

Part 14

Other Eligibility Rules

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140 Does someone have to have a Social Security number to get MassHealth?

Federal Medicaid rules require that someone have a Social Security number or apply for a Social Security number in order to get Medicaid with the exception of Emergency Medicaid (MassHealth Limited). However, a person does not need to have a Social Security number if he or she is applying on behalf of someone else, such as a child, but is not applying for full MassHealth for himself or herself.

Certain otherwise eligible immigrants may not be able to obtain Social Security numbers. They should not be denied MassHealth for this reason, but may have to explain their problem in reply to computer-generated notices that ask for proof that they have obtained or applied for a Social Security number or may have to supply proof that they applied for a number and were unable to obtain one.

130 C.M.R. §§ 503.003, 517.006; 42 C.F.R. § 435.910

141 What does it mean when the application says applicants have to assign rights to medical support and third-party payments?

MassHealth is generally the payer of last resort, and the MassHealth agency will attempt to identify third parties who may be liable to pay part or all of a member's medical costs. The MassHealth agency requires that applicants assign to it rights to medical support and other third-party payments as a condition of eligibility for MassHealth. Third-party payments include health insurance payments or other payments for medical benefits that a third party is legally liable to make on a member's behalf. If there is a spouse or former spouse or parent living outside the home, that person may have a duty to provide support, including medical support, to a spouse or child. The assignment includes a duty to cooperate with the agency if necessary to establish paternity, obtain an order of medical support, enforce an existing order or identify other liable third parties. The child support enforcement

agency (the Department of Revenue) is supposed to pursue medical support for a child when health insurance is available from an absent parent for a reasonable cost.

130 C.M.R. §§ 503.004, 517.009; 42 C.F.R. § 433.145.

142 What can be done when pursuing medical support may lead to domestic violence?

If cooperating with medical support would result in serious physical or emotional harm to the parent, the child, or someone else in the household, the member has good cause not to cooperate. Good cause can be claimed on Supplement B of the MassHealth MBR form or, if the situation arises after application, by notifying the Benefit Coordination unit at the MassHealth agency (617-886-8048, Michelle). Without good cause, a member may lose MassHealth coverage for failure to cooperate unless the member is a minor child or pregnant woman.

130 C.M.R. § 503.005; 42 C.F.R. § 433.147(c)(2).

143 What does it mean when the application says applicants have to assign rights to third-party recoveries?

Third-party recoveries are payments as a result of an accident, illness, injury, or other loss. Members must inform the MassHealth agency when anyone covered by MassHealth is involved in an accident or has an injury that may result in a lawsuit or insurance claim, and assign to the MassHealth agency the right to recover medical benefits from the proceeds of any claim. Under state law the assignment of the right to recover from third parties is automatic when the applicant applies for MassHealth, and the MassHealth agency has a lien against the third-party recovery.

130 C.M.R. §§ 503.006; 517.011. *See also* G.L. c. 118E, § 22. For limitations on recovery imposed by federal law, see *Arkansas Dept. of Health and Human Svcs. v. Ahlborn*, 547 U.S. 268 (2006) (Medicaid lien against personal injury settlement must be limited to portion of settlement allocated to past medical expenses).

144 When does someone with MassHealth have to maintain other available health insurance?

Applicants for and recipients of MassHealth Standard or CommonHealth may be required to cooperate in maintaining health insurance available at no greater cost to them than the premiums otherwise charged for MassHealth, or in enabling the agency to purchase cost-effective health insurance under MassHealth Standard/CommonHealth Premium Assistance (MSCPA). Under MSCPA, the member will remain eligible for Standard/CommonHealth to supplement coverage not available under the other health insurance.

130 C.M.R. § 507.003 (MSCPA).

Children eligible for Family Assistance may also be required to obtain private employer-sponsored insurance as a condition of eligibility. MassHealth will provide Family Assistance Premium Assistance to enable the family to afford the employer-sponsored insurance. In Family Assistance Premium Assistance, unlike MSCPA, a child will not be able to keep MassHealth direct coverage to supplement the employer-sponsored plan.

130 C.M.R. § 503.007 (Family Assistance).

People age 65 and over and institutionalized individuals of any age are required to take all necessary steps to obtain any benefits to which the member is legally entitled unless doing so would cause them harm. However, members are not required to apply for TAFDC, EAEDC, SSI, or state veteran's benefits. In addition, seniors are required to maintain health insurance available to them at no cost including Medicare and private insurance where the premium cost is paid by the MassHealth agency.

130 C.M.R. § 517.008.

Part 15

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145 What services does MassHealth cover?

Federal Medicaid requires coverage of certain “mandatory” services and permits coverage of other “optional” services; it also permits reasonable limits on the amount, duration, and scope of both mandatory and optional services. MassHealth covers all mandatory and most optional services in MassHealth Standard and CommonHealth but imposes a variety of limitations and controls on the scope of services. The 1115 demonstration and SCHIP authorize the agency to offer fewer benefits for the other types of MassHealth coverage. Further, even if a service is included as a covered benefit, the MassHealth agency may still deny payment if the service is not medically necessary for the particular patient.

Each type of MassHealth covers certain specific medical services. Table 17 lists 40 services covered in MassHealth Standard and CommonHealth and the fewer number of services available in three other types of MassHealth: Family Assistance, Basic and Essential and in Commonwealth Care. The MassHealth Managed Care Organizations (MMCOs), the SCO plans and the Behavioral Health Partnership provide certain additional services as well. See Part 10 and Table 9 in Appendix B for a further description of services covered in Commonwealth Care.

146 What sources describe the services covered in MassHealth?

To know whether a particular service is covered one must first know what type of MassHealth the individual has: MassHealth Standard, CommonHealth, Family Assistance, Basic, Essential or Limited. Once this is known, the best place to start is with the state regulations. Table 17 cites to the regulation for each service. Medicaid services are often described by the type of provider that bills for the service, e.g., physician or community health center. When consulting the regulations be sure to look for the description of eligible providers as well as eligible services. For example, the regulations at 130 C.M.R. § 432 on therapy services only describe services by independent therapists. Therapy services by home health agencies, and outpatient hospital departments are described in the regulations for home health services and outpatient hospital services at 130 C.M.R. §§ 403 and 410.

Part 15 n Covered Services

In addition to the regulations, the MassHealth agency publishes 50 provider manuals that describe services in more detail, such as by listing specific procedure codes that are covered or excluded. The MassHealth agency also publishes provider bulletins and transmittal letters notifying providers of changes to the manuals and new policies. The regulations, provider manuals and provider bulletins, transmittals and other information about covered services are posted on the MassHealth website.

The Partnership and the MassHealth Managed Care Organizations offer additional services that are not described in the regulations, but are generally described in their member handbooks and websites as well as in their contracts with the MassHealth agency. Some MCOs may offer such extras as child bicycle helmets and child car seats for example. See Part 20 for their websites.

Finally, state and federal law should be consulted to identify the required scope of covered services. Generally only a few services are specified in state law. *See, e.g.,* G.L. c. 118E, §§ 10A–10C (prenatal care, childbirth, and postpartum care; newborn hearing screening tests; and items necessary for treatment of diabetes). A useful starting point in researching federal law is the National Health Law Program Guide to the Medicaid Program listed in Part 20.

For Commonwealth Care, the most detailed description of covered benefits will be in the Explanation of Benefits produced by each Managed Care Organization. It will be included in a Member Handbook and is generally posted on the MCOs website. Like the MassHealth MCOs, some Commonwealth Care MCOs may offer extra benefits not required in the MCOs contract with the Connector such as chiropractic services. The Connector website also includes a schedule of copayments and required benefits for each Commonwealth Care plan type.

147 What services are covered by MassHealth Standard?

MassHealth Standard is the most comprehensive type of coverage. It is more comprehensive than most private health insurance because it covers long-term nursing home and other institutional care and a range of long-term services and supports designed to avoid institutional care such as personal care attendants, private duty nursing, and adult day health. The services it covers are listed in

Table 17. Generally, MassHealth Standard is the only type of MassHealth that covers long-term nursing home care, but it is covered under traditional Medicaid rules not the 1115 demonstration (Medicaid reform).

130 C.M.R. § 450.105(A).

148 What is covered by CommonHealth?

CommonHealth covers the same kinds of services as MassHealth Standard. See Table 17. However, there are differences between CommonHealth and Standard in the amount, duration, and scope of services and when prior authorization is required. For example, CommonHealth generally only covers short-term nursing home stays. It covers long-term institutionalized care only for children who are ineligible for MassHealth Standard during the five-year period after becoming legal permanent residents. 130 C.M.R. § 519.012(B).

130 C.M.R. § 450.105(E).

149 What is covered by Family Assistance Premium Assistance?

Under Family Assistance Premium Assistance, the individual receives assistance paying the employee share of the premium cost of employer-sponsored coverage. The benefits consist of whatever benefits are covered under the employer-sponsored plans. However, the employer-sponsored plan must meet the basic benefit level in order for the employee to be eligible for Premium Assistance. The basic benefit level must equal “minimum creditable coverage” as defined by the Connector. Family Assistance direct coverage is not available to supplement the limitations of the employer-sponsored plan except for individuals who are HIV positive. Cost-sharing for children in premium assistance will be reimbursed for well-child visits, and after total costs exceed 5 percent of gross family income.

130 C.M.R. § 505.005; 956 C.M.R. § 500.00 (minimum creditable coverage).

150 What is covered by Family Assistance Direct Coverage?

Family Assistance direct coverage covers fewer services than MassHealth Standard or CommonHealth as shown in Table 17 but still provides comprehensive coverage comparable to most commercial insurance. It does not cover nonemergency transportation, or certain other specialized services for adults or people with disabilities.

130 C.M.R. § 450.105(H)(3).

151 What is covered by MassHealth Basic?

MassHealth Basic covers fewer services than MassHealth Standard, CommonHealth or Family Assistance as shown in Table 17. Further, even where the same kinds of services are listed for MassHealth Standard and Basic there are differences between them in the amount, duration, and scope of services and when prior authorization is required. For example, a home health agency must have prior authorization to provide skilled nursing to MassHealth Basic members and the service is limited to a short-term period following discharge from a hospital (130 C.M.R. § 403.419(C)); these limitations on home health services do not apply to the other coverage types.

130 C.M.R. § 450.105(B).

152 What coverage is available to recipients of EAEDC prior to enrollment into MassHealth Basic?

Coverage under MassHealth Basic, unlike the other MassHealth coverage types (except Essential), does not begin until enrollment with a managed care plan. Individuals and couples who are eligible for cash assistance under EAEDC are eligible for certain covered services before they enroll in managed care and begin MassHealth Basic coverage. The DTA office will issue a temporary paper Medicaid card on request to enable a member to use the EAEDC benefits before receiving a MassHealth card. See Part 4 on the use of temporary MassHealth cards. The following services are covered for EAEDC recipients from the effective date of EAEDC eligibility:

- n physician services;
- n community health center services;
- n prescription drugs;
- n insulin and diabetic supplies;
- n intravenous therapies, e.g., chemotherapy;
- n substance abuse treatment in public detoxification and outpatient centers; and
- n diagnostics and testing necessary for the determination or redetermination of eligibility for EAEDC upon referral from a physician or community health center.

130 C.M.R. § 450.106.

153 What is covered by MassHealth Essential?

MassHealth Essential covers fewer services than MassHealth Standard, CommonHealth, Family Assistance or Basic as shown in Table 17. Unlike Basic,

no home health services are covered in MassHealth Essential, and it does not cover eyeglasses or orthotics. The limitations of MassHealth Essential are a significant problem for the elderly and disabled special status and PRUCOL immigrants who have this type of coverage.

130 C.M.R. § 450.105(I).

154 What is covered by MassHealth Limited?

MassHealth Limited covers emergency services only. This coverage type is available to people who meet the eligibility criteria for MassHealth Standard, but are noncitizens who do not have an immigration status eligible for Standard. It is sometimes coupled with another type of coverage with no immigration status criteria or more liberal immigration status criteria than Standard such as Essential plus Limited, CMSP plus Limited, or Healthy Start plus Limited.

Emergency services are defined as the treatment of a medical condition with acute symptoms of sufficient severity to seriously jeopardize the individual's health without immediate medical attention. This includes labor and delivery, and treatment for certain chronic conditions in limited circumstances, such as dialysis for people with kidney failure. Organ transplants are specifically excluded by federal law. A 1997 provider bulletin provides a more detailed description of covered emergency services. The following services should be covered by MassHealth Limited:

- n emergent and urgent inpatient acute hospital admissions;
- n services provided by an outpatient hospital emergency department;
- n elective inpatient stays and outpatient ambulatory visits, and ancillary services, including services provided by community health centers or dialysis clinics, but only for certain medical conditions requiring immediate attention (this includes chronic dialysis);
- n emergency dental treatment;
- n transportation by ambulance for emergency services;
- n oxygen equipment and supplies;

- n antibiotics and other medically necessary drugs needed to treat an emergency medical condition, e.g., insulin for an insulin-dependent diabetic;
- n For drugs other than antibiotics, the pharmacist must follow instructions on the Pharmacy On-Line Payment System (POPS) screen, to code the emergency need.
- n when physicians bill separately from a hospital or clinic, physician services are generally only covered if the site of care is a hospital emergency room;
- n other services from other providers such as home health agencies or chronic/rehabilitation hospitals are generally not covered unless there has been a determination by the MassHealth office of clinical affairs, on a case by case basis, of an emergency medical need.
- n **Example:** An indigent individual in a wheelchair with renal failure was living in a homeless shelter within a short distance from a chronic care hospital that offered outpatient dialysis and provided all his other medical care. MassHealth Limited pays for dialysis provided by a clinic or acute care hospital but does not ordinarily cover any chronic hospital services. The chronic care hospital wrote to the Medicaid director requesting an exception in order to bill Limited for this service for this individual, and it was granted. There is no established process to request such an exception.

130 C.M.R. § 450.105(G). *See also* All Provider Bulletin 101, June 1997, *Reimbursable Services for MassHealth Limited Members*; G.L. c. 118E, § 16D(5).

155 What is covered by MassHealth Prenatal?

MassHealth Prenatal provides immediate temporary coverage for pregnant women who appear to be eligible based on information in the application form that has not yet been verified. This immediate coverage only extends to ambulatory prenatal care. Once verification is supplied, pregnant women who qualify for MassHealth Standard will be eligible for all covered services.

130 C.M.R. § 450.105(F).

156 What additional services are available to seniors?

Senior Care Options (SCO) is a voluntary managed care program that provides comprehensive coverage through senior care organizations and their network of providers. It blends funding from Medicaid, Medicare, and Elder Services to provide more flexible benefits to people age 65 and older who are eligible for MassHealth Standard without a spenddown and live within designated service areas. The **Home and Community Based Services** program and **PACE** programs also offer services to individuals who are enrolled in those programs that are not otherwise available in MassHealth Standard. See Part 11 for more about those two programs.

See 130 C.M.R. § 508.008.

157 What additional services and benefits are available for children under EPSDT?

Children and young adults under age 21 are entitled to a broad range of health services under a Medicaid program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).¹⁸ All children enrolled in MassHealth Standard and CommonHealth are entitled to EPSDT services.

Under EPSDT, the MassHealth agency is obligated to:

- n assure that all children have regular check-ups, up-to-date immunizations, and other preventive health care services;
- n assure that the health problems of children are promptly diagnosed and treated; and

¹⁸ For MassHealth eligibility purposes a child becomes an adult at age 19, but for purposes of services, a child becomes an adult at age 21.

n inform families about Medicaid services for children and provide families help in obtaining services.

Under EPSDT, states must provide all necessary optional services to children whether or not the state offers such services to adults, and states cannot limit the amount, duration, and scope of medically necessary services to children regardless of the limitations that apply to adults. Under EPSDT, state Medicaid programs must provide services needed to “correct or ameliorate” physical or mental illnesses and conditions in a child. See Question 172, *How can EPSDT help a child get additional services?*, below.

130 C.M.R. § 450.140 et seq.; 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

158 What additional services are available to children with serious mental disorders or with autism?

Children with serious mental disorders were successful in an EPSDT lawsuit seeking additional behavioral health services, particularly additional in-home services. The lawsuit was called Rosie D. The Children’s Behavioral Health Initiative is the name of the program that is implementing the relief ordered by the court in the Rosie D. lawsuit. Improved education, outreach and screening services were implemented in December 2007. Improved assessments became available in 2008; in 2009 five new behavioral health services will be available: in-home behavior management and monitoring, in-home therapy, therapeutic mentoring, mobile crisis intervention, and crisis stabilization. The lawyers for the children have created a website with more information for parents, advocates, and providers about available and soon to be available services. See www.rosied.org.

For children who do not have serious mental disorders but do have autism another new program was implemented in November 2007. The Home and Community Based Services Waiver for Young Children with Autism provides specialized services such as applied behavioral analysis for certain children under age nine diagnosed with autism spectrum disorder. Total enrollment is capped at 80 children and there is currently a waiting list. The program is jointly operated by

the Office of Medicaid and the Department of Developmental Services (formerly known as the Department of Mental Retardation). 130 C.M.R. § 519.007(E).

159 What dental services are available in MassHealth?

From 2003 to 2006, dental services for adults were generally limited to emergency services. However, on July 1, 2006 MassHealth restored dental services to adults. Adults do not have access to the same scope of services as children and youth under age 21, however, they do now have access to a relatively full range of dental services including preventative and restorative services and dentures. MassHealth has also begun to post a list of participating dental providers and take other steps to address the longstanding shortage of dentists willing to participate in MassHealth. A third-party administrator, DORAL Dental, administers the MassHealth dental program.

Children and youth under age 21 are eligible for a fuller range of dental services than adults including medically necessary orthodontia. The agency evaluates the medical need for orthodontia by using a measure called the Par Index. A score of 24 or more on the Par Index is considered evidence of the need for braces, a lower score requires additional evidence of medical necessity. Information about the Par Index is in the Dental Provider Manual.

130 C.M.R. § 420 et seq. (dental services).

160 When is a service medically necessary?

MassHealth will pay for a service only if it is medically necessary. A service is medically necessary if:

- n it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause

suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and

- n there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services less costly to the agency include services that will be paid by third-party insurers or are available at no cost to the member.

130 C.M.R. § 450.204(A). *See also* MassHealth Guidelines for Medical Necessity Determinations posted in the “Provider Library” section of www.mass.gov/MassHealth.

Example: A Medicaid MCO refused to pay for a transplant procedure that was part of a clinical trial on the grounds that its contract excluded experimental procedures. The MCO refused to reverse its decision in the internal grievance procedure. The fair hearing officer found that the MassHealth recipient and his doctors had supplied sufficient authoritative evidence that the procedure was reasonably calculated to prevent or alleviate a condition that endangered life. Therefore, the procedure satisfied the definition of medical necessity and could not be denied as experimental. *See* 130 C.M.R. § 450.204(E).

161 When does a service require prior authorization?

For most services, a participating MassHealth provider can deliver the service and send his or her bill to MassHealth. If the service is covered and the patient was eligible on the date of service, MassHealth will ordinarily pay the provider at the Medicaid rate. However, for certain services, the provider must get advance approval from the MassHealth agency before the service is delivered; these services are subject to prior authorization. The regulations on specific categories of service describe when a particular service requires prior authorization. The provider manuals also contain instructions for providers on when prior authorization is required and how to submit a request for prior approval. If prior authorization is denied, both the provider and the member should get notice, and have the right to appeal.

A process similar to prior authorization applies prior to a hospital admission for elective surgery. The process is called preadmission screening. It requires the provider to give notice to the MassHealth agency and get approval before a hospital admission for elective surgery. Denials of admission can be appealed on an expedited basis. After admission, the agency may determine that a hospital level of care is no longer required. Patients will be given notice and an opportunity to appeal such level of care decisions as well.

130 C.M.R. §§ 450.207, 610.015(E).

162 What are the time limits for the MassHealth agency to give prior authorization?

The MassHealth agency must act on requests for prior authorization within the following time limits from the date of the request:

- n **pharmacy services:** 24 hours (in an emergency the pharmacist can provide at least a 72-hour supply of the prescribed drug without prior authorization);
- n **transportation to medical services:** seven calendar days or earlier if necessary to avoid risk to health;
- n **private duty nursing:** 14 calendar days;
- n **durable medical equipment (DME):** 15 calendar days or earlier in a medical emergency; and
- n **all other services:** 21 calendar days.

130 C.M.R. §§ 450.303, 409.408 (DME).

163 What can be done if prior authorization is denied?

The beneficiary and the provider should each receive a notice when a request for prior authorization is denied. The denial can be appealed through the fair hearing process. Unfortunately, MassHealth prior authorization denial notices are often difficult to understand. The agency or the provider should be able to decode the notice. The recipient or his or her advocate have the right to obtain a copy of the prior authorization file, and can attempt to speak to the consultant who made the clinical decision. To succeed the member will usually need additional information from the provider substantiating the need for the service within the meaning of the applicable rules. See Part 18, Notice and Appeal Rights.

164 When are out-of-state services covered?

In MassHealth Standard out-of-state services are covered if

- n there is a medical emergency,
- n return to Massachusetts for needed care would endanger health, or
- n it is the general practice of a particular locality to receive services out of state.

Out-of-state services must also be covered when there are no in-state providers who can deliver the service.

In Basic, CommonHealth, and Family Assistance, out-of-state services are only covered if there is a medical emergency.

130 C.M.R. § 450.109.

165 How does MassHealth help with transportation?

All MassHealth coverage types include emergency ambulance service. Only MassHealth Standard and CommonHealth also cover nonemergency transportation. Unfortunately return trips from the provider to home, and facility to facility transfers by ambulance are usually considered a nonemergency. Such medically necessary nonemergency ambulance trips were briefly covered in Family Assistance, Basic and Essential but proposed rules are expected to eliminate this coverage in 2009. Check the rules for the current status of this coverage.

In MassHealth Standard and CommonHealth, only transportation to obtain medical services reimbursable under MassHealth will be covered for nonemergency transportation. Members who have nonemergency transportation available at no cost through family or friends are not eligible for transportation services. Maximus, the private contractor that administers the Customer Service Center, also administers the program for nonemergency transportation.

Members are eligible for reimbursement for the costs of public transportation or private automobile, whichever is less expensive, or, in the case of urgent medical need, of taxis. The member is responsible for submitting a bill to MassHealth for reimbursement of transportation expenses including documentation from the medical provider that the travel was for the purpose of obtaining reimbursable services, and receipts for the costs of transportation. Members can obtain more information about how to get reimbursed for transportation costs from the Customer Service Center. 130 C.M.R. §§ 407.415; 407.431(A), (B).

For people who do not have access to transportation or who cannot use public transportation due to a medical condition, the MassHealth agency will arrange transportation. A medical provider must authorize non-emergency transportation by completing a Prescription for Transportation form (PT-1). The MassHealth agency has contracts with Regional Transportation Authorities to provide transportation. The Customer Service Center notifies the member that he or she is eligible for assistance with transportation and provides a toll-free number for the Regional Transit Authority in the area to arrange accessible transportation in advance of the medical appointment. The authorization is good for all trips for all approved services to the approved provider for six months for acute care or one year for chronic care.

130 C.M.R. §§ 407.421 (authorization for transportation), 407.401 et seq. generally.

166 What is the MassHealth drug list?

The MassHealth agency is trying to control pharmacy costs by making it harder to get certain expensive drugs that it considers no more effective than less costly drugs. It has developed a drug list identifying which drugs can be obtained with only a doctor's prescription, and which drugs also require prior authorization from the MassHealth agency. The drug list is posted on the pharmacy page of the MassHealth agency website at www.mass.gov/MassHealth.

Generally, prior authorization is needed for any brand name drug if a generic equivalent is available. Also, for certain classes of drugs, prior authorization is needed for any but the least expensive therapeutic equivalent drug. In order to obtain prior authorization, a prescriber must document why the more costly drug is medically necessary; often, this requires evidence of an unsuccessful attempt to use the less costly drug. Prior authorization forms for different classes of drugs are posted on the pharmacy page of the MassHealth website.

Starting in October 2007, drugs available through outpatient pharmacies eligible for payment from the Health Safety Net must follow the rules applicable to the MassHealth drug list including its procedures for requesting prior authorization, and will charge the same copayments as MassHealth.

Under federal Medicaid law, MassHealth must cover any FDA-approved drug produced by a manufacturer who participates in the federal drug rebate program for any "medically accepted indication." This term includes the FDA-approved uses as well as certain off-label uses recognized in national drug compendia. *See* 42 U.S.C. §§ 1396r-8(d), 1396r-8(k)(6).

Additional useful information about the MassHealth pharmacy benefit:

- n In an emergency, a pharmacist can dispense at least a three-day supply of a prescribed drug even if prior authorization is required and was not obtained. 130 C.M.R. § 406.422(C).

- n MassHealth members who are denied prior authorization for a drug that MassHealth had approved in the past, can appeal and continue receiving the prescribed drug pending appeal; the Drug Utilization Review (DUR) office at the University of Massachusetts Medical School represents the agency in pharmacy appeals.
- n Even if the MassHealth rules limit coverage of an FDA-approved drug, most can be obtained with prior authorization if the limitations on payment would result in inadequate treatment for a diagnosed medical condition. 130 C.M.R. § 406.422(A).
- n Certain over the counter drugs are covered by MassHealth if a doctor has prescribed them; a list of over the counter drugs available with a prescription and that do not require prior authorization are posted on the MassHealth website. 130 C.M.R. § 406.412(B).

167 How has drug coverage changed for people with both MassHealth and Medicare?

Almost all elderly MassHealth recipients and many younger people with disabilities have Medicare coverage in addition to MassHealth; these people are called dual eligibles. On January 1, 2006 Medicare began offering a drug benefit through participating drug plans (Medicare Part D). Dual eligibles no longer have MassHealth drug coverage for drugs that are covered under Medicare Part D. (A few drugs like benzodiazepines and over the counter drugs are not covered by Medicare Part D and remain available to dual eligibles through MassHealth.) Instead, most dual eligibles have drug coverage through private Medicare drug plans or through their Medicare Advantage plans. Some dual eligibles with private health insurance may choose to forego Medicare drug coverage in favor of the drug coverage offered by their private health insurance.

Dual eligibles (and people eligible for the Medicare Savings Programs) are automatically eligible for “extra help” in the form of a low-income subsidy to make the Medicare drug plans affordable. In addition, MassHealth recipients newly eligible for Medicare will be randomly enrolled into a drug plan by CMS if they do not first choose a plan on their own. However, dual eligibles are able to

change drug plans at any time; this is important because plans differ in various ways including what drugs they cover.

To further protect dual eligibles, under state law, MassHealth will pay the difference between any higher copayment charged dual eligibles under Medicare Part D and the MassHealth copayment limits of \$2 or \$3, and will provide a one-time 72-hour emergency supply of a drug if the Medicare drug plan will not pay.

For more information on Medicare Part D, see www.medicare.gov.

130 C.M.R. § 406.414(C); Chapter 175, St. 2005 as amended by Section 86, Chapter 139, St. 2006; 20 C.F.R. Part 423 (Medicare Prescription Drug Benefit).

168 What benefits are available to help people quit smoking?

On July 1, 2006 MassHealth began offering a new smoking cessation benefit in all MassHealth coverage types (except MassHealth Limited). The new benefit includes individual and group tobacco cessation counseling and pharmacotherapy and is described in the regulations and manuals for physicians, community health centers, outpatient hospitals and pharmacies.

See All Provider Bulletin 155 (June 2006).

169 What happens if someone needs to go into a nursing home?

MassHealth Standard, CommonHealth, and Commonwealth Care all cover short-term nursing home care. However, only MassHealth Standard covers long-term nursing home care, and, in addition to clinical criteria for nursing home care, special financial eligibility rules apply. In order to be eligible for MassHealth

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Standard to pay or continue paying for nursing home care, an “institutionalized individual” must meet the following eligibility criteria:

- n be a Massachusetts resident;
- n be a U.S. citizen, or a qualified or protected noncitizen;
- n be under age 18 or over 64, or between 18 and 64 and disabled;
 - n Certain disabled special status immigrant children under age 19 may be eligible for long-term nursing home care in CommonHealth, see 130 C.M.R. § 519.012(B).
- n be determined medically eligible for nursing facility services in accordance with 130 C.M.R. § 456.00;
 - n For children under 22 the clinical criteria are in 130 C.M.R. § 519.007(A)(4);
 - n for adults age 22 or older the clinical criteria are in 130 C.M.R. § 456.409 (except for persons age 65 or older enrolled in a SCO).
- n have countable assets less than \$2,000 for an individual or assets under a married couple standard in accordance with 130 C.M.R. § 520.016(B);
- n instead of an upper income limit, contribute a portion of income to the costs of care as defined in 130 C.M.R. § 520.026; and
- n not have transferred resources for less than fair market value during a specified “look-back” period as described in 130 C.M.R. § 520.0018 and § 520.019.

130 C.M.R. § 519.006.

For more information on this topic, see *Estate Planning for the Aging or Incapacitated Client in Massachusetts* (MCLE, Inc. rev. ed. 1998 & Supp. 2002, 2005, 2007).

170 What can be done if a needed service is denied or not covered?

What can be done about a service denial depends on the reason for the denial. If MassHealth acts on a prior authorization request for a service, or makes a level of care determination, the recipient should get notice and the agency's action can be appealed by the recipient as explained above. If MassHealth denies payment after the provider has delivered a service, under current agency policy, only the provider can appeal the payment denial. However, if the reason for the payment denial was because the recipient was not eligible on the date of service, the recipient can appeal the underlying eligibility denial or termination, but may have to address questions about the timeliness of his or her appeal.

If a provider refuses to provide a service because the provider anticipates that MassHealth will deny payment because the service is not covered, there are several ways that the recipient can resolve the situation as discussed further below:

- n If a member is not now on MassHealth Standard or CommonHealth, he or she may be able to upgrade his or her MassHealth coverage to Standard or CommonHealth and obtain additional services.
- n If a member is under 21 years of age, he or she may be able to get additional services covered and avoid service limitations under EPSDT.
- n A person with a disability may be able to avoid limitations on covered services if necessary as a reasonable accommodation to a disability.
- n Depending on the covered service, a request for prior authorization may be a way to get additional services.
- n A member may be able to challenge the legality of state limitations on the amount, duration, and scope of services under federal Medicaid law.

171 How can upgrading MassHealth coverage help get additional services?

Some types of MassHealth coverage cover more services than others. See Table 17. If a service would be covered under a richer type of MassHealth than the type in which the member is currently enrolled, one solution is to try to upgrade coverage. A recipient may not be in the most comprehensive benefit for which he or she is eligible if he or she has not reported a change in circumstances, did not complete the disability determination process, or simply did not supply all relevant information.

Example: A long-term unemployed person obtained MassHealth Essential but never reported or verified that he was also HIV positive. He was unable to get eyeglasses because it is not a covered benefit in MassHealth Essential. When his social worker assisted him in sending MassHealth verification of his HIV-positive status, he was able to obtain Family Assistance which does cover eyeglasses.

172 How can EPSDT help a child get additional services?

Early and Periodic Screening, Diagnosis and Treatment can both help a child get services that are authorized under the Medicaid law, but that MassHealth has not chosen to cover, and it can help avoid service limitations, like a limitation on only a certain number of catheters per year. In both cases, the services must be necessary to “correct or ameliorate” a medical condition.

The regulations state that a medical provider can use the prior authorization process to request prior authorization for a medically necessary service for a child under age 21 that is not otherwise covered by MassHealth. 130 C.M.R. § 450.144. However, it appears that this procedure is little known and little used. The assistance of an advocate will likely be required to use EPSDT to access services not otherwise covered by MassHealth.

Example: A recent lawsuit challenged the failure of MassHealth to provide comprehensive in-home mental health services for mentally ill children. After a trial in which experts testified about the mental health needs of the children and the limitations of available MassHealth services, the federal district court agreed that additional services were required by EPSDT. The state is now implementing the relief ordered as the Children’s Behavioral Health Initiative. *Rosie D. v. Romney* (W.D. Mass. 2006) (opinion posted in the “Health” section of www.masslegalservices.org).

173 How can someone get services as a reasonable accommodation of a disability?

State and federal antidiscrimination laws require government programs to make reasonable modifications to rules, policies, or practices to enable a person with a disability who meets the essential eligibility requirements of a program to benefit from the program unless to do so would be a fundamental alteration of the program. 28 C.F.R. Part 35.

Example: The MassHealth agency denied coverage for the client’s daughter to be her personal care attendant (PCA) based on a rule then in place excluding family members as PCAs. (The rule has been liberalized since then.) The client could not benefit from the services of other PCAs, despite repeated trials, because her mental illness made her unmanageable around anyone but her daughter. The daughter had given up her job to care for her mother. The Superior Court agreed that the limitation on PCAs had to be modified in order to avoid denying an otherwise qualified person access to a program benefit on the basis of her disability. The court ordered the MassHealth agency to approve and pay for the client’s daughter as a PCA. *Garcia v. Warring*, Hampden Superior Court No. 01-907 B, Order of July 29, 2002 (opinion posted in the “Health” section of www.masslegalservices.org).

174 How can someone get additional services through the prior authorization process?

Prior authorization requirements differ in the extent to which otherwise uncovered services can be approved. For example, the rule on pharmacy services contains various limitations but authorizes prior authorization “if the limitations on payment would result in inadequate treatment for a diagnosed medical condition.” 130 C.M.R. § 406.412. If a provider can supply information showing that the need for an otherwise not covered pharmacy benefit meets this standard, and is medically necessary, it should be covered. However, not all the covered service rules provide opportunities for additional coverage through the prior authorization process. Advocates must consult the rule for the particular service required.

175 How can federal Medicaid law expand state limitations on services?

Federal Medicaid law requires that states cover certain “mandatory” services and gives states the option of covering other “optional” services. 42 U.S.C. § 1396d. Within each kind of service, federal regulations require that services be “sufficient in amount, duration, and scope to reasonably achieve their purpose.” 42 C.F.R. § 440.230(b). Federal regulations also prohibit a state from imposing arbitrary limitations on services based solely on diagnosis, type of illness, or condition. 42 C.F.R. § 440.230(c). However, a state may impose reasonable limitations based on medical necessity or utilization review. MassHealth is required by federal Medicaid law to comply with these federal standards. The National Health Law Program’s *Guide to the Medicaid Program* is a good source for researching federal Medicaid requirements.