospital that participates in MassHealth or who meet 130 CMR 450.119(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 450.119(F)(2);

(2) independent nurse practitioners who have a collaborative arrangement with a MassHealth-participating physician who meets the criteria of 130 CMR 450.119(B)(1);

(3) community health centers (freestanding or hospital-licensed) with at least one physician on staff who meets the criteria of 130 CMR 450.119(B)(1);

(4) acute hospital outpatient departments with at least one physician on staff who meets the criteria of 130 CMR 450.119(B)(1);

(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 450.119(B)(1) or (2); and

(c) has signed the participating PCP contract; and

(6) providers who are enrolled as PCCs pursuant to 130 CMR 450.118(G).

(C) Community Health Center Participation. When a community health center is a participating PCP, it must assign each enrollee to an individual practitioner who meets the requirements of 130 CMR 450.119(B)(1) or (2).

(D) Hospital Outpatient Department Participation. When a hospital outpatient department is a participating PCP, it must assign each enrollee to an attending physician who meets the requirements of 130 CMR 450.119(B)(1) or (2).

(E) Group Practice Participation. When a group practice participates as a participating PCP, 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 450.119(B)(1) or (2); and

(2) must assign each enrollee to an individual practitioner who meets the criteria under 130 CMR 450.119(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 participating PCP or as a physician in a group practice participating PCP notwithstanding the physician's inability to meet certain eligibility requirements set forth in 130 CMR 450.119(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 450.119.

(G) Rate of Payment. The MassHealth agency pays participating PCPs an enhanced fee for primary care services, in accordance with the terms of the participating PCP contract.

(H) Termination.

(1) If the MassHealth agency determines that a participating PCP has failed to fulfill any of the obligations stated in the MassHealth agency's regulations or participating PCP contract, the MassHealth agency may terminate the participating PCP 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 participating PCP group practice has failed to fulfill any of the obligations stated in the MassHealth agency's regulations or the participating PCP contract, the MassHealth agency may terminate the participating PCP contract pursuant to 130 CMR 450.119(H)(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 450.119(B)(1) or (2).

(I) Referral for Services.

(1) Referral Requirement. All services provided by a clinician or provider other than the Primary Care ACO member's participating PCP require referral from the member's participating PCP in order to be payable, unless the service is exempted under 130 CMR 450.119(I)(5). This referral requirement also applies to services delivered by individual practitioners who are part of a group practice participating PCP and who have not been identified by the group practice as providers who may be assigned Primary Care ACO members under 130 CMR 450.119(E). In order to make a referral, participating PCPs must follow the processes described in the participating PCP contract.

(2) Time Frames for Referral. Whenever possible, the participating PCP should make the referral before the member's receipt of the service. However, the participating PCP may issue a referral retroactively if the participating PCP 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 participating PCP for services that require a participating PCP referral only when a referral has been submitted by the member's participating PCP.

(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 450.119(I)(4), the following services provided by a clinician or other provider other than the member's participating PCP do not require a referral from the member's participating PCP 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 are provided up 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 individuals with intellectual disabilities (ICF/ID);
(x) services delivered to a homeless member outside of the participating PCP's office pursuant to 130 CMR 450.119(J);
(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;
(gg) medication assisted treatment (MAT) for opioid use disorder; and
(hh) additional services provided to members by providers in the member's Primary Care ACO's referral circle pursuant to the MassHealth agency's contract with the Primary Care ACO.

(J) Services to Homeless Members. To provide services to homeless members according to 130 CMR 450.119(I)(5)(x), 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 participating PCP 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.

(K) Recordkeeping and Reporting.

(1) Participating PCP Recordkeeping Requirement. The participating PCP 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 450.119(K)(2).

(2) Reporting Requirements. The participating PCP 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.

(L) 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.

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

(130 CMR 450.120 through 450.122 Reserved)

450.123: Managed Care Compliance with Mental Health Parity

(A) MCOs, Accountable Care Partnership Plans, SCOs, and ICOs and their behavioral health subcontractors 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.

(B) Annual Certification of Compliance with Federal Mental Health Parity Law. Each MCO, Accountable Care Partnership Plan, SCO, and ICO must annually review its administrative and other practices, including the administrative and other practices of any behavioral health subcontractors or third party administrators, for compliance with the relevant provisions Federal Mental Health Parity Law, regulations, and guidance.

(1) Each MCO, Accountable Care Partnership Plan, SCO, and ICO must submit a certification signed by the chief executive officer and chief medical officer stating that the entity has completed a comprehensive review of the administrative practices of the entity for compliance with the necessary provisions of State Mental Health Parity Laws and Federal Mental Health Parity Law.

(2) If the MCO, Accountable Care Partnership Plan, SCO, or ICO determines that all administrative and other practices were in compliance with relevant requirements of the Federal Mental Health Parity Law, the annual certification will affirmatively state that all relevant administrative and other practices were in compliance with Federal Mental Health Parity Law.

(3) If the MCO, Accountable Care Partnership Plan, SCO, or ICO determines that any administrative or other practices were not in compliance with relevant requirements of the Federal Mental Health Parity Law, the annual 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 entity has taken to bring these practices into compliance.

(C) A member enrolled in an MCO, Accountable Care Partnership Plan, SCO, or ICO 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 service contractor.