



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



MassHealth
Transmittal Letter ALL-234
June 2021

TO: All Providers Participating in MassHealth
FROM: Daniel Tsai, Assistant Secretary for MassHealth
RE: All Provider Manuals (Cost Sharing Limits)

MassHealth is amending its regulations at 130 CMR 450.000: *Administrative and Billing Regulations*, effective July 1, 2021, to reflect updated cost sharing rules. Specifically, section 130 CMR 450.130: *Copayments Required by the MassHealth Agency* is being amended.

These amendments ensure that a member's cost sharing obligation, including copays and premiums, will not exceed 5% of the member's monthly income per month. Specifically, the amendments replace the current \$250 annual pharmacy copay cap with a member-specific monthly copay cap not to exceed 2% of the member's monthly income per month. Members will be assigned their individual monthly copay cap based on the lowest individual income level within their household. MassHealth will notify members whenever their monthly copay cap changes or whenever they meet their current copay cap. Monthly copay caps will be established in \$10 increments, ranging from \$0 to \$60 per month, depending on income. Member premiums will not exceed 3% of monthly income per month, except for those members in CommonHealth, for whom there is federal authority to exceed that limit.

These amendments are effective beginning July 1, 2021. However, for the duration of the federal COVID-19 Public Health Emergency, MassHealth will also ensure that members will not be charged more than \$250 in total copays annually, even if the member's individual 2% cap monthly cap would allow for annual copays to exceed that amount.

The amendments also expand the circumstances in which the agency can allow for a waiver or reduction of premiums as follows. The current regulation allows for a hardship waiver or reduction when a member has "outstanding" or "currently owed" medical or dental expenses totaling more than 7.5% of the family group's income. This revised regulation allows a member to seek a premium hardship waiver or reduction for medical or dental expenses totaling more than 7.5% of the family group's income if the expenses were "paid" within the twelve-month period before the member applied for a premium hardship waiver or reduction.

Additionally, the amended regulations expand the circumstances in which the agency can provide for a waiver or reduction of premiums when a member enrolled in CommonHealth has high premiums that may interfere with their ability to pay for other essential expenses, or when any member faces negative financial consequences due to a natural disaster or public health emergency.

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, 2021.

MassHealth Website

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

[Sign up](#) to receive email alerts when MassHealth issues new transmittal letters and provider bulletins.

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 1-9, 1-10, and 1-35 through 1-38

OBSOLETE MATERIAL

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

All Provider Manuals

Pages 1-9 and 1-10 — transmitted by Transmittal Letter ALL-226

Pages 1-35 through 1-38 — transmitted by Transmittal Letter ALL-231

Commonwealth of Massachusetts MassHealth Provider Manual Series All Provider Manuals	Subchapter Number and Title 1. Introduction (130 CMR 450.000)	Page 1-9
	Transmittal Letter ALL-234	Date 07/01/21

(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. The MassHealth

Commonwealth of Massachusetts MassHealth Provider Manual Series All Provider Manuals	Subchapter Number and Title 1. Introduction (130 CMR 450.000)	Page 1-10
	Transmittal Letter ALL-234	Date 07/01/21

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;

Commonwealth of Massachusetts MassHealth Provider Manual Series All Provider Manuals	Subchapter Number and Title 1. Introduction (130 CMR 450.000)	Page 1-35
	Transmittal Letter ALL-234	Date 07/01/21

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)

Commonwealth of Massachusetts MassHealth Provider Manual Series	Subchapter Number and Title 1. Introduction (130 CMR 450.000)	Page 1-36
	Transmittal Letter ALL-234	Date 07/01/21

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 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 equal to or less than the copayment amount, the member must pay the payment rate for the service minus one cent. 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 maximums set forth in 130 CMR 450.130(C). (*See* also 130 CMR 506.011 through 506.018, 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.

- (1) Members are responsible for the MassHealth copayments described in 130 CMR 450.130(B), up to a monthly maximum of 2% of applicable monthly income. Each member’s monthly copayment cap will be calculated using 2% of the lowest income in the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable, and assigning the member a monthly cap of the nearest \$10 increment that corresponds to 2% of the applicable income without exceeding 2%. A further explanation of this calculation is publicly available on MassHealth’s website.
- (2) Members are responsible for the MassHealth premiums described in 130 CMR 506.012 up to a monthly maximum of 3% of applicable monthly income, except no such limit applies to CommonHealth members. Each member’s monthly premium cap will be calculated using 3% of the lowest income in the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable. A further explanation of this calculation is publicly available on MassHealth’s website.

(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;

Commonwealth of Massachusetts MassHealth Provider Manual Series	Subchapter Number and Title 1. Introduction (130 CMR 450.000)	Page 1-37
	Transmittal Letter ALL-234	Date 07/01/21
All Provider Manuals		

- (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)(1) and (2) 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 when adjusted for family size.

Commonwealth of Massachusetts MassHealth Provider Manual Series	Subchapter Number and Title 1. Introduction (130 CMR 450.000)	Page 1-38
	Transmittal Letter ALL-234	Date 07/01/21

(2) 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.
- (3) 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)