



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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MassHealth
Eligibility Letter 219
July 31, 2017

TO: MassHealth Staff

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: MassHealth Managed Care Requirements – Physician Assistants as Primary Care Clinicians; Other Clarifications

Revisions to MassHealth regulations at 130 CMR 508.000 are briefly described below. These changes are effective for dates of service on and after August 1, 2017.

Primary Care Clinician (PCC) Updates to 130 CMR 508.000

Updates to 130 CMR 508.005 allow PCC Plan members to select an eligible physician assistant as their primary care provider within a group practice PCC. In addition, the requirements for all other available types of PCCs were clarified and streamlined (see 130 CMR 508.005(A)(1)(a)1. through 6.).

Other Updates to 130 CMR 508.000

Additional revisions to 130 CMR 508.000 clarify or update certain other MassHealth policies, as described below.

- Clarification relating to Services of MassHealth’s Behavioral Health Contractor: MassHealth has clarified that those non-emergency behavioral health services covered by the MassHealth’s contract with the behavioral health contractor may only be obtained from a provider who has an agreement with the MassHealth’s behavioral health contractor.
- Updates pertaining to One Care plans (Integrated Care Organizations (ICOs)): MassHealth has clarified in these regulations that:
 - Integrated Care Organizations (ICOs) are also called “One Care plans” and members in One Care Plans are participants in the Duals Demonstration.

- MassHealth Standard members enrolled in a One Care plan after age 65 may change One Care plans and remain in the Duals Demonstration.
- MassHealth is not required to do so, but may assign eligible members to a One Care Plan under specified circumstances, including but not limited to when there is at least one One Care Plan in a service area.
- Members with other health insurance (with the exception of Medicare) are excluded from participating in One Care.

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508.001: MassHealth Member Participation in Managed Care

(A) MassHealth-contracted Managed Care Organization (MCO) and Primary Care Clinician Plan (PCC Plan): Mandatory Enrollment. MassHealth members who are younger than 65 years old must enroll in a MassHealth-contracted MCO available for their coverage type or in the PCC Plan, except for members described in 130 CMR 508.001(B) or excluded from managed care pursuant to 130 CMR 508.002(A) or (B).

(B) MassHealth-contracted MCO and PCC Plan: Voluntary Enrollment. The following MassHealth members may, but are not required to, enroll in a MassHealth-contracted MCO available for their coverage type or in the PCC Plan:

- (1) MassHealth members who are receiving services from DCF or DYS;
- (2) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program*. Such members may choose to receive all services on a fee-for-service basis;
- (3) MassHealth members who are enrolled in a home- and community-based services waiver. Such members may choose to receive all services on a fee-for-service basis; or
- (4) MassHealth members who are receiving Title IV-E adoption assistance as described at 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance*. Such members may choose to receive all services on a fee-for-service basis.

(C) Senior Care Organizations (SCO). MassHealth members who are 65 years of age or older may enroll in a SCO pursuant to 130 CMR 508.008(A).

(D) Integrated Care Organizations (ICO). MassHealth members who are 21 through 64 years of age at time of enrollment may enroll in an ICO pursuant to 130 CMR 508.007(A).

(E) MassHealth Behavioral Health Contractor.

- (1) MassHealth Standard and CommonHealth members who are younger than 21 years of age and who are excluded from participation in a MassHealth-contracted MCO under 130 CMR 508.002(A)(1) or (2) or the PCC Plan under 130 CMR 508.002(B)(1) or (2) must enroll with the MassHealth behavioral health contractor.
- (2) MassHealth members who are receiving services from DCF or DYS and who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO must enroll with the MassHealth behavioral health contractor.
- (3) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program* and 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.

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(4) MassHealth members who are enrolled in a home- and community-based services waiver and 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.

(5) MassHealth members who are receiving Title IV-E adoption assistance as described at 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance* and 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.

508.002: MassHealth Members Excluded from Participation in Managed Care

(A) MassHealth-contracted MCO. The following MassHealth members are excluded from participation in a MassHealth-contracted MCO:

- (1) a member who has Medicare;
- (2) a member who has access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*;
- (3) a member who is 65 years of age or older. Such member may voluntarily enroll in a senior care organization (SCO) in accordance with the requirements at 130 CMR 508.008(A);
- (4) a member in a nursing facility, chronic disease or rehabilitation hospital, intermediate care facility for the mentally retarded (ICF/MR), or a state psychiatric hospital for other than a short-term rehabilitative stay;
- (5) a member who is eligible solely for
 - (a) MassHealth Limited; or
 - (b) Children's Medical Security Plan (CMSP);
- (6) a member who is receiving medical services through the Emergency Aid to the Elderly, Disabled and Children (EAEDC) Program pursuant to 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*;
- (7) a member who is receiving hospice care through MassHealth on a fee-for-service basis, or who is terminally ill as documented by a medical prognosis of a life expectancy of six months or less; and
- (8) a member who has presumptive eligibility.

(B) PCC Plan. The following MassHealth members are excluded from participation in the PCC Plan:

- (1) a member who has Medicare;
- (2) a member who has access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*;
- (3) a member who is 65 years of age or older;
- (4) a member in a nursing facility, chronic disease or rehabilitation hospital, ICF/MR, or a state psychiatric hospital for other than a short-term rehabilitative stay;

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- (5) a member who is eligible solely for
 - (a) MassHealth Limited; or
 - (b) Children's Medical Security Plan (CMSP);
- (6) a member who is receiving medical services through the EAEDC Program pursuant to 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*;
- (7) a member who is receiving hospice care through MassHealth on a fee-for-service basis, or who is terminally ill as documented by a medical prognosis of a life expectancy of six months or less; and
- (8) a member who has presumptive eligibility.

(C) SCO. The following MassHealth members 65 years of age and older are excluded from participating in a senior care organization (SCO):

- (1) a member who has access to other health insurance, with the exception of Medicare, that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*;
- (2) a member who does not live in the designated service area of a SCO;
- (3) a member in a chronic disease or rehabilitation hospital or ICF/MR;
- (4) a member who is not eligible for MassHealth Standard;
- (5) a member who has presumptive eligibility;
- (6) a member who is diagnosed as having end-stage renal disease;
- (7) a member who is enrolled in a home- and community-based services waiver, except the Home- and Community-Based Services Waiver-Frail Elder as described at 130 CMR 519.007(B): *Home- and Community-Based Services Waiver-Frail Elder*; and
- (8) a member who is a refugee described at 130 CMR 522.002: *Refugee Resettlement Program*.

(D) ICO. The following MassHealth members 21 through 64 years of age who are enrolled in Medicare Parts A and B and are eligible for Medicare Part D are excluded from participation in an integrated care organization (ICO):

- (1) a member who has other health insurance, with the exception of Medicare, that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*;
- (2) a member in an ICF/MR;
- (3) a member who is not eligible for MassHealth Standard or CommonHealth;
- (4) a member who has presumptive eligibility;
- (5) a member who is enrolled in a home- and community-based services waiver; and
- (6) a member who is a refugee described at 130 CMR 522.002: *Refugee Resettlement Program*.

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508.003 Enrollment in a MassHealth Managed Care Provider

In accordance with 130 CMR 508.004 through 508.008, members required or permitted to select a managed care provider may select any MassHealth managed care provider from the MassHealth agency's list of MassHealth managed care providers for the member's coverage type in the member's service area, if the provider is able to accept new members.

508.004: MassHealth-contracted Managed Care Organizations (MCOs)

(A) Enrollment in a MassHealth-contracted MCO.

(1) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member's obligation to select an MCO or other managed care provider within the time period specified by the MassHealth agency.

(a) Available MassHealth-contracted MCOs. The MassHealth agency notifies the member of the availability of MassHealth-contracted MCOs in the member's service area. The list of MCOs that the MassHealth agency will make available to members will include those MCOs that contract with the MassHealth agency to serve the coverage type for which the member is eligible and provide services within the 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) Out-of-area MCOs. A member who seeks to enroll with an MCO 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 MCO 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.

(2) Assignment to a Managed Care Provider. If a member does not choose an available MassHealth-contracted MCO or other 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 an available MassHealth-contracted MCO or other managed care provider.

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- (a) The MassHealth agency assigns a member to a MassHealth-contracted MCO or other managed care provider only if the MCO or other managed care provider is
 - 1. available for the member's coverage type;
 - 2. in the member's service area as described in 130 CMR 508.004(A)(1)(a);
 - 3. physically accessible to the member, if the member is disabled;
 - 4. suitable for the member's age and sex (for example, the member is the appropriate age for a pediatrician);
 - 5. 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
 - 6. located in an area to which the member has available transportation.
- (b) For MassHealth Standard members only:
 - 1. If the MassHealth agency determines that no MassHealth managed care provider meeting the criteria of 130 CMR 508.004(A)(2)(a) is available in the member's service area, the member may
 - a. choose not to enroll with a MassHealth managed care provider as long as such circumstances prevail; or
 - b. select an available MassHealth managed care provider outside of the member's service area.
 - 2. Any MassHealth Standard member who is not enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.004(A)(2)(b)1.a. 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 508.004(A)(2)(b)1. the MassHealth agency determines that a MassHealth managed care provider meeting the criteria of 130 CMR 508.004(A)(2)(a) 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 508.004(A)(2)(b)1.b.
- (3) Notification. The MassHealth agency will notify a member in writing of the name and address of the member's MassHealth-contracted MCO, and the member's enrollment effective date with the MCO.

(B) Obtaining Services when Enrolled in a MassHealth-contracted MCO.

- (1) Primary Care Services. When the member selects or is assigned to a MassHealth-contracted MCO, that MCO will deliver the member's primary care, decide if the member needs medical or other specialty care from other providers, and determine referral requirements for such necessary medical services.

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(2) Other Medical Services (Excluding Behavioral Health Services). 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. Members who enroll in a MassHealth-contracted MCO receive behavioral health services through that MCO. 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.

(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 choose 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: *Administrative and Billing Regulations*.

(C) Member Choice to Transfer or Disenroll from a MassHealth-contracted MCO. Members enrolled with an MCO, including but not limited to MassHealth CarePlus members, may transfer to another available MassHealth managed care provider as provided in 130 CMR 508.004(C). Transfers for MassHealth CarePlus members will take effect on the first day of the month following the member’s transfer request; provided however that MassHealth CarePlus members may transfer at any time in accordance with 130 CMR 508.004(C)(3) through (4). The MassHealth agency will notify members in writing of their disenrollment rights at least annually.

(1) Members enrolled with an MCO may transfer to another available MassHealth managed care provider for any reason during a plan selection period.

(a) For members newly enrolled with an MCO, except for members reenrolled in accordance with 130 CMR 508.004(E), the plan selection period occurs during the first 90 days of the member’s enrollment with the MCO.

(b) For all other members, the plan selection period will be a 90-day period that occurs annually.

(c) The MassHealth agency may designate additional plan selection periods at its discretion.

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(2) Except as set forth in 130 CMR 508.004(C)(3), a member enrolled with an MCO must remain enrolled with the MCO for the fixed enrollment period. For all members, the fixed enrollment period is the period of time when a member is not in a plan selection period. Members enrolled in an MCO pursuant to 130 CMR 508.001(B)(1) will not have a fixed enrollment period.

(3) At any time, a member may request a transfer out of the member's current MCO for any of the reasons listed in 130 CMR 508.004(C).

(a) The following reasons defined as cause for disenrollment in 42 CFR 438.56(d)(2):

1. the member moves out of the MCO's service area;
2. the MCO does not, because of moral or religious objections, cover the service the member seeks;
3. the member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or
4. other reasons, including but not limited to, poor quality of care, lack of access to services covered, or lack of access to providers experienced in dealing with the member's health-care needs;

(b) the MCO is no longer contracted with the MassHealth agency to cover the member's service area;

(c) the member adequately demonstrates to the MassHealth agency that the MCO has not provided access to providers that meet the member's health care needs over time, even after member's request for assistance;

(d) the member is homeless, the MassHealth agency's records indicate the member is homeless, and the MCO cannot accommodate the geographic needs of the member;

(e) the member adequately demonstrates to the MassHealth agency that the MCO substantially violated a material provision of its contract with MassHealth agency;

(f) the MassHealth agency imposes a sanction on the MCO that specifically allows for members to disenroll from the MCO without cause;

(g) the member adequately demonstrates to the MassHealth agency that the MCO is not meeting the member's language, communication, or other accessibility needs or preferences; or

(h) the member adequately demonstrates to the MassHealth agency that key network providers, including PCPs, specialists, or behavioral health providers, leave the MCO network.

(4) The MassHealth agency will determine that the requirements needed for a member transfer have been met. The MassHealth agency's determination is a ground for appeal in accordance with 130 CMR 610.032(A).

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- (5) Members voluntarily enrolled with an MCO pursuant to 130 CMR 508.001(B) may
- (a) transfer to another MassHealth-contracted MCO in accordance with the provisions of 130 CMR 508.005(C)(5);
 - (b) transfer to the PCC Plan at any time; or
 - (c) transfer out of the MassHealth managed care program at any time except as otherwise provided in 130 CMR 508.001(E).

(D) Other Disenrollment of Member from MCO. The MassHealth agency may disenroll a member from an MCO, at the MCO's 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. If the MassHealth agency approves a request for disenrollment under 130 CMR 508.005(D), it will state the good cause basis for disenrollment in a notice to the member in accordance with 130 CMR 610.032(A)(11).

(E) Reenrollment. Any member enrolled with an MCO who loses and then regains managed care eligibility may be automatically reenrolled with the MCO with which the member was most recently enrolled, if such MCO is available for the member's coverage type.

- (1) A member enrolled with an MCO who loses managed care eligibility during a plan selection period will receive a new plan selection period upon regaining eligibility.
- (2) A member enrolled with an MCO who loses managed care eligibility during the fixed enrollment period will not receive a new plan selection period upon regaining managed care eligibility; provided, however, that if a member's loss of managed care eligibility causes the member to miss part or all of the member's annual plan selection period, the member will receive a new plan selection period upon regaining managed care eligibility.

(F) Copayments. Members who are enrolled in MassHealth-contracted 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 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;
- (3) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment and Cost Sharing Requirement Exclusions* and 520.038: *Services Subject to Copayments*; and
- (4) include the copayment maximums set forth in 130 CMR 506.018: *Maximum Cost Sharing* and 520.040: *Maximum Cost Sharing*. (See also 130 CMR 450.130: *Copayments Required by the MassHealth Agency*.)

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508.005: MassHealth Primary Care Clinician Plan (PCC Plan)

(A) Enrollment in the PCC Plan.

(1) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member's obligation to select the PCC Plan or other managed care provider within the time period specified by the MassHealth agency.

(a) Available PCCs. The MassHealth agency notifies the member of the availability of primary care clinicians (PCCs) in the 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. The list of PCCs 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 who is board-eligible or board-certified in family practice, pediatrics, internal medicine, obstetrics, gynecology, or obstetrics/gynecology and otherwise meets the requirements of 130 CMR 450.118(B)(1). A physician specialist must provide primary care services to PCC Plan enrollees;
2. an independent certified nurse practitioner who specializes in family practice, pediatrics, internal medicine, obstetrics, gynecology or obstetrics/gynecology, and otherwise meets the requirements of 130 CMR 450.118(B)(2). An independent certified nurse practitioner specialist must provide primary care services to PCC Plan enrollees;
3. a licensed community health center that meets the requirements of 130 CMR 450.118(B)(3);
4. an acute hospital outpatient department that meets the requirements of 130 CMR 450.118(B)(4);
5. a group practice that meets the requirements of 130 CMR 450.118(B)(5); or
6. a physician assistant in a group practice that meets the requirements of 130 CMR 450.118(B)(6).

(b) Out-of-area PCCs. A member who seeks to enroll with a PCC 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 PCC where the MassHealth agency determines that

1. there is no PCC 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 PCC is equal to or less than the travel time to a PCC in the member's service area, or the medical benefit of receiving care from a PCC in the member's service area is substantially outweighed, as determined by the MassHealth agency, by the medical benefit of

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receiving care from the out-of-area PCC requested by the member.

(2) Assignment to the PCC Plan. If a member does not choose the PCC Plan or other 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 the PCC Plan or other MassHealth managed care provider.

(a) The MassHealth agency assigns a member to the PCC Plan or other managed care provider only if the PCC Plan or other managed care provider is

1. available for the member's coverage type;
2. in the member's service area as described in 130 CMR 508.005(A)(1)(a);
3. physically accessible to the member, if the member is disabled;
4. suitable for the member's age and sex (for example, the member is the appropriate age for a pediatrician);
5. 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
6. located in an area to which the member has available transportation.

(b) For MassHealth Standard members only:

1. If the MassHealth agency determines that no MassHealth managed care provider meeting the criteria of 130 CMR 508.005(A)(2)(a) is available in the member's service area, the member may
 - a. choose not to enroll with a MassHealth managed care provider as long as such circumstances prevail; or
 - b. select an available MassHealth managed care provider outside of the member's service area.
2. Any MassHealth Standard member who is not enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.005(A)(2)(b)1.a. 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 508.005(A)(2)(b)1., the MassHealth agency determines that a MassHealth managed care provider meeting the criteria of 130 CMR 508.005(A)(2)(a) 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 508.005(A)(2)(b)1.b.

(3) Notification. The MassHealth agency will notify a member in writing of the name and address of the member's PCC, and the member's enrollment effective date with the PCC.

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(B) Obtaining Services when Enrolled with the PCC Plan.

(1) Primary Care. When the member selects or is assigned to the PCC Plan, the member's selected or assigned PCC will deliver the member's primary care, decide if the member needs medical or other specialty care from other providers, and make referrals for such necessary medical services.

(2) Other Medical Services (excluding Behavioral Health). All medical services, except those services listed in 130 CMR 450.118(J): *Referral for Services*, require a referral or authorization from the member's 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.

(3) Behavioral Health Services. All members enrolled with the PCC Plan receive behavioral health (mental health and substance use disorder) services, except those services not covered under the MassHealth contract with the behavioral health contractor, through the MassHealth behavioral health contractor as follows:

(a) Nonemergency Behavioral Health Services. Behavioral health services covered by the MassHealth agency's contract with the behavioral health contractor, 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 those 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.

(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 may choose 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: *Administrative and Billing Regulations*.

(C) Member Choice to Transfer or Disenroll from the PCC Plan. Members may transfer from the PCC Plan to another available MassHealth managed care provider at any time. Transfers for MassHealth CarePlus members will take effect on the first day of the month following the member's transfer request; provided, however, that MassHealth CarePlus members may transfer at any time in accordance with 130 CMR 508.004(C)(3) through (4).

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(D) Other Disenrollment of Member from the PCC Plan.

- (1) The MassHealth agency may disenroll a member from a PCC's panel, at the PCC's request, if the PCC 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.
- (2) If the MassHealth agency approves a request for disenrollment under 130 CMR 508.005(D)(1)(a) and (b), it will state the good cause basis for disenrollment in a notice to the member in accordance with 130 CMR 610.032(A)(11).

(E) Reenrollment. Any member in the PCC Plan who loses and then regains managed care eligibility may be automatically reenrolled with the PCC Plan, if the PCC Plan is available for the member's coverage type.

(F) Copayments. MassHealth requires MassHealth members enrolled in the PCC Plan to make the copayments described in 130 CMR 506.014 through 506.018 and 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.

(130 CMR 508.006 Reserved)

508.007: Integrated Care Organizations

(A) Eligibility.

- (1) In order to be eligible to enroll in an integrated care organization (ICO), a MassHealth member must meet all of the following criteria, and may not be enrolled or concurrently participate in any of the programs or plans listed in 130 CMR 508.007(F):
 - (a) be 21 through 64 years of age at the time of enrollment;
 - (b) be eligible for MassHealth Standard as defined in 130 CMR 450.105(A): *MassHealth Standard* or MassHealth CommonHealth as defined in 130 CMR 450.105(E): *MassHealth CommonHealth*;
 - (c) be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*; and
 - (d) live in a designated service area of an ICO.
- (2) If a member is enrolled in an ICO and turns age 65 years of age and is eligible for MassHealth Standard, he or she may elect to remain in One Care after age 65 years of age.

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(B) Selection Procedure and Assignment to an ICO.

(1) The MassHealth agency will notify members

- (a) of the availability of an ICO in their service area and how to enroll in an ICO;
- (b) that, in any service area with at least one ICO, MassHealth may assign eligible members who do not choose an ICO but have not opted out of the Duals Demonstration; and
- (c) how to opt out of the Duals Demonstration.

(2) An eligible member may enroll in any ICO in the member's service area by making a written or verbal request to MassHealth or its designee. A service area is the specific geographical area of Massachusetts in which an ICO agrees to provide ICO services. Service listings can be obtained from the MassHealth agency or its designee. The list of integrated care organizations (ICOs) that the MassHealth agency will make available to members will include those ICOs that contract with the MassHealth agency and provide services within the member's service area. ICOs are also referred to as One Care plans. Members enrolled in an ICO (One Care plan) are participants in the Duals Demonstration, also known as One Care.

(3) MassHealth provides written notice at least 60 days in advance of its assignment of any eligible members to an ICO. The notice includes the ICO to which the member is being assigned, information about how to enroll in a different ICO, if available, and information about how to opt out of the Duals Demonstration.

(C) Obtaining Services When Enrolled in an ICO. When a member is enrolled in an ICO in accordance with the requirements under 130 CMR 508.007(A), the ICO will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, the ICO is required to provide evidence of its coverage, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to specialty, behavioral health, and long-term services and supports.

(D) Disenrollment from an Integrated Care Organization. A member may disenroll from an ICO at any time by notifying the MassHealth agency or its designee verbally or in writing. A member who disenrolls from an ICO, but does not select another ICO or opt out of the Duals Demonstration, may be automatically assigned another ICO provided that MassHealth provides a written notice at least 60 days in advance of any auto assignment. The notice includes the ICO to which the member is assigned, information about how to enroll in a different ICO if available, and information about how to opt out of the Duals Demonstration. Disenrollment requests that are received by the MassHealth agency on the last calendar day of the month will be effective on the first day of the following month.

(E) Disenrollment from the Duals Demonstration. A member may opt out of the Duals Demonstration at any time by notifying the MassHealth agency or its designee verbally or in writing. Requests that are received by the MassHealth agency on the last calendar day of the month will be effective on the first day of the following month.

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(F) Other Programs. A member may not be enrolled in an ICO and concurrently participate or be enrolled in any of the following programs or plans:

- (1) programs described at 130 CMR 519.007: *Individuals Who Would Be Institutionalized*;
- (2) Medicare demonstration program or Medicare Advantage plan, except for a Medicare Advantage Special Needs Plan for Dual Eligibles contracted as an ICO;
- (3) any Medicare Demonstrations wherein concurrent participation in the Duals Demonstration is prohibited;
- (4) Employer Group Waiver Plans or other employer-sponsored plans; or
- (5) plans receiving a retiree drug subsidy.

(G) Copayments. Members who are enrolled in an ICO must make copayments in accordance with the ICO's MassHealth copayment policy. Those ICO copayment policies must

- (1) be approved by MassHealth;
- (2) exclude the persons and services listed in 130 CMR 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;
- (3) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment and Cost Sharing Requirement Exclusions* and 520.038: *Services Subject to Copayments*; and
- (4) include the copayment maximums set forth in 130 CMR 506.018: *Maximum Cost Sharing* and 520.040: *Maximum Cost Sharing*. (See also 130 CMR 450.130: *Copayments Required by the MassHealth Agency*.)

508.008: 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 65 years of age 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: *Eligibility for a Deductible*;
- (5) not be a resident of an intermediate care facility for the intellectually disabled (ICF/MR); and
- (6) not be an inpatient in a chronic or rehabilitation hospital.

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

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senior care organizations (SCOs) that the MassHealth agency will make available to members will include those SCOs that contract with the MassHealth agency and provide services within the member's service area.

(C) Obtaining Services When Enrolled in a SCO. When a member chooses to enroll in a senior care organization (SCO) in accordance with the requirements under 130 CMR 508.008, the SCO 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 SCO 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 SCO 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 SCO where the SCO 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 (SCO) under 130 CMR 508.008, a member may not concurrently participate in

- (1) any program described in 130 CMR 519.007: *Individuals Who Would be Institutionalized*, except the Home- and Community-based Services Waiver-Frail Elder described in 130 CMR 519.007(B): *Home- and Community-based Services Waiver-Frail Elder*;
- (2) any Medicare demonstration program or Medicare Advantage plan, except for Medicare Advantage Special Needs Plan for Dual Eligibles contracted as a SCO; or
- (3) an ICO described in 130 CMR 508.007.

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- (G) Copayments. Members who are enrolled in a SCO must make copayments in accordance with the SCO's MassHealth copayment policy. Those SCO copayment policies must
- (1) be approved by MassHealth;
 - (2) exclude the persons and services listed in 130 CMR 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;
 - (3) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment and Cost Sharing Requirement Exclusions* and 520.038: *Services Subject to Copayments*; and
 - (4) include the copayment maximums set forth in 130 CMR 506.018: *Maximum Cost Sharing* and 520.040: *Maximum Cost Sharing*. (See also 130 CMR 450.130: *Copayments Required by the MassHealth Agency*.)

508.009: Behavioral Health Contractor

The following applies to MassHealth members who are not in the PCC Plan and who receive behavioral health services through MassHealth's behavioral health contractor. (See 130 CMR 508.001(E).)

(A) Nonemergency Behavioral Health Services. Behavioral health services, except for emergency services and those services not covered under the MassHealth contract with the behavioral health contractor, 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 those 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.

508.010: Right to a Fair Hearing

Members are entitled to a fair hearing under 130 CMR 610.000: *MassHealth: Fair Hearing Rules* to appeal

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

(B) a determination by the MassHealth behavioral health contractor, by one of the MassHealth contracted MCOs or SCOs as further described in 130 CMR 610.032(B), if the member has exhausted all remedies available through the contractor's internal appeals process;

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(C) the MassHealth agency's denial of a request for an out-of-area MassHealth managed care provider under 130 CMR 508.004(A)(1)(b) or 508.005((A)(1)(b);

(D) the MassHealth agency's disenrollment of a member from an MCO under 130 CMR 508.004(D) or from a PCC's panel under 130 CMR 508.005(D), or discharge of a member from a SCO under 130 CMR 508.008(E); or

(E) the MassHealth agency's determination that the requirements for a member transfer under 130 CMR 508.004(C)(3) or 508.005(C) have not been met.

508.011: Timely Notice of Appealable Actions

(A) Whenever an MCO, SCO, ICO, 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, and ICO, 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, ICO, or behavioral health contractor determines, that following the standard time frame in 130 CMR 508.011(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, ICO, 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 ten 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, ICO, or behavioral health contractor's prior authorization procedures;

(b) failure to follow referral rules; and

(c) failure to file a timely claim.

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(B) Whenever an MCO, SCO, ICO, 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 508.011(A)(1) and (2), whichever is applicable, it must send a notice to the member on the date that such time frame expires.

508.012: Time Limits for Resolving Internal Appeals

(A) MCOs, SCOs, ICOs, and the behavioral health contractor must resolve standard internal appeals within 45 days after receiving the appeal, including any extensions pursuant to 130 CMR 508.012(C).

(B) Where the provider requests an expedited appeal or the MCO, SCO, ICO, or behavioral health contractor determines (for a request from the member) that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO, SCO, ICO, or the behavioral health contractor must resolve the internal appeal on an expedited basis within 72 hours after receiving the appeal, unless the time frames are extended by up to 14 days pursuant to 130 CMR 508.012(C), in which event the MCO, SCO, ICO, or behavioral health contractor must resolve the appeal within 17 days after receiving the appeal. If the MCO, SCO, ICO, or behavioral health contractor denies a member's request for expedited resolution of an internal appeal, the MCO, SCO, ICO, or behavioral health contractor must resolve the appeal in accordance with the time frames in 130 CMR 508.012(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, ICO, or behavioral health contractor cannot deny a provider's request (on the member's behalf) that an internal appeal be expedited.

(C) MCOs, SCOs, ICOs, and the behavioral health contractor may extend the time frame for resolving internal appeals under the following circumstances, provided that, if the MCO, SCO, ICO, or the behavioral health contractor extends the time frame, it must give the member written notice of the reason for the extension:

- (1) the member requested the extension;
- (2) the MCO, SCO or the behavioral health contractor showed (to the MassHealth agency's satisfaction) that there is a need for additional information and how the extension is in the member's interest; or
- (3) the ICO showed (to the satisfaction of the MassHealth agency and the Centers for Medicare & Medicaid Services (CMS)) that there is a need for additional information and how the extension is in the member's interest.

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508.013: Timely Notice of Internal Appeal Decisions

(A) MCOs, SCOs, ICOs, 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 508.012.

(B) Notice from an MCO, a SCO, an ICO, 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.

REGULATORY AUTHORITY

130 CMR 508.000: M.G.L. c. 118E, §§ 7 and 12