Important Information About MassHealth Coverage Changes Effective January 1

January is a time of great change for healthcare in Massachusetts. The Affordable Care Act (ACA) offers a chance for an expansion of the MassHealth program and the launch of a new MassHealth plan called MassHealth CarePlus.

Effective January 1st, 2014, approximately 300,000 members became eligible for new MassHealth coverage types. Eligible members who were previously enrolled in MassHealth Basic, MassHealth Essential, Commonwealth Care, the Insurance Partnership or the Health Safety Net were enrolled starting January first in MassHealth Standard, Family Assistance or CarePlus.

Members and their families, as well as providers, should be aware of these changes to ensure a smooth transition.

What is MassHealth CarePlus?

MassHealth CarePlus is a new benefit plan for adults 21 to 64 years old whose income is at or below 133 percent of the federal poverty level, and who do not qualify for MassHealth Standard. MassHealth CarePlus offers a wide range of health benefits, such as doctor and clinic visits, hospital stays, prescription medicines, mental and behavioral health, and substance abuse services. MassHealth CarePlus is provided through six health plans known as managed care organizations (MCOs), unless the member is enrolled in other insurance outside MassHealth, such as through an employer. Members receive full coverage for CarePlus covered services on a fee-for-service basis until their enrollment in a health plan is effective. MassHealth will not enroll Care Plus members who are enrolled in other insurance into a health plan, and those members will receive CarePlus benefits that are not provided by the other insurance on a fee-for-service basis.

The six health plans serving MassHealth CarePlus members are BMC HealthNet Plan, CeltiCare Health Plan, Fallon Community Health Plan, Health New England, Neighborhood Health Plan and Network Health. The specific plans available vary depending on where the member lives.

What should members do?

The majority of MassHealth members – about 80 percent – did not experience any change in their coverage when the ACA went into effect on January 1st. Members who did experience a change should have received letters from MassHealth in November and December explaining the coming changes. These changes took effect automatically on January first – members do *not* have to re-apply to qualify for the new MassHealth coverage.

Most MassHealth CarePlus members who were previously enrolled in a MassHealth or Commonwealth Care MCO remain with their current MCO. Some MassHealth CarePlus members needed to enroll in a new health plan if they were previously enrolled in the PCC Plan or were not enrolled in a health plan through MassHealth or Commmonwealth Care in the last year. Members who needed to enroll in a new plan should have received a letter from

MassHealth in December telling them about their health plan options. If they did not contact MassHealth to select a plan, then MassHealth has enrolled them in one of the available CarePlus MCOs where the member lives, effective January 1, 2014. CarePlus members enrolled in a new health plan can expect to receive a welcome packet from their new plan in early January. However, members may not receive their new health plan ID and welcome packet right away. Until the new health plan ID arrives, members can use their MassHealth ID when they go to the pharmacy or seek medical services, and providers can look up the member's eligibility and health plan enrollment.

Members also may contact MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) or their health plan if they have any questions about their coverage. Members can also contact MassHealth Customer Service if they do not know what health plan they are enrolled in or if they wish to change plans. In most cases, a member's request to change health plans will be effective on the first day of the next month.

What should providers do?

As always, providers should check MassHealth's Eligibility Verification System (EVS) every time they provide services, and every day of an inpatient hospital stay, to confirm a member's eligibility and enrollment. Providers especially should be sure to check EVS in early 2014 for any updates to members' coverage type or managed care enrollment. If a member's managed care enrollment has changed, providers should contact the new health plan as soon as possible to ensure authorization for all medically necessary services. Please see below for contact information for each of the CarePlus MCOs. In addition, if a member does not have his or her health plan ID yet, the provider should look up the member in EVS using the member's MassHealth ID or other identifying information.

Providers should also be aware that CarePlus health plans will generally cover medically necessary services during the first 30 days of the member's enrollment in the plan even if the provider is outside the CarePlus health plan's network. Providers are encouraged to contact the member's CarePlus health plan to confirm or obtain authorization, if needed, for services. Please see below for further details.

Will members have access to health care services right away if they change to a new plan?

Yes, members whose coverage is changing will continue to have access to health care services as they transition to their new coverage and plan. CarePlus members may have a small co-pay for certain services such as prescription medications.

MassHealth and the CarePlus MCOs are working to ensure a smooth transition for all new members. All of the CarePlus MCOs are making accommodations to facilitate continuity of care so that members can continue to see existing providers for medically necessary services for at least 30 days, even if the provider is outside of the CarePlus MCO's network. This includes but is not limited to upcoming appointments; ongoing treatment such as chemotherapy or treatment for behavioral health or substance use; scheduled and unscheduled inpatient care (medical and behavioral health); and other medically necessary services. Providers are encouraged to contact the member's CarePlus health plan to confirm or obtain authorization, if needed, for

services.

The table below outlines what members who are transitioning to a MassHealth CarePlus MCO can expect if they need different kinds of services:

Pharmacy	If a member has an existing prescription and needs a refill, that member should see no change in the usual refill process unless a Prior Authorization (PA) is required by the new CarePlus MCO. If a PA is required for that medication by the new CarePlus MCO, at a minimum members will receive a 72-hour supply of the medication until a PA can be processed. If the new CarePlus MCO does not require a PA for that medication, a refill will be provided.
Emergency Room	A MassHealth CarePlus MCO member having a medical emergency may seek emergency care at any emergency room, whether it is in the member's CarePlus MCO network or not. Emergency services will be covered at no cost to the member.
Inpatient Care (medical or behavioral Health)	A member who is receiving inpatient care may remain in the hospital as long as medically necessary, but the hospital should contact the new plan right away. The new MCO is responsible for providing coverage for medically necessary inpatient hospital care for new members from the first day of enrollment.
Outpatient Treatment - Medical	CarePlus members may continue to seek medically necessary services and see existing providers for outpatient primary or specialty care, including outpatient surgery, during the initial transition period (30 days). This includes medical appointments and ongoing medical treatment. Members and/or providers should contact the member's new plan as soon as possible to inform the plan of upcoming medical appointments and/or any ongoing course of treatment or existing prior authorizations.
Outpatient Treatment Behavioral Health and Substance Use Disorder	CarePlus members who are in ongoing treatment for behavioral health (BH) or substance use may continue to seek services during the initial transition period. CarePlus MCOs will honor PAs for BH covered services, for medically necessary care, even if the provider is out-of-network for no less than 30 days, for BH outpatient and BH diversionary services. "Continuing care" involving BH covered services, beyond what has been authorized previously, will be addressed by the member and/or the member's BH provider, and the CarePlus MCO, to plan for any needed continuing care, beyond what had been covered throughout the "transition of care" period. Members and/or their providers should reach out to the member's new plan as soon as possible to inform them of any ongoing courses of treatment or existing prior authorizations.
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) and	CarePlus members will have continued access to durable medical equipment (DME) and prosthetics, orthotics and supplies (POS) that were previously authorized during the transition period. Members will also have access to physical therapy (PT), occupational therapy (OT) and speech therapy (ST) that were previously authorized. CarePlus MCOs will authorize or continue existing authorization for DME POS, PT, OT, and ST for

outpatient therapies (PT, OT and ST)	transitioning members for 30 days without medical necessity review. Requests for DME, POS PA for ongoing services with an out-of-network provider will also be authorized for a minimum of 30 days while the Plan works to transition the member to an in-network provider. Members and/or their providers should reach out to the member's new plan as soon as possible to inform them of any ongoing courses of treatment or existing prior authorizations.

What if a CarePlus member is not currently enrolled in a CarePlus health plan?

Because CarePlus health plan enrollment is generally effective on the first of the month, some CarePlus members will have a period of time when they are eligible for CarePlus before their health plan enrollment becomes effective. During this time, they have full coverage for CarePlus covered services through MassHealth on a fee-for-service basis. This is very similar to how coverage currently works for MassHealth Standard and CommonHealth members. Even if a member is not yet enrolled in a plan, the member may access health care services, and providers can bill MassHealth directly for medically necessary covered services provided to CarePlus-eligible members.

In addition, some members may not be enrolled in a health plan because they have other insurance or MassHealth's records indicate that they have other insurance. In this case, MassHealth will pay on a fee-for-service basis for medically necessary CarePlus covered services that are not covered by the member's primary insurance.

If CarePlus-eligible members who are not enrolled in a health plan have questions about their coverage or would like to enroll in a health plan, they should call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

Where can I find out more information?

For more information on the changes coming to MassHealth coverage, read the Frequently Asked Questions on MassHealth's website; http://www.mass.gov/eohhs/provider/insurance/masshealth/aca/the-aca-and-masshealth-member-related-faq.html.

If you are a member or provider and have specific questions about a member's coverage or health plan enrollment, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) or the member's health plan:

BMC HealthNet Plan

Member Services:
1-888-566-0010

Provider Services:

1-888-566-0008

Nurse Advice Line:
800-973-6273

Pharmacy Services:
Call Member Services or Provider Services. Select Pharmacy option.

Behavioral Health Services:
Member Services:
1-888-217-3501
Provider Services:
1-866-444-5155

Durable Medical Equipment, Prosthetics, Orthotics and Supplies:
1-866-802-6471

CeltiCare Health Plan

Member Services:
1-855-678-6975

Provider Services:
1-855-678-6975

Behavioral Health Services:
1-866-896-5053

Fallon Community Health Plan

Member Services:
1-800-341-4848

Provider Services:
1-866-275-3247

Behavioral Health Services:
1-888-421-8861 (24/7)

Health New England

Member Services:
1-800-786-9999

Provider Services:
1-800.842-4464 ext. 5000

Behavioral Health Services:
1-800-495-0086

Neighborhood Health Plan

Member Services:
1-800-462-5449

Provider Services:
1-855-444-4647

Behavioral Health Services:
1-800-414-2820

Network Health

Member Services:
1-888-257-1985

Provider Services:
1-888-257-1985

Behavioral Health:
1-888-257-1985