Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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Boston, MA 02111
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MassHealth
Eligibility Letter 200
June 1, 2010

TO: MassHealth Staff

FROM: Terence G. Dougherty, Medicaid Director

RE: **Revisions to Managed Care Regulations**

MassHealth is revising the regulations about managed care. The revisions

- allow members in the following MassHealth programs to enroll in a managed care organization (MCO) or in the Primary Care Clinician (PCC) Plan if they meet other managed care eligibility requirements: Essential members, Standard members who have breast or cervical cancer, and Family Assistance members who are HIV positive to enroll. Historically, such members could only enroll in the PCC Plan;
- require MassHealth CommonHealth members who are eligible for managed care to receive services through either an MCO or the PCC Plan. Historically, such members could choose to receive all services on a fee-for-service basis; and
- allow MassHealth members who are Native Americans or Alaskan Natives who are enrolled in an MCO to choose to receive services through an Indian provider, even if that provider is not part of the managed care network.

These regulations are effective July 1, 2010.

Please note that we have made a minor change in the format of the regulations in Chapter 508. We eliminated the double spaces between the (1)s and (2)s, (a)s and (b)s, and (i)s and (ii)s. This format now matches the official format for the Code of Massachusetts Regulations (CMR). We will reformat other chapters as time allows, and will reissue them via eligibility letters, since this will change the pagination. This change will streamline the processing of these regulations and ensure consistency among all the MassHealth regulations.

MANUAL UPKEEP

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508.002 (3 of 3)	508.002 (3 of 4)	E.L. 135
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508.001: MassHealth Managed Care Requirement

(A) Member Participation.

(1) MassHealth members who are under age 65, except those MassHealth members who are receiving services from the Department of Children and Families (DCF) or the Department of Youth Services (DYS) or who are receiving Title IV-E adoption assistance described in 130 CMR 522.003, must enroll in the Primary Care Clinician (PCC) Plan or a MassHealth-contracted managed care organization (MCO), unless excluded from participation as described in 130 CMR 508.004.

(2) MassHealth Standard and CommonHealth members who are under the age of 21 and who are excluded from participation in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(A) or (B) must enroll with the MassHealth behavioral-health contractor.

(3) MassHealth Standard and CommonHealth members who are under the age of 21 and who are excluded from participation in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(I), (J), or (K) are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(4) MassHealth members who are receiving services from DCF or DYS 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 must enroll with the MassHealth behavioral-health contractor.

(5) MassHealth members who are receiving Title IV-E adoption assistance as described at 130 CMR 522.003 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.

(B) Obtaining Services.

(1) Primary Care. When the member selects or is assigned to either a PCC or MCO, that MassHealth managed care provider will deliver the member's primary care, decide if the member needs medical care from other providers, and make referrals for such necessary medical services.

(2) Other Medical Services (Excluding Behavioral-Health Services).

(a) Service Delivery to Members Enrolled in the PCC Plan. All medical services to members enrolled in the PCC Plan, except those services listed in 130 CMR 450.118(J), require a referral or authorization from the PCC. MassHealth members enrolled in the PCC Plan may receive those services listed in 130 CMR 450.118(J), for which they are otherwise eligible, without a referral from their PCC.

(b) Service Delivery to Members Enrolled in an MCO. All medical services to members enrolled in an MCO, except those services not covered under the MassHealth contract with the MCO and family planning services, are subject to the referral requirements of the MCO. MassHealth members enrolled in an MCO may receive family planning services from any MassHealth family planning provider and do not need an authorization or referral in order to receive such services. Members enrolled with an MCO should contact their MCO for information about covered services and referral requirements.

(3) Behavioral-Health Services.

(a) Members Enrolled in the PCC Plan. All members who enroll in the PCC Plan receive behavioral-health (mental health and substance abuse) services through the MassHealth behavioral-health contractor. See 130 CMR 508.003.

(b) Members Enrolled in an MCO.

(i) Members who enroll in a MassHealth-contracted MCO that is under contract to provide behavioral-health services receive behavioral-health services through that MCO.

(ii) All behavioral-health services to members enrolled in an MCO, except those services not covered under the MassHealth contract with the MCO, are subject to the authorization requirements of the MCO. Members enrolled with an MCO should contact their MCO for information about covered services and authorization requirements.

(c) Members with Presumptive or Time-Limited Eligibility, or Fee-for-Service. Members with presumptive or time-limited eligibility, or fee-for-service receive behavioral-health services through any qualified participating MassHealth provider.

(4) Native Americans and Alaska Natives. Individuals who are Native Americans (within the meaning of "Indians" as defined at 42 U.S.C. 1396u-2) or Alaska Natives who participate in managed care under MassHealth may chose to receive covered services from an Indian health-care provider. Such Indian health-care providers may participate in MassHealth subject to applicable provisions of 130 CMR 450.000.

508.002: Choosing a MassHealth Managed Care Provider

All MassHealth members, except those excluded under 130 CMR 508.004, must enroll with a MassHealth managed care provider. For MassHealth Basic members, described at 130 CMR 505.006(B), and MassHealth Essential members, described at 130 CMR 505.007(B) and (E), services are available only as of the member's enrollment effective date, as established by the MassHealth agency in accordance with 130 CMR 508.002(A), with a MassHealth managed care provider. In no event will a MassHealth Basic or Essential member who is eligible for the purchase of medical benefits be enrolled with a MassHealth managed care provider with an effective date that is before the MassHealth agency's issuance of a notice to the member stating that the member is eligible for MassHealth Basic or Essential. MassHealth Essential members described in 130 CMR 505.007(E) are also provided services under MassHealth Limited pursuant to 130 CMR 505.007(E) and 505.008.

(A) Selection of a Managed Care Provider.

(1) Procedure. The MassHealth agency notifies the member of the availability of MassHealth managed care providers in the member's service area, and of the member's obligation to select such a provider within the time period specified by the MassHealth agency. The member may select any provider from the MassHealth agency's list of MassHealth managed care providers in the member's service area, if the provider is able to accept new patients. For MassHealth Basic and MassHealth Essential members, the member's enrollment date is no later than 10 business days after the MassHealth agency received all information needed to enroll the member with a MassHealth managed care provider.

(2) Member's Service Area. The member's service area is determined by the MassHealth agency based on zip codes or geographic area. Service area listings may be obtained from the MassHealth agency.

(B) Assignment to a Managed Care Provider. If a member does not choose a managed care provider within the time period specified by the MassHealth agency in a notice to the member, the MassHealth agency assigns the member to a MassHealth managed care provider.

(C) Criteria for Assigning Members.

(1) The MassHealth agency assigns a member eligible to enroll with a managed care provider only if the provider is:

(a) in the member's service area as described in 130 CMR 508.002(A)(2);

(b) physically accessible to the member, if the member is disabled;

(c) suitable for the member's age and sex (for example, the member is the appropriate age for a pediatrician);

(d) able to communicate with the member directly or through an interpreter, unless there is no medical care available in the member's service area that meets this requirement; and

(e) located in an area to which the member has available transportation.

(2) (a) For MassHealth Standard members only, if the MassHealth agency determines that no MassHealth managed care provider meeting the criteria of 130 CMR 508.002(C)(1) is available in the member's service area, the member may

(i) choose not to enroll with a MassHealth managed care provider as long as such circumstances prevail; or

(ii) select an available MassHealth managed care provider outside of the member's service area.

(b) Any MassHealth Standard member who is not enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.002(C)(2)(a)(i) must obtain any behavioral-health services through the MassHealth behavioral-health contractor. All other services for which the member is eligible may be obtained through any qualified participating MassHealth provider.

(3) If, after a determination by the MassHealth agency under 130 CMR 508.002(C)(2)(a), the MassHealth agency determines that a MassHealth managed care provider meeting the criteria of 130 CMR 508.002(C)(1) has become available, the member must enroll with such a provider, unless the member is otherwise enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.002(C)(2)(a)(ii).

(D) Notification. The MassHealth agency will notify a member in writing of the name and address of the member's MassHealth managed care provider, and the member’s enrollment effective date with the provider.

(E) Transfer. The member may transfer to or from an available MassHealth managed care provider at any time.

(F) Out-of-Area Managed Care Provider. A member who seeks to enroll with a MassHealth managed care provider outside of the member's service area must submit a request in writing to the MassHealth agency on forms provided by the MassHealth agency. The MassHealth agency will grant a request for an available out-of-area MassHealth managed care provider where the MassHealth agency determines that

(1) there is no MassHealth managed care provider available in the member's service area that is able to communicate with the member directly or through an interpreter; or

(2) the travel time or distance to the requested out-of-area MassHealth managed care provider is equal to or less than the travel time to a MassHealth managed care provider in the member's service area, or the medical benefit of receiving care from a MassHealth managed care provider in the member's service area is substantially outweighed, as determined by the MassHealth agency, by the medical benefit of receiving care from the out-of-area MassHealth managed care provider requested by the member.

(G) Disenrollment of Members.

(1) The MassHealth agency may disenroll a member from an MCO, upon request, if the MCO demonstrates to the MassHealth agency's satisfaction that the MCO has made reasonable efforts to provide medically necessary services to the member through available primary care providers or other relevant network providers and, despite such efforts, the continued enrollment of the member with the MCO seriously impairs the MCO's ability to furnish services to either this particular member or other members.

(2) The MassHealth agency may disenroll a member from a PCC's panel, upon request, if the provider demonstrates to the MassHealth agency's satisfaction that:

(a) there is a pattern of noncompliant or disruptive behavior by the member that is not the result of the member's special needs;

(b) the continued enrollment of the member with the provider seriously impairs the provider's ability to furnish services to either this particular member or other members; or

(c) the PCC is unable to meet the medical needs of the member.

(3) If the MassHealth agency approves a request for disenrollment under 130 CMR 508.002(G)(1) and (2), it will state the good cause basis for disenrollment in a notice to the member in accordance with 130 CMR 610.032(A)(11).

(H) Reenrollment. Any member who loses and then regains managed care eligibility may be automatically reenrolled with the MassHealth managed care provider with which the member was most recently enrolled.

508.003: Behavioral-Health Contractor

The following applies to MassHealth members who receive behavioral-health services through MassHealth's behavioral-health contractor. See 130 CMR 508.001(B)(3).

(A) Nonemergency Behavioral-Health Services. All behavioral-health services, except for emergency services, may be obtained only from a provider that has entered into an agreement with the MassHealth behavioral-health contractor. The MassHealth behavioral-health contractor is responsible for authorizing or denying behavioral-health services based on the member's medical need for those services.

(B) Emergency Behavioral-Health 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 MassHealth behavioral-health contractor.

508.004: Members Excluded from Participation in the Primary Care Clinician Plan or a MassHealth Managed Care Organization

The following members are excluded from participation in the MassHealth Primary Care Clinician (PCC) Plan or a MassHealth-contracted managed care organization (MCO):

(A) a MassHealth member who has Medicare;

(B) a MassHealth member who has or has access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001;

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

(D) a MassHealth member in a nursing facility, chronic disease or rehabilitation hospital, state school for the mentally retarded, or a state psychiatric hospital for other than a short-term rehabilitative stay;

(E) a MassHealth member who is eligible solely for
(1) MassHealth Limited;
(2) MassHealth Prenatal;
(3) Children's Medical Security Plan (CMSP); or
(4) Healthy Start;

(F) a MassHealth Standard or CommonHealth member who is receiving hospice care through MassHealth, 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;

(H) a MassHealth member who has presumptive or time-limited eligibility;

(I) a MassHealth member who is enrolled in the Kaileigh Mulligan Program described at 130 CMR 519.007(A);

(J) a MassHealth member who is enrolled in a home- and community-based services waiver; and

(K) a MassHealth member who is a refugee described at 130 CMR 522.002.

508.005: MassHealth Managed Care Providers

(A) Primary Care Clinicians Participating in the PCC Plan. The list of primary care clinicians that the MassHealth agency will make available to members may include any one of the following who is approved as a PCC by the MassHealth agency 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 MassHealth agency 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 MassHealth agency will make available to members will include those MCOs that contract with the MassHealth agency and provide services within the member’s service area.

(C) Senior Care Organizations. The list of senior care organizations that the MassHealth agency will make available to members will include those senior care organizations that contract with the MassHealth agency 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 MassHealth agency'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 MassHealth behavioral-health contractor, by one of the MassHealth managed care organization (MCO) contractors, or by a senior care organization (SCO), as further described in 130 CMR 610.032(B), if the member has exhausted all remedies available through the contractor's internal appeals process;

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

(D) the MassHealth agency's disenrollment 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 MassHealth agency 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 MassHealth agency and the Centers for Medicare and Medicaid Services. Service area listings may be obtained from the MassHealth agency 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 MassHealth agency or its designee. Disenrollment notices received by the MassHealth agency 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 MassHealth agency may discharge or transfer a member from a senior care organization where the senior care organization demonstrates to the MassHealth agency's satisfaction a pattern of noncompliant or disruptive behavior by the member or for other good cause. In each case, the MassHealth agency 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.

508.009: Timely Notice of Appealable Actions

(A) Whenever an MCO, SCO, or the behavioral-health contractor reaches a decision that constitutes an appealable action, as described in 130 CMR 610.032(B), it must send a notice to the member within the following time frames that describes its decision and its internal appeal procedures:

(1) for a standard service authorization decision to deny or provide limited authorization for a requested service, no later than 14 days following receipt of the request for service, unless the time frame is extended up to 14 additional days because the member or a provider requested the extension or the MCO, SCO, or behavioral-health contractor can demonstrate a need for additional information and how the extension is in the member's interest;

(2) for an expedited service decision to deny or provide limited authorization for a requested service, where a provider requests, or an MCO, SCO, or behavioral-health contractor determines, that following the standard time frame in 130 CMR 508.009(A) could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, no later than three business days after receipt of the request for service, unless the time frame is extended up to 14 additional calendar days because the member requested the extension or the MCO, SCO, or behavioral-health contractor can demonstrate a need for additional information and how the extension is in the member's interest;

(3) for termination, suspension, or reduction of a previous authorization for a service, at least 10 days before the action, except as provided in 42 CFR 431.213; and

(4) for denial of payment where coverage of the requested service is at issue, on the day of the payment denial, except that no notice is necessary for procedural denials, which include, but are not limited to, the following:

(a) failure to follow the MCO, SCO, or behavioral-health contractor's prior authorization procedures;

(b) failure to follow referral rules; and

(c) failure to file a timely claim.

(B) Whenever an MCO, SCO, or the behavioral-health contractor fails to reach a decision on a standard or expedited service authorization within the time frames described in 130 CMR 508.009(A)(1) and (2), whichever is applicable, it must send a notice to the member on the date that such time frame expires.

508.010: Time Limits for Resolving Internal Appeals

(A) MCOs, SCOs, and the behavioral-health contractor must resolve standard internal appeals within 45 days after receiving the appeal, including any extensions pursuant to 130 CMR 508.010(C).

(B) Where the MCO, SCO, or behavioral-health contractor determines (for a request from the member or the provider, in making the request on the member's behalf) that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, MCOs, SCOs, or the behavioral-health contractor must resolve the internal appeal on an expedited basis within three business days after receiving the appeal, unless the time frames are extended by up to 14 days pursuant to 130 CMR 508.010(C), in which event the MCO, SCO, or behavioral-health contractor must resolve the appeal within 17 days after receiving the appeal. If the MCO, SCO, or behavioral-health contractor denies a member's request for expedited resolution of an internal appeal, the MCO, SCO, or behavioral-health contractor must resolve the appeal in accordance with the time frames in 130 CMR 508.010(A) and must make reasonable efforts to give the member prompt, oral notice of the denial and follow up within two calendar days with a written notice. The MCO, SCO, or behavioral-health contractor cannot deny a provider's request (on the member's behalf) that an internal appeal be expedited.

(C) MCOs, SCOs, and the behavioral-health contractor may extend the time frame for resolving internal appeals under the following circumstances, provided that, if the MCO, SCO, or the behavioral-health contractor extends the time frame, it must, for any extension not requested by the member, give the member written notice of the reason for the extension:

(1) if the member requests the extension; or

(2) if the MCO, SCO or the behavioral-health contractor shows (to the MassHealth agency's satisfaction, upon request) that there is a need for additional information and how the extension is in the member's interest.

508.011: Timely Notice of Internal Appeal Decisions

(A) MCOs, SCOs, and the behavioral-health contractor must provide notice of an internal appeal decision concerning an appealable action, as described in 130 CMR 610.032(B), within the timeframes described in 130 CMR 508.010.

(B) Notice from an MCO, SCO or the behavioral-health contractor concerning an internal appeal must be in writing and, for an expedited internal appeal, reasonable efforts must be made to provide oral notice.

(130 CMR 508.012 through 508.015 Reserved)

508.016: Copayments Required by MassHealth

MassHealth requires MassHealth members who are not enrolled in MCOs to make the copayments described in 130 CMR 520.036 through 520.040. If the usual and customary fee for the service is less than the copayment amount, the member must pay the amount of the service. Members who are enrolled in MassHealth MCOs must make copayments in accordance with the MCO's MassHealth copayment policy. Those MCO copayment policies must

(1) be approved by MassHealth;
(2) exclude the persons and services listed in 130 CMR 520.037;
(3) not exceed the MassHealth copayment amounts set forth in 130 CMR 520.038; and
(4) include the calendar-year maximum set forth in 130 CMR 520.040. (See also 130 CMR 450.130.)