Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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MassHealth
Eligibility Letter 116
January 1, 2004

TO: MassHealth Staff

FROM: Beth Waldman, Director, Office of Medicaid Beth Waldman

RE: **Senior Care Options**

Effective January 2, 2004, most MassHealth Standard members aged 65 and older will have the option of enrolling in a coordinated health plan called Senior Care Options (SCO). SCO is a comprehensive health plan that covers all of the services covered under MassHealth and Medicare, through a senior care organization and its network of providers.

MassHealth members who are enrolled in SCO will not be covered for any services provided outside the senior care organization and its network of providers.

To enroll in SCO, a MassHealth Standard member must:

- be aged 65 or older;
- live in a designated service area of a senior care organization;
- not be diagnosed as having end-stage renal disease;
- not be subject to a six-month deductible period under 130 CMR 520.028;
- not be a resident of an intermediate care facility for the mentally retarded (ICF/MR); and
- not be an inpatient in a chronic or rehabilitation hospital.

Enrollment in SCO is voluntary. A member may disenroll from a senior care organization at any time by contacting the senior care organization to request disenrollment. Requests received by the last business day of the month will be effective on the first day of the following month.

Members may not be concurrently enrolled in SCO and any of the following programs:

- the Home and Community-Based Services Waiver described in 130 CMR 519.007(B);
- the Section 1915 Home and Community-Based Services Waiver for the Mentally Retarded administered by the Department of Mental Retardation;
- the Program of All-Inclusive Care for the Elderly (PACE) described in 130 CMR 519.007(C); and
- any Medicare+Choice plan or Medicare demonstration program.

These regulations are effective January 2, 2004.

MANUAL UPKEEP

Insert	**Remove**	**Trans. By**
501.001 (6 of 6)	501.001 (6 of 6)	E.L. 114
508.000	508.000	E.L. 96
508.004	508.004	E.L. 109
508.005	508.005	E.L. 51
508.006	508.006	E.L. 80
508.008 (1 of 2)	--	--
508.008 (2 of 2)	--	--
610.033	610.033	E.L. 110

Person Who Is HIV Positive – a person who has submitted verification that he or she has tested positive for the human immunodeficiency virus (HIV).

Premium – a charge for payment to the Division that may be assessed to members of MassHealth Standard, MassHealth CommonHealth, or MassHealth Family Assistance.

Premium Assistance Payment – an amount contributed by the Division toward the cost of employer-sponsored health-insurance coverage for certain MassHealth members.

Presumptive Eligibility – a time-limited period of conditional eligibility for children based on the applicant's declaration of family group gross income.

Primary-Care Clinician (PCC) Plan – a managed-care option administered by the Division through which enrolled members receive primary care and other medical services. See 130 CMR 450.118.

Qualified Employer – a small employer who:

(1) purchases health insurance that meets the Basic-Benefit Level;

(2) contributes at least 50 percent of the cost of employees' health-insurance premiums; and

(3) has completed an Employer Application form and been approved by the Division or its contractor(s) as a qualified employer pursuant to 130 CMR 650.010(A).

Quality Control – a system of continuing review to measure the accuracy of eligibility decisions.

Senior Care Organization – an organization that participates in MassHealth under a contract with the Division and the Centers for Medicare and Medicaid Services to provide a comprehensive network of medical, health-care, and social-service providers that integrates all components of care, either directly or through subcontracts. Senior care organizations are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

Small Business – see definition for small employer.

Small Employer – an employer that has no more than 50 employees who work 30 hours or more a week, or a self-employed individual.

Substantial Gainful Activity – generally, employment that provides a set amount of gross earnings as determined by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

Third Party – any individual, entity, or program that is or may be responsible to pay all or part of the expenditures for medical benefits.

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508.004: Members Excluded from Participation in Managed Care

The following members are excluded from required participation in the Division's managed care options, and receive those MassHealth services for which they are eligible from any qualified participating MassHealth provider of those services:

(A) a MassHealth Standard or CommonHealth member who has other health insurance, including Medicare;

(B) a MassHealth Family Assistance, Basic, or Essential member who has or has access to other health insurance;

(C) a member who is aged 65 or older, except for MassHealth Standard members who may voluntarily enroll in a senior care organization in accordance with the requirements under 130 CMR 508.008;

(D) a MassHealth Standard member institutionalized in:

(1) a nursing facility;

(2) a chronic disease or rehabilitation hospital;

(3) a state school for the mentally retarded; or

(4) a state psychiatric hospital;

(E) a member who is eligible solely for:

(1) MassHealth Limited; or

(2) MassHealth Prenatal;

(F) a MassHealth Standard or CommonHealth member who is receiving hospice care through the Division, or who is terminally ill as documented by a medical prognosis of a life expectancy of six months or less;

(G) a member who is receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106; and

(H) a MassHealth Standard or MassHealth Family Assistance member who has presumptive or time-limited eligibility is excluded from enrolling in the PCC Plan or an MCO for primary care.

508.005: MassHealth Managed Care Providers

(A) Primary Care Clinicians Participating in the PCC Plan. The list of primary care clinicians that the Division will make available to members may include any one of the following who is approved as a PCC by the Division and who practices within the member's service area:

(1) a physician in one of the following fields of medicine:

(a) internal medicine;

(b) family or general practice;

(c) pediatrics;

(d) obstetrics;

(e) gynecology;

(f) obstetrics/gynecology; or

(g) physiatry;

(2) a physician specialist who is board-certified or eligible for board certification in internal medicine or pediatrics and who agrees to provide primary care in accordance with Division requirements;

(3) an independent nurse practitioner;

(4) a licensed community health center with one or more practicing physicians who meet the requirements of 130 CMR 508.005(A)(1);

(5) an acute hospital outpatient department with one or more practicing physicians who meet the requirements of 130 CMR 508.005(A)(1); or

(6) a group practice with one or more practicing physicians or independent nurse practitioners who meet the requirements of 130 CMR 508.005(A)(1).

(B) Managed Care Organizations. The list of MCOs that the Division will make available to members will include those MCOs that contract with the Division and provide services within the member's service area.

(C) Senior Care Organizations. The list of senior care organizations that the Division will make available to members will include those senior care organizations that contract with the Division and provide services within the member's service area.

508.006: Right to a Fair Hearing

Members are entitled to a fair hearing under 130 CMR 610.000 et seq. to appeal:

(A) the Division's determination that the MassHealth Standard member is required to enroll with a MassHealth managed care provider under 130 CMR 508.001(A);

(B) a determination by the Division's behavioral health contractor, under 130 CMR 508.003(A), by one of the Division's managed care organization (MCO) contractors, under 130 CMR 508.001(B)(2)(b), or by a senior care organization under 130 CMR 508.008(C), to deny, reduce, modify, or terminate a covered service, if the member has exhausted all remedies available through the contractor's internal appeals process;

(C) the Division's denial of a request for an out-of-area MassHealth managed care provider under 130 CMR 508.002(F); or

(D) the Division's disenrollment or transfer of a member from a MassHealth managed care provider under 130 CMR 508.002(G).

(130 CMR 508.007 Reserved)

508.008: Voluntary Enrollment in Senior Care Organizations

(A) Enrollment Requirements. In order to voluntarily enroll in a senior care organization, a MassHealth Standard member must meet all of the following criteria:

(1) be aged 65 or older;

(2) live in a designated service area of a senior care organization;

(3) not be diagnosed as having end-stage renal disease;

(4) not be subject to a six-month deductible period under 130 CMR 520.028;

(5) not be a resident of an intermediate care facility for the mentally retarded (ICF/MR); and

(6) not be an inpatient in a chronic or rehabilitation hospital.

(B) Selection of a Senior Care Organization. The Division will notify members of the availability of a senior care organization in their service area and of the procedures for enrollment. An eligible member may voluntarily enroll in any senior care organization in the member's service area. A service area is the specific geographical area of Massachusetts in which a senior care organization agrees to serve its contract with the Division and the Centers for Medicare and Medicaid Services. Service area listings may be obtained from the Division or its designee.

(C) Obtaining Services. When a member chooses to enroll in a senior care organization in accordance with the requirements under 130 CMR 508.008, the senior care organization will deliver the member's primary care and will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, each senior care organization is required to provide evidence of its coverage, including a complete list of participating providers, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to covered services such as specialty, behavioral health, and long-term-care services.

(D) Disenrollment from a Senior Care Organization. A member may disenroll from a senior care organization at any time by submitting a notice of disenrollment to the Division or its designee. Disenrollment notices received by the Division or its designee by the 20th day of the month will be effective the first day of the following month.

(E) Discharge or Transfer. The Division may discharge or transfer a member from a senior care organization where the senior care organization demonstrates to the Division's satisfaction a pattern of noncompliant or disruptive behavior by the member or for other good cause. In each case, the Division will state the good cause basis for discharge or transfer in a notice to the member.

(F) Other Programs. While voluntarily enrolled in a senior care organization under 130 CMR 508.008, a member may not concurrently participate in any of the following programs:

(1) the Home and Community-Based Services Waiver described in 130 CMR 519.007(B);

(2) the Section 1915 Home and Community-Based Services Waiver for the Mentally Retarded administered by the Department of Mental Retardation;

(3) the Program of All-Inclusive Care for the Elderly (PACE) described in 130 CMR 519.007(C); and

(4) any Medicare+Choice plan or Medicare demonstration program.

(130 CMR 508.009 through 508.015 Reserved)

(8) the failure of the Division to act upon a request for assistance within the time limits required by Division regulations;

(9) the Division's determination that the member is subject to the provisions of 130 CMR 508.000;

(10) the Division's denial of an out-of-area provider under 130 CMR 508.002(F);

(11) the Division's disenrollment of a member from a managed-care provider under 130 CMR 508.002(G) or 508.008(E);

(12) a determination by the Division's behavioral health contractor, under 130 CMR 508.003(A), by one of the Division's managed-care organization (MCO) contractors, under 130 CMR 508.001(B)(2)(b), or by a senior care organization under 130 CMR 508.008(C) to deny, reduce, modify, or terminate a covered service, if the member has exhausted all remedies available through the contractor's internal appeals process; and

(13) the Division's determination to enroll a member in the Controlled Substance Management Program under the provisions of 130 CMR 406.442.

(B) Nursing facility residents have the right to request an appeal of any nursing facility-initiated transfer or discharge.

(C) Determinations of temporary eligibility for presumptive coverage or prenatal coverage are not appealable. See 130 CMR 502.008(C).

(D) Employers have the right to request an appeal of any denial or termination from the Insurance Partnership, or to appeal the amount of the Insurance Partnership payment they receive.

610.033: Coercive or Otherwise Improper Conduct

(A) Definitions.

(1) Coercive conduct means knowingly compelling an applicant, member, or former member by force, threat, intimidation, or other abuse of position to take action that is injurious to his or her best interest and that he or she would not otherwise have done.

(2) Improper conduct means reckless and unreasonable abuse of authority that interferes with the applicant's, member's, or former member's exercise of rights under MassHealth.

(B) Remedies. When a hearing officer has found coercive or otherwise improper conduct on the part of any Division employee directly involved in the applicant's, member's, or former member's case at a fair hearing, the enrollment center director will:

(1) assign a different worker; and

(2) initiate appropriate personnel action including the insertion of a written reprimand and a copy of the written findings, if any, in the worker's personnel file.