




MassHealth
Transmittal Letter ALL-235
January 2022

TO: All Providers Participating in MassHealth

FROM: Amanda Cassel Kraft, Assistant Secretary for MassHealth 

RE: *All Provider Manuals (Coverage of Acupuncture and Urgent Care Clinic Services for Certain MassHealth Members)*

This letter transmits updates to 130 CMR 450.000: *Administrative and Billing Regulations*, which are listed as Subchapters 1 through 3 in all provider manuals. These amendments, which are effective January 21, 2022, add acupuncture and urgent care clinic services as covered services under MassHealth Standard, MassHealth CarePlus, and MassHealth CommonHealth, as well as for certain MassHealth Family Assistance members. Updates also exempt urgent care clinic services from the PCC and Primary Care ACO referral requirements.

These amendments correspond to the establishment of new program regulations 130 CMR 447.000: *Acupuncture Services* and 130 CMR 455.000: *Urgent Care Clinic Services*, which are also effective January 21, 2022.

MassHealth Website

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Questions

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NEW MATERIAL

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

All Provider Manual

Pages 1-7 through 1-16, 1-27, 1-28, and 1-31 through 1-34

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

All Provider Manual

Pages 1-7, 1-8, and 1-11 through 1-16 — transmitted by Transmittal Letter ALL-224

Pages 1-27, 1-28, and 1-31 through 1-34 — transmitted by Transmittal Letter ALL-226

Pages 1-9 and 1-10 — transmitted by Transmittal Letter ALL-234

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450.105: Coverage Types

A member is eligible for services and benefits according to the member's coverage type. Each coverage type is described below. Payment for the covered services listed in 130 CMR 450.105 is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment. See individual program regulations for information on covered services and specific service limitations, including age restrictions applicable to certain services.

(A) MassHealth Standard.

(1) Covered Services. The following services are covered for MassHealth Standard members (*see* 130 CMR 505.002: *MassHealth Standard* and 519.002: *MassHealth Standard*):

- (a) abortion services;
- (b) acupuncture services;
- (c) adult day health services;
- (d) adult foster care services;
- (e) ambulance services;
- (f) ambulatory surgery services;
- (g) audiologist services;
- (h) behavioral health services;
- (i) certified nurse midwife services;
- (j) certified nurse practitioner services;
- (k) certified registered nurse anesthetist services;
- (l) Chapter 766: home assessments and participation in team meetings;
- (m) chiropractor services;
- (n) clinical nurse specialist services;
- (o) community health center services;
- (p) day habilitation services;
- (q) dental services;
- (r) durable medical equipment and supplies;
- (s) early intervention services;
- (t) family planning services;
- (u) hearing aid services;
- (v) home health services;
- (w) hospice services;
- (x) independent nurse (private duty nursing) services;
- (y) inpatient hospital services;
- (z) laboratory services;
- (aa) nursing facility services;
- (bb) orthotic services;
- (cc) outpatient hospital services;
- (dd) oxygen and respiratory therapy equipment;
- (ee) personal care services;
- (ff) pharmacy services;
- (gg) physician services;
- (hh) physician assistant services;

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- (ii) podiatrist services;
- (jj) prosthetic services;
- (kk) psychiatric clinical nurse specialist services;
- (ll) rehabilitation services;
- (mm) renal dialysis services;
- (nn) speech and hearing services;
- (oo) therapy services: physical, occupational, and speech/language;
- (pp) transportation services;
- (qq) urgent care clinic services;
- (rr) vision care; and
- (ss) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth Standard members must enroll with a MassHealth managed care provider unless excluded from enrollment with a MassHealth managed care provider. (*See* 130 CMR 450.117 and 508.000: *MassHealth: Managed Care Requirements.*) 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.

(3) MCOs, Accountable Care Partnership Plans, SCOs, and ICOs. For MassHealth Standard members who are enrolled in an MCO, Accountable Care Partnership Plan, SCO, or ICO, 130 CMR 450.105(A)(3)(a) and (b) apply.

(a) The MassHealth agency does not pay a provider other than the MCO, Accountable Care Partnership Plan, SCO, or ICO for any services that are covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, SCO, or ICO except for family planning services that were not provided or arranged for by the MCO, Accountable Care Partnership Plan, SCO, or ICO. It is the responsibility of the provider to verify the scope of services covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, SCO, or ICO.

(b) The MassHealth agency pays providers other than the MCO, Accountable Care Partnership Plan, SCO, or ICO for those services listed in 130 CMR 450.105(A)(1) that are not covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, SCO, or ICO. 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 or a Primary Care ACO receive behavioral health services only through the MassHealth behavioral health contractor. (*See* 130 CMR 450.124.)

(b) MassHealth Standard members enrolled in an MCO, Accountable Care Partnership Plan, SCO, or ICO receive behavioral health services only through the MCO, Accountable Care Partnership Plan, SCO, or ICO. (*See* 130 CMR 450.117.)

(c) MassHealth Standard members who are not enrolled in an MCO, Accountable Care Partnership Plan, SCO, ICO, or with the behavioral health contractor may receive behavioral health services from any participating MassHealth provider of such services.

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(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*.

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

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- (ff) renal dialysis services;
- (gg) speech and hearing services;
- (hh) therapy services: physical, occupational, and speech/language;
- (ii) transportation services;
- (jj) urgent care clinic services;
- (kk) vision care; and
- (ll) 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) MCOs and Accountable Care Partnership Plans. For MassHealth CarePlus members who are enrolled in an MCO or Accountable Care Partnership Plan, the following rules apply.
- (a) The MassHealth agency does not pay a provider other than the MCO or Accountable Care Partnership Plan for any services that are covered by the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan, except for family planning services that were not provided or arranged for by the MCO or Accountable Care Partnership Plan. It is the responsibility of the provider to verify the scope of services covered by the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan.
 - (b) The MassHealth agency pays providers other than the MCO or Accountable Care Partnership Plan for those services listed in 130 CMR 450.105(B)(1) that are not covered by the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan. 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 or Primary Care ACO receive behavioral health services only through the MassHealth behavioral health contractor (See 130 CMR 450.124).
 - (b) MassHealth CarePlus members enrolled in an MCO or Accountable Care Partnership Plan receive behavioral health services only through the MCO or Accountable Care Partnership Plan. (See 130 CMR 450.117.)
 - (c) MassHealth CarePlus members who are not enrolled in an MCO, Accountable Care Partnership Plan, or with the behavioral health contractor 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.

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(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 with any MassHealth managed care provider 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 with a MassHealth managed care provider 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) acupuncture services;
- (c) adult day health services;
- (d) adult foster care services;
- (e) ambulance services;
- (f) ambulatory surgery services;
- (g) audiologist services;
- (h) behavioral health services;
- (i) certified nurse midwife services;
- (j) certified nurse practitioner services;
- (k) certified registered nurse anesthetist services;
- (l) Chapter 766: home assessments and participation in team meetings;
- (m) chiropractor services;
- (n) clinical nurse specialist services;
- (o) community health center services;
- (p) day habilitation services;
- (q) dental services;
- (r) durable medical equipment and supplies;

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- (s) early intervention services;
- (t) family planning services;
- (u) hearing aid services;
- (v) home health services;
- (w) hospice services;
- (x) independent nurse (private duty nursing) services;
- (y) inpatient hospital services;
- (z) laboratory services;
- (aa) nursing facility services;
- (bb) orthotic services;
- (cc) outpatient hospital services;
- (dd) oxygen and respiratory therapy equipment;
- (ee) personal care services;
- (ff) pharmacy services;
- (gg) physician services;
- (hh) physician assistant services;
- (ii) podiatrist services;
- (jj) prosthetic services;
- (kk) psychiatric clinical nurse specialist services;
- (ll) rehabilitation services;
- (mm) renal dialysis services;
- (nn) speech and hearing services;
- (oo) therapy services: physical, occupational, and speech/language;
- (pp) transportation services;
- (qq) urgent care clinic services;
- (rr) vision care; and
- (ss) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth CommonHealth members must enroll with a MassHealth managed care provider or ICO unless excluded from participation in a MassHealth managed care provider. (*See* 130 CMR 450.117 and 508.000: *Managed Care Requirements.*)

(3) MCOs, Accountable Care Partnership Plans, and ICOs. For MassHealth CommonHealth members who are enrolled in an MCO, Accountable Care Partnership Plan, or ICO, 130 CMR 450.05(E)(3)(a) and (b) apply.

(a) The MassHealth agency does not pay a provider other than the MCO, Accountable Care Partnership Plan, or ICO for any services that are covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, or ICO, except for family planning services that were not provided or arranged for by the MCO, Accountable Care Partnership Plan, or ICO. It is the responsibility of the provider to verify the scope of services covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, or ICO.

(b) The MassHealth agency pays providers other than the MCO, Accountable Care Partnership Plan, or ICO for those services listed in 130 CMR 450.105(E)(1) that are not covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, or ICO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

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(4) Behavioral Health Services.

(a) MassHealth CommonHealth members enrolled in the PCC Plan or a Primary Care ACO receive behavioral health services only through the MassHealth behavioral health contractor. (*See* 130 CMR 450.124.)

(b) MassHealth CommonHealth members enrolled in an MCO, Accountable Care Partnership Plan, or ICO receive behavioral health services only through the MCO, Accountable Care Partnership Plan, or ICO. (*See* 130 CMR 450.117.)

(c) MassHealth CommonHealth members who are not enrolled in an MCO, Accountable Care Partnership Plan, or ICO, or with the behavioral health contractor may receive behavioral health services from any participating MassHealth provider of such services.

(d) MassHealth CommonHealth members who are younger than 21 years of age and who are excluded from participation in a MassHealth managed care provider or ICO under 130 CMR 508.002(A)(1) or (2) must enroll with the MassHealth behavioral health contractor.

(5) 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.

(6) 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 enrolled members of ICO-covered benefits. ICOs are responsible for providing enrolled members 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).

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(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% 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 5% 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.

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(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) acupuncture services;
- (c) ambulance services (emergency only);
- (d) ambulatory surgery services;
- (e) audiologist services;
- (f) behavioral health services;
- (g) certified nurse midwife services;
- (h) certified nurse practitioner services;
- (i) certified registered nurse anesthetist services;
- (j) Chapter 766: home assessments and participation in team meetings;
- (k) chiropractor services;
- (l) clinical nurse specialist services;
- (m) community health center 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) inpatient hospital services;
- (v) laboratory services;
- (w) nurse midwife services;
- (x) nurse practitioner services;
- (y) orthotic services;
- (z) outpatient hospital services;
- (aa) oxygen and respiratory therapy equipment;
- (bb) pharmacy services;
- (cc) physician services;
- (dd) physician assistant services;
- (ee) podiatrist services;
- (ff) prosthetic services;
- (gg) psychiatric clinical nurse specialist services;
- (hh) rehabilitation services;
- (ii) renal dialysis services;
- (jj) speech and hearing services;
- (kk) therapy services: physical, occupational, and speech/language;
- (ll) urgent care clinic services;
- (mm) vision care; and
- (nn) X-ray/radiology services.

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(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 in an urgent care clinic;
- (w) services delivered by an anesthesiologist or a certified registered nurse anesthetist;
- (x) services delivered in an intermediate care facility for individuals with intellectual disabilities (ICF/ID);

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- (y) services delivered to a homeless member outside of the PCC office pursuant to 130 CMR 450.118(K);
- (z) services delivered to diagnose and treat sexually transmitted diseases;
- (aa) services delivered to treat an emergency condition;
- (bb) services provided under a home- and community-based waiver;
- (cc) sterilization services when performed for family planning services;
- (dd) surgical pathology services;
- (ee) tobacco-cessation counseling services;
- (ff) transportation to covered care;
- (gg) 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
- (hh) 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)(y), 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.

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(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

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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 in an urgent care clinic;
- (w) services delivered by an anesthesiologist;
- (x) services delivered in an intermediate care facility for individuals with intellectual disabilities (ICF/ID);
- (y) services delivered to a homeless member outside of the participating PCP's office pursuant to 130 CMR 450.119(J);
- (z) services delivered to diagnose and treat sexually transmitted diseases;
- (aa) services delivered to treat an emergency condition;
- (bb) services provided under a home- and community-based waiver;
- (cc) sterilization services when performed for family planning services;
- (dd) surgical pathology services;
- (ee) tobacco-cessation counseling services;
- (ff) transportation to covered care;
- (gg) vision care in the following categories (*see* Subchapter 6 of the *Vision Care Manual*): visual analysis frames, single-vision prescriptions, bifocal prescriptions, and repairs;
- (hh) medication assisted treatment (MAT) for opioid use disorder; and
- (ii) 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.

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

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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.