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

MassHealth
Transmittal Letter ALL-231
June 2020

TO: All Providers Participating in MassHealth

FROM: Amanda Cassel Kraft, Acting Medicaid Director

RE: All Provider Manuals (Elimination of Copayments for Certain Services and Populations)

MassHealth is amending its copay regulations at 130 CMR 450.130, effective July 1, 2020. These amendments identify additional categories of MassHealth members and services that are exempt from copays. Please note that copays for acute inpatient hospital stays were eliminated on March 18th, 2020, and copays do not apply to COVID-19 testing and treatment services for the duration of the national emergency.

The following services are newly excluded from copays.

- FDA-approved medications for detoxification and maintenance treatment of substance use disorders (SUD);
- preventive services rated Grade A and B by the US Preventive Services Task Force (USPSTF)[1] or broader exclusions specified by MassHealth (e.g., low-dose aspirin; colonoscopy preparation); and
- vaccines and their administration recommended by the Advisory Committee on Immunization Practices (ACIP)[2].

The following populations are newly excluded from copays:

- members with incomes at or under 50% federal poverty level (FPL); and
- members categorically eligible for MassHealth because they are receiving other public assistance ("referred eligibles") such as Supplemental Security Income (SSI), Transitional Aid to Families with Dependent Children (TAFDC), or services through the Emergency Aid to the Elderly, Disabled and Children (EAEDC) Program.

For more information about MassHealth copays, please refer to 130 CMR 450.130 and www.mass.gov/copayment-information-for-providers.

These regulations are effective July 1, 2020.

MassHealth Website

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

[1] As these ratings may be updated by the USPSTF.
[2] As these recommendations may be updated by the ACIP.

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 (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 i and 1-35 through 1-40

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

All Provider Manuals

Pages i, 1-35, 1-36, 1-39, and 1-40 — transmitted by Transmittal Letter ALL-224
Pages 1-37 and 1-38 — transmitted by Transmittal Letter ALL-230

1. Introduction

450.124: Behavioral Health Services

(A) Behavioral Health Contractor. Except as provided in 130 CMR 450.124(B) and (C), all behavioral health services covered by the MassHealth agency's contract with the behavioral health contractor (the Contractor) are authorized, provided, and paid solely by the Contractor. Payment for such services is 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. Members may obtain emergency behavioral health services from any qualified participating MassHealth provider as well as any provider that has entered into an agreement with the Contractor. Providers should refer to MassHealth bulletins for information and guidance on submission of claims for emergency department behavioral health visits.

(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 an MCO, Accountable Care Partnership Plan, SCO, or ICO; and

(2) members who are excluded from participating in managed care under 130 CMR 508.002: *MassHealth Members Excluded from Participation in Managed Care* unless such member is enrolled with the behavioral health contractor pursuant to 130 CMR 508.001(E).

(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 payment rate for the service is less than the copayment amount, the member must pay the payment rate for the service. Members who are enrolled in MCOs, Accountable Care Partnership Plans, SCOs, and ICOs must make copayments in accordance with the such entity's copayment policy. Those 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(C), 508.005(C), 508.006(A)(3), 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 for pharmacy services, unless excluded in 130 CMR 450.130(D) or (E).

(1) $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
(2) $3.65 for each prescription and refill for all other generic and over-the-counter drugs, and all brand-name drugs covered by MassHealth.

(C) Maximum Cost Sharing. Members are responsible for the MassHealth copayments described in 130 CMR 450.130(B), up to the maximum of $250 for pharmacy services per calendar year.

(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 15th, she is exempt from the copayment requirement until August 1st);

(c) MassHealth Limited members;
(d) MassHealth Senior Buy-In members or MassHealth Standard members for drugs covered under Medicare Parts A and B only, when provided by a Medicare-certified provider;
(e) members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for individuals with intellectual disabilities or who are admitted to a hospital from such a facility or hospital;
(f) members receiving hospice services;
(g) persons receiving medical services through the EAEDC Program pursuant to 130 CMR 450.106, if they do not receive MassHealth CarePlus, MassHealth Standard, or MassHealth Family Assistance;
(h) members who are former foster care individuals and who are eligible for MassHealth Standard until they reach the age of 21 or the age of 26, as specified in 130 CMR 505.002(H): *Eligibility Requirements for Former Foster-Care Individuals*;
(i) members who are American Indians or Alaska Natives who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or through referral, in accordance with federal law;
(j) "referred eligible" members, who are:
1. persons who receive Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA) and who receive MassHealth Standard under 130 CMR 505.002(A)(2) or 130 CMR 519.002(B);
2. persons who receive Transitional Aid to Families with Dependent Children (TAFDC) cash assistance from the Department of Transitional Assistance (DTA) and who receive MassHealth Standard under 130 CMR 505.002(A)(3);
3. children, young adults, and parents and caretaker relatives who receive Emergency Aid to the Elderly, Disabled and Children (EAEDC) cash assistance and who receive MassHealth Standard under 130 CMR 505.002(K) or 130 CMR 519.002(D), MassHealth Family Assistance under 130 CMR 505.005(G) or 130 CMR 519.013(C), or MassHealth CarePlus under 130 CMR 505.008(B);
4. children receiving medical assistance under 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance*, because they are receiving Title IV-E or state-subsidized adoption or foster-care assistance;
5. persons who receive extended eligibility for MassHealth Standard under 130 CMR 505.002(L) or 130 CMR 519.002(C); and
6. persons who receive MassHealth Standard or CarePlus because they are eligible for Refugee Medical Assistance (RMA) under 130 CMR 522.002: *Refugee Resettlement Program*; and

(k) members whose applicable income for the purposes of calculating copayments is at or below 50% of the FPL.

(2) Members who have accumulated copayment charges totaling the calendar-year maximum of $250 on pharmacy services do not have to pay further MassHealth copayments on pharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for pharmacy services.
(3) Members who are inpatients in a hospital do not have to pay a copayment for pharmacy services provided as part of the hospital stay.

(E) Excluded Services. The following services are excluded from the copayment requirement described in 130 CMR 450.130(B):

(1) family-planning services and supplies such as oral contraceptives, contraceptive devices such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;

(2) detoxification and maintenance treatment of an individual for substance use disorders using FDA approved medications (including methadone, buprenorphine, buprenorphine/naloxone, and naltrexone);

(3) preventive services assigned a grade of 'A' or 'B' by the United States Preventive Services Task Force (USPSTF), or such broader exclusion as specified by MassHealth;

(4) all approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP);

(5) smoking cessation products and drugs;

(6) emergency services; and

(7) provider-preventable services as defined in 42 CFR 447.26(b).

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

(G) Collecting Copayments.

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

(2) The MassHealth agency will deduct the amount of the copayment from the amount paid to the provider, whether or not the provider collects the copayment from the member, unless the member or service is exempt according to 130 CMR 450.130(D) or (E). Providers must not deduct the copayment amount from the amount claimed. Providers may not refuse services to any members who are unable to pay the copayment at the time service is provided.

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

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

(130 CMR 450.131 through 450.139 Reserved)

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

(A) Legal Basis.

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

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

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

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

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

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

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

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

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

450.141: EPSDT Services: Definitions

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

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

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

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

(1) screenings that are medically necessary to determine the existence of a suspected illness or condition, or a change in or complication of a preexisting condition;

(2) the provision of the full-range of EPSDT screening or treatment services delivered at an age other than one listed on the Medical or Dental Schedule to update the member's care according to the Medical or Dental Schedule; or

(3) additional screening or treatment services provided to a member whose care is already up to date according to the Medical or Dental Schedule.

Periodic Visit — the provision of screening procedures appropriate to the member's age and medical history, as prescribed by the Medical Schedule or the Dental Schedule.

Primary Care — health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, certified nurse practitioner, or certified nurse midwife, or physician assistant to the extent the furnishing of those services is legally authorized in the Commonwealth. Primary care does not include emergency or post stabilization services provided in a hospital or other setting.

Primary Care Providers — a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, certified nurse practitioner, certified nurse midwife, or physician assistant.

450.142: EPSDT Services: Medical Protocol and Periodicity Schedule and Dental Protocol and Periodicity Schedule

(A) Providers of Periodic and Interperiodic Visits.

(1) Primary care providers must offer to conduct periodic and medically necessary interperiodic visits to screen all members younger than 21 years of age (except members enrolled in MassHealth Limited) in accordance with the Medical Schedule, and must provide or refer such members to assessment, diagnosis, and treatment services.

(2) Hospitals and community health centers that provide primary care services must offer to conduct periodic and medically necessary interperiodic visits to screen all members younger than 21 years of age (except members enrolled in MassHealth Limited) in accordance with the Medical Schedule, and must provide or refer such members to assessment, diagnosis, and treatment services.

(3) The health assessments described in the Medical Schedule are payable when provided by a physician, certified nurse practitioner, certified nurse midwife, hospital, community health center, or physician assistant.