Part 16

Service Delivery

176 What is fee-for-service?

Sometimes MassHealth beneficiaries are entitled to see any provider who is participating in the MassHealth program, and providers are paid a fee for each covered service they provide. This system is called fee-for-service. Providers must apply to the MassHealth agency to become participating providers and agree to comply with MassHealth billing rules and other requirements. MassHealth providers must accept the MassHealth payment rate as payment in full. In Massachusetts, the Division of Health Care Finance and Policy sets the rates for the fee-for-service system.

G.L. c. 118E, § 36 (eligible providers); G.L. c. 118G, § 7 (determination of rates of payment).

177 What is managed care?

Sometimes, MassHealth beneficiaries are not free to see any provider participating in MassHealth. Instead they are required to enroll in some kind of managed care plan. In managed care, a primary care physician or other provider acts as a gatekeeper and the MassHealth member can generally only see other providers and specialists if the primary care physician makes a referral.

MassHealth uses several different kinds of managed care arrangements. It contracts with Managed Care Organizations (MCOs) that are paid a flat amount per month to deliver certain MassHealth covered services to each person who chooses to enroll in the MCO. The beneficiary receives care only from the network of providers who participate in the MCO; this may include some providers who do not participate in MassHealth fee-for-service. However, some kinds of MassHealth services, like dental services, are not covered by the MCO contract. The member continues to use the fee-for-service system for these services.

MassHealth also uses another kind of managed care arrangement called the Primary Care Clinician Plan (PCC). MassHealth contracts with certain clinicians to act as gatekeepers. They are paid an enhanced rate under the fee-for-service

system. The member needs a referral from the PCC to see a specialist, but with a referral, can see any participating Medicaid provider. Providers are still paid on a fee-for-service basis. People who choose the PCC Plan receive mental health and substance abuse services through another kind of managed care called a behavioral health carve-out.

Currently, the Massachusetts Behavioral Health Partnership (the Partnerhsip) provides behavioral health services to people enrolled in the PCC plan. MassHealth has a contract with the Partnership to organize a network of providers of mental health and substance abuse services. The agency pays the Partnership a monthly fee for each enrolled member, and the Partnership is responsible for recruiting providers, authorizing services, and paying providers for authorized mental health and substance abuse services for people enrolled in the PCC Plan.

For many years, only four Managed Care Organizations (and the Partnership) have participated in MassHealth. In July 2010, a new MCO began offering services in western Massachusetts. Some time in 2012, the Office of Medicaid will be entering into a new behavioral health contract for the PCC Plan, and the vendor may change. References to the Partnership should be understood as referring to the current behavioral health vendor.

178 Which MassHealth members are required to use Managed Care?

Most individuals enrolled in MassHealth are required to participate in some form of managed care. Many EPSDT-eligible children otherwise exempt from mandatory managed care are now required to enroll in managed care in order to obtain behavioral health services not available in the fee for service system. Currently, only the following members are excluded from mandatory participation in managed care children and youth under age 21 receiving services from DCF, DYS, or Title IV-E adoption assistance,

- however, if such children do not voluntarily enroll in the PCC Plan or with an MCO, they will be enrolled in the Partnership for their behavioral health services; children receiving IV-E adoption assistance may opt out of the Partnership and receive behavioral health through the fee for service system instead;

- individuals with Medicare or other health insurance,
  - however, MassHealth Standard and CommonHealth members under age 21 must enroll with the Partnership for their behavioral health services;
- individuals eligible by virtue of the Kaileigh Mulligan program, or enrolled in a home and community-based waiver or receiving medical care under the refugee resettlement program,
  - however, such members under age 21 are enrolled with the Partnership for their behavioral health but may opt-out to the fee-for-service system instead;
- age 65 or over,
- institutionalized for other than a short-term rehabilitative stay,
- solely eligible for Limited, Prenatal, CMSP, or Healthy Start,
- terminally ill or receiving hospice care,
- receiving EAEDC health benefits, or
- presumptively eligible during a 60-day period.

130 C.M.R. §§ 508.001, 508.004.

179 What kind of managed care choices do MassHealth members have?

MassHealth members who must participate in managed care have a choice between participating in the PCC Plan, or enrolling with one of the MCOs under contract with the MassHealth agency. If no suitable managed care provider is available, as determined by the agency, a member can be excused from enrolling in managed care. To be suitable, a provider must be physically accessible to the member and meet certain other requirements. An important protection in MassHealth is that members can choose to change doctors within plans or change plans at any time. This enables individuals to switch plans when dissatisfied with the current plan or when they were automatically assigned to a plan that does not

meet their needs. (This is different from Commonwealth Care, where members are generally locked-into plan choices for the year.)

The elderly and certain people with disabilities who are not required to enroll in managed care may voluntarily choose to participate in the SCO or PACE managed care programs. Individuals obtain enrollment assistance from the SCO or PACE plan.

See 130 C.M.R. § 508.002.

180 Which MCOs and SCOs currently participate in MassHealth?

The MassHealth agency enters into contracts with participating MCOs to enroll MassHealth beneficiaries. Providers participating in the MCO network deliver all services covered by the MCO's contract with the agency. Beneficiaries may prefer an MCO because some providers who do not participate in MassHealth as fee-for-service providers do participate as part of an MCO network. Currently only five MCOs participate in MassHealth:

- Health Net (operated by the Boston Medical Center);
- Neighborhood Health Plan;
- Network Health (formerly owned by the Cambridge Health Alliance, but now owned by Tufts Health Plan);
- Fallon Community Health Plan; and
- Health New England.

In the Senior Care Options program, participating plans contract with both the MassHealth agency and Medicare. Currently, there are four participating plans:

- Commonwealth Care Alliance,
- NaviCare (HMO),
- Senior Whole Health, and

- United Healthcare (formerly Evercare).

181 What services are not delivered by the MassHealth MCOs?

People enrolled in an MCO receive most services from the MCO network of providers, but still receive some MassHealth services under the fee-for-service system. For example, the current MCO contracts do not include dental services. MCO members use their MassHealth cards to obtain dental services from any dentist who participates in MassHealth. Also, federal Medicaid law guarantees families the right to obtain family planning services from any participating Medicaid provider of such services not just those in the MCO network. Beneficiaries are mailed information about what services are covered by the MCO and what services are available on a fee-for-service basis when they enroll. See Part 20 for the websites of the MCOs.

182 What providers are in the PCC Plan?

The primary care clinician in the PCC Plan delivers primary care, decides if care is needed by other providers and makes referrals to specialists and other providers as necessary. Eligible clinicians include physicians, nurse practitioners, community health centers, acute hospital outpatient departments, and group practices. There are over 1,700 PCC sites available to MassHealth members. Currently, less than one-half of those required to use managed care are in the PCC Plan.

130 C.M.R. § 508.005.

183 Is a referral from the PCC needed for every type of service?

No. Although generally, the PCC must make a referral in order for a member to see a specialist, no referral from the PCC is needed for certain types of services, including emergency care, family planning, dental care, and over 20 other services listed in the regulations.

See 130 C.M.R. § 450.118.

184 Which MassHealth coverage types use primarily fee-for-service?

Currently persons age 65 or over in MassHealth Standard receive services primarily through the fee-for-service system. People age 65 and over have voluntary managed care options through the Senior Care Options (SCO) program and the PACE program. 130 C.M.R. §§ 508.002 (when managed care is required), 508.004 (members excluded from managed care), 508.008 (SCO), 519.007(C) (PACE).

185 How does someone decide on a PCC versus an MCO?

A vendor for the MassHealth agency sends out an Enrollment Guide describing the PCC Plan and the available MCOs including a selection form to be returned by the member within 14 days. Individuals may also call health benefits advisors at the Customer Service Center toll-free line, 1-800-841-2900, for assistance in choosing a plan.

Usually people decide between a PCC and the Partnership or one of the four MCOs based on the availability of primary care providers and specialists who have cared for them in the past. Health benefits advisors at the Customer Service Center should be able to answer questions about which providers are participating in which plan.

If members do not choose a PCC or MCO by telephoning Customer Service with their choice or returning the enrollment form, they will be assigned to a plan by MassHealth. Generally, about 80 percent of members choose their own managed care plan, and 20 percent are automatically assigned.

130 C.M.R. § 508.002.

186 If a member is assigned to a plan and wishes to change, can he or she do so?

Yes. If a member is assigned to a plan he or she does not want, he or she can change plans at any time. A member required to participate in managed care can change plans and providers within plans at any time for any reason.

See 130 C.M.R. § 508.002(D).

187 How long will it take to enroll in managed care in MassHealth Basic and Essential?

In MassHealth Basic and MassHealth Essential, unlike the other MassHealth coverage types, eligibility for services does not begin until the member is enrolled in managed care on the effective date established by the agency. The member can establish a managed care enrollment effective date in the following ways:

- After a member receives a notice of eligibility for MassHealth Basic or Essential, call the Customer Service Center and supply all the information needed to enroll into managed care. The MassHealth agency will send

members a managed care selection provider form to be returned by a deadline. If members do not select a managed care provider by the deadline, the MassHealth agency will select one for the member. *See* 130 C.M.R. § 508.002.

188 How are mental health services delivered in MassHealth Managed Care?

People enrolled in the PCC Plan receive mental health and substance abuse services from a behavioral health vendor, currently the Behavioral Health Partnership (the Partnership), a subsidiary of a national company called ValueOptions. For members enrolled in a PCC plan, the Partnership is responsible for delivering all covered mental health and substance abuse services, including inpatient hospitalization, through its network of providers. However, PCC members can receive emergency mental health services from any provider and the emergency service provider will be paid by the Partnership. The Partnership is not an MCO, but, like an MCO, it decides when a service proposed by a provider in its network will be authorized.

People who are enrolled in an MCO plan do not receive services from the Partnership but from the MCO. However, some MCOs may have their own behavioral health carve-outs, e.g., BMC Health Net, and Neighborhood Health Plan contracts out behavioral health services to a company called Beacon Health Systems.

People who are not in managed care receive behavioral health and substance abuse services from any participating Medicaid provider under the fee-for-service system.

See 130 C.M.R. § 450.124, and the Partnership's and MCOs' websites listed in Part 20.

189 How does managed care work for the homeless?

The MassHealth application form asks if a member is homeless. If someone indicates that he or she is homeless and does not select a managed care provider, the agency's practice is to assign the PCC plan and not an MCO. A homeless person can obtain services from an approved provider at a site like a homeless shelter or soup kitchen without a referral from the PCC.

See 130 C.M.R. § 450.118.

190 What can be done if a MassHealth MCO, SCO or the Partnership refuses a needed service?

Federal Medicaid law requires that state contracts with managed care plans include an internal grievance procedure. 42 C.F.R. § 434.32. The information included in the enrollment packet sent to new members should describe how to file a grievance under the plan's internal grievance procedure. This information should also be available on the plan's website and by calling its toll-free number. In addition to the internal grievance procedure, members can also file appeals under the Medicaid fair hearing process. The MassHealth regulations provide a right to a fair hearing to resolve the following disputes related to managed care:

- the agency's decision that the member must enroll in managed care;
- a decision by the Partnership, MCO, or SCO to deny, reduce, modify, or terminate a covered service *if the member has exhausted all remedies through the internal grievance system*;
- the agency's denial of a request for an out of state managed care provider; or
- the agency's involuntary disenrollment or transfer of a member from a managed care provider.

See 130 C.M.R. § 508.006.

191 What can be done to find a provider who accepts MassHealth?

The Customer Service Center maintains a database of providers participating in MassHealth, and is supposed to assist members in finding a provider. If a service is the responsibility of an MCO, SCO, or the Partnership, it should assist members in locating a provider and members have the right to file a grievance about the failure to deliver covered services promptly. Sometimes, the lack of adequate providers may be grounds to avoid the requirement that someone participate in managed care and to return to the fee-for-service system. On the other hand, sometimes an MCO, SCO, or the Partnership may have providers in their networks who do not otherwise participate in MassHealth and changing to a managed care plan may improve access to more providers.

The agency has an affirmative obligation under the Medicaid Act to assure that beneficiaries receive services with "reasonable promptness." Legal advocates have been able to use this and other provisions of the Medicaid act to challenge inadequate rates and other barriers that prevent members from finding participating providers. A recent case successfully challenged the shortage of participating dentists in MassHealth and has resulted in a series of changes designed to increase access to dental services. *See Health Care for All v. Romney* (D. Mass. 2006) (court decision posted on the "Health" section of www.masslegalservices.org).

192 Can a provider legally choose not to accept a new MassHealth patient?

Federal law does not require providers to participate in Medicaid. However, under state law, health care providers are among those prohibited from discriminating against patients on the basis of the source of payment of their health care. This

antidiscrimination rule prohibits health care providers who do participate in MassHealth from discriminating against MassHealth patients, for example by accepting no new MassHealth patients when new patients with private insurance are being accepted. There is an exception to this rule to allow dentists to limit the number of MassHealth patients they accept; it is intended to encourage more dentists to participate in MassHealth. *See* St. 2006, c. 139, § 90.

G.L. c. 151B, § 4(10); 130 C.M.R. § 450.202; *see Hennessey v. Berger*, 403 Mass. 648 (1988) (interpreting G.L. c. 151B, § 4(10) prior to its amendment in 1989).

193 How are bills paid if someone has health insurance and MassHealth?

People enrolled in MassHealth Standard and CommonHealth may have other insurance in addition to MassHealth. If a MassHealth recipient has other health insurance, MassHealth will be the payer of last resort. This means a participating MassHealth provider must bill the other health insurance first before it can bill MassHealth. Like all MassHealth providers, the provider must accept the MassHealth payment for a covered service as payment in full even if the MassHealth payment is nothing. If the other health insurance pays only part of the bill, MassHealth will pay the lesser of:

- what the member would owe under the insurance policy including coinsurance, deductibles, and copayments; or
- the provider's charge or maximum MassHealth payment, whichever is less, minus the payment by the other insurance.

Example: A provider charges $1,000 for a medical service. The member's insurance pays $800 representing 80 percent of the usual and customary charge; the member's coinsurance is $200. The maximum MassHealth payment for this kind of service is $850. In this situation, MassHealth will pay $50 because its maximum payment less the insurance payment ($850-$800) is less than the member's coinsurance of $200. Participating providers must accept the MassHealth payment as payment in full therefore the member is not liable for the remaining $150.

See 130 C.M.R. § 450.317.

Domestic violence: If the private insurance is through an absent parent and using the private coverage would disclose the location or otherwise jeopardize a victimof domestic violence, the member can avoid the obligation to use the private coverage by asserting good cause with the MassHealth Benefit Coordination office. See Part 14.

Part 17

Premiums and Cost-Sharing

194 How much does it cost to get MassHealth?

There are no premium charges for anyone with gross family income at or under 150 percent of the poverty level, or for MassHealth Prenatal. There are monthly premium charges for one small program in MassHealth Standard and for most people enrolled in MassHealth Family Assistance or CommonHealth. See Table 18 in Appendix B for a comparison of premium charges in MassHealth. There are also nominal copayments for prescription drugs and inpatient hospital stays that apply to adults in all direct coverage types except MassHealth Limited.

In addition, some people with income (and assets) in excess of program limits can qualify for MassHealth after meeting a deductible or spenddown. For more information on establishing eligibility after meeting a deductible, see Part 12, Financial Eligibility.

195 How much does MassHealth Standard cost?

There are no premium charges for anyone in MassHealth Standard except for women who enrolled through the Breast and Cervical Cancer Treatment Program with gross family income over 150 percent of poverty. Their premium varies with income. See Table 18 in Appendix B. Adults in MassHealth are charged copayments, see below.

See 130 C.M.R. § 506.011(I).

196 How much does Family Assistance for Children cost?

There is a monthly premium charge for children in Family Assistance with family income over 150 percent of the poverty level. The premium charge is per child up

to a family maximum for three or more children, and varies by income. See Table 18 for current monthly premium amounts for children with Family Assistance direct coverage.

For **Family Assistance Premium Assistance**, MassHealth will pay a "premium assistance payment" representing a portion of the employee's share of the health insurance premium; the family will be responsible for the balance of the employee's premium cost. The "estimated" family share of the premium cost is the same amount that the family would have been charged for direct coverage, and will always be the minimum cost to the family. However, in some circumstances a family may have to pay more than the estimated amount if the premium assistance payment would otherwise exceed the "cost effective" amount. See Table 8 in Appendix B for the upper payment limits in SFY 2012. A family may opt for direct coverage for the child if their share of the premium cost exceeds 5 percent of gross family income. Premium Assistance will also reimburse families for cost-sharing for any preventive services for eligible children or after aggregate premium and cost-sharing payments for children exceed 5 percent of gross family income.

See 130 C.M.R. §§ 506.012(D), 506.011(I).

197 How much does MassHealth for HIV-positive adults cost?

For HIV-positive adults with income over 150 percent of poverty, there is a monthly premium charge for MassHealth Family Assistance direct coverage or Premium Assistance that varies by income. See Table 18 for the current premium amounts. In premium assistance, the amount MassHealth pays toward the cost of private insurance will never exceed the upper payment limits shown in Table 8.

130 C.M.R. § 506.011(I).

198 How much does MassHealth Family Assistance for employees in the Insurance Partnership cost?

For employees of qualified employers or self-employed individuals in the Insurance Partnership, MassHealth Family Assistance will pay a "premium assistance payment" representing a portion of the employee's share of the health insurance premium; the employee will be responsible for the balance of the employee's premium cost. Family Assistance Premium Assistance will not reimburse adults for their copayments, deductibles or other cost sharing under the employer's plan. However, the "minimum creditable coverage" standard that insurance must satisfy imposes some limits on cost-sharing.

The premium cost to the employee will be the difference between the employee share of the premium cost and either the upper payment limit shown on Table 8 or the premium charge that varies by income shown on Table 18 whichever is more. Unlike the other cost-effective amounts shown in Table 8, the amount for childless adults in Family Assistance Premium Assistance has never been raised since the program began; the maximum amount of assistance is $150 per person per month.

If there are children in the family, the premium will be based on the Family Assistance income-based premium schedule and the cost effective amounts for children. See Tables 18 and 8 in Appendix B. The adults in the family will not have to pay an additional premium for their coverage.

If the qualified employer in the Insurance Partnership is a self-employed person, he or she will have to pay 50 percent of the cost of coverage in order to be a qualifying employer in addition to paying the employee share of the premium cost. Self-employed individuals receive a subsidy of up to $150 per month for single coverage or up to $300 per month for coverage as a married couple. *See* 130 C.M.R. §§ 506.012(E), 506.011(I).

199 How does Family Assistance work if an applicant is self-employed?

Since it began in 2000, most of the adults receiving Family Assistance Premium Assistance in the Insurance Partnership have been self-employed. The 2006 state health reform changed this in two ways: first, it disqualified self-employed individuals from receiving the employer subsidy in addition to the premium assistance payment, and second, it created the Commonwealth Care program. In the Insuance Partnership, a self-employed person pays 50 percent of the cost of coverage as a qualified employer, and is reimbursed for a portion of the remaining 50 percent of the cost of coverage. In most cases, it will be significantly less expensive for the self-employed individual not to apply for the Insurance Partnership but for Commonwealth Care instead.

Example: Assume a self-employed mother has two children and income at 175 percent of poverty; private health insurance costs her $800 per month for family coverage with no subsidy. Her costs for health insurance go down to $424 per month with assistance from MassHealth Family Assistance and the Insurance Partnership. See the calculations below. However, if instead of applying for the Insurance Partnership, she applies for Commonwealth Care for herself and Family Assistance for her children, her premium cost for Commonwealth Care for herself may be as little as $39 per month and the $24 premium for her two children in Family Assistance will be waived.

Total monthly premium cost	$800
Employer share of cost (50% minimum)	– 400
Employee share of cost	400
Estimated employee share ($12 * 2 children)	– 24
Estimated MassHealth premium assistance	$376
Cost-effective amount for 2 children (Table 8)	$558
MassHealth payment (Lesser of estimated or cost effective)	$376
Total cost to self-employed mother ($400 +24)	$424

200 How much does CommonHealth cost?

Individuals with family income greater than 150 percent of poverty who are enrolled in CommonHealth are charged a monthly premium. The amount of the premium is based on income and whether or not the individual has other health insurance. A full premium is charged for someone with no other insurance or with insurance that MassHealth helps pay. A reduced "supplemental" premium is charged for someone who has other insurance that MassHealth does not help pay.

See Table 18 for the current premium amounts by income. Premium charges for children under 300 percent of poverty in CommonHealth are adjusted to be the same as premium charges for children in Family Assistance.

130 C.M.R. § 506.011.

201 What happens if family members are in programs with different premium charges?

A family with members in two different MassHealth programs that charge premiums such as CommonHealth and Family Assistance will be charged the premium for only one program, whichever one is higher. A family with more than one member in CommonHealth is generally charged only one premium. However, in both Family Assistance and CommonHealth, a family with income between 150 percent and 300 percent of poverty will be charged per child for up to three children.

For families with income between 150 percent and 300 percent of poverty, premiums for a child in Family Assistance, CommonHealth or CMSP will be waived for any month in which the child's parent is enrolled and paying a monthly premium for Commonwealth Care.

130 C.M.R. § 506.011.

202 What happens if someone misses a premium payment?

MassHealth members who are charged a monthly premium are mailed a monthly invoice. If a member is billed for a premium payment and does not pay within 60 days of the date of the bill, the MassHealth agency will send an advance notice of termination. Benefits will not end if the member:

- reports a decrease in gross family income to 150 percent of poverty or less;
    - Someone with income too low to be charged a premium will not be terminated for nonpayment of past due premiums but the past due amounts remain a debt for which he or she will continue to be billed.
- pays all premium payments that have been due for 60 days or more;
- applies for and is granted a financial hardship waiver of the past due premiums; or
- establishes a satisfactory payment plan with the premium billing office.
    - If the member does not make a payment on the payment plan within 30 days of the date on the bill, he or she will receive another notice of termination, and if no payments are made, benefits will end.

In cases of extreme financial hardship, the MassHealth agency can waive payment of past due or future premiums or reduce the amount of premiums. A hardship request form is available from the MassHealth agency and posted at www.masslegalservices.org. Denial of a hardship waiver is appealable. If benefits are terminated, a member can re-establish eligibility only by:

- reapplying if gross family income is now at or below 150 percent of poverty;
- paying in full all payments due;
- entering into a payment plan with premium billing office;
- applying for and obtaining a financial hardship waiver of the overdue premiums, or

- reapplying and if eligible, waiting 24 months after which outstanding premiums will be waived;

Customer Service or MEC. Contact the Customer Service office to work out a payment plan, request a hardship waiver or dispute whether payments were made. Contact the MEC if a drop in income or increase in family size brings gross family income to 150 percent of poverty or less and no monthly premium is due for ongoing coverage, or to dispute whether premiums were correctly assessed based on the family's past income.

130 C.M.R. § 506.011.

203 What are the grounds for a MassHealth hardship premium waiver?

People with income over 150 percent of poverty who are charged premiums in MassHealth but cannot afford them can obtain a waiver or reduction of premiums based on extreme financial hardship. The waiver request form can be obtained from the Customer Service/Premium billing office. (A similar process is available in Commonwealth Care, but the grounds are a little different and a different request form is used.) A family experiencing one of the following hardships may qualify for a MassHealth premium waiver:

- homeless, more than 30 days in arrears in rent or mortgage, or has a current eviction or foreclosure notice;
- has been shut off, refused service, or has a current shut off notice for an essential utility;
- has debts for medical/dental expenses that are more than 7.5 percent of gross family income; or
- has experienced a significant, unexpected increase in essential expenses within the last six months.

130 C.M.R. § 506.011(F).

204 Can providers who accept MassHealth still send members bills?

Generally, participating providers must accept the amounts paid by MassHealth as payment in full for covered services for an eligible member. There is no balance billing. If MassHealth pays nothing because the provider made a billing error, the provider cannot demand payment from the member. The only exceptions are the limited situation in which MassHealth providers are authorized to collect a nominal copayment, or when people in long-term care are required to contribute a patient-paid amount to the costs of care. Also, MassHealth members who are receiving only premium assistance to pay for employer-sponsored insurance will be liable for the copayments and other cost-sharing allowed under the employer's plan.

If a member sees a provider who is not a participating MassHealth provider, or if a member is in managed care and sees a provider for whom a referral is needed without a referral, or if a health service is not covered at all by MassHealth or if someone was not eligible on the date of service, the provider may be sending a bill. Whether or not a MassHealth member is liable will depend on the circumstances. Someone in this situation should consult a legal advocate.

In addition, under the Health Safety Net rules, an acute hospital cannot pursue collection activity for a debt owed by a current MassHealth recipient.

130 C.M.R. § 450.203; G.L. c. 118E, § 36; 42 C.F.R. § 447.15 (Medicaid/MassHealth); 114.3 C.M.R. § 13.08(3) (Health Safety Net).

205 How much are the copayments in MassHealth?

The copayments shown below are the maximum currently allowed in MassHealth. Subject to the exemptions described below, the following copayments are due at the pharmacy or the hospital when services are received:

- $1 for certain generic or over the counter drugs to treat diabetes, high blood pressure or high cholesterol, i.e., antihyperglycemics, antihpyertensives, or antihyperlipidemics, and $3.65 for all other drugs; and
- $3 for a hospital in-patient stay.

If someone has private insurance and MassHealth, the pharmacy should bill the private insurance first, and bill MassHealth for any private insurance copay greater than the $1–$3.65 copay allowed in MassHealth.

- MassHealth does not currently allow mail order pharmacies to participate as providers, therefore it will not pay for mail order copayment charges for recipients with private insurance who use a mail order option. If the private insurer requires use of mail order for maintenance drugs, the pharmacy should assist the member to arrange for MassHealth to be the primary payer for drug coverage if the alternative is copayments in excess of the allowable $1–$3.65 maximum.

Annual caps: In 2012, there is an annual cap of $250 for pharmacy copayments and $36 for in-patient hospital copayments. Once a cap has been reached, the MassHealth agency will send notice that no further copayments are due for the remainder of the calendar year.

See 130 C.M.R. §§ 450.130, 506.013-506.017, 520.036-520.040.

206 What happens if someone cannot afford the copayment?

A provider cannot deny a service to someone who is unable to pay at the time the service is needed, however, a member will still owe the provider the amount of the copayment. If a pharmacy insists on payment as a condition of dispensing the drug and the member is unable to pay, the Customer Service Center should be able to intervene with the pharmacy.

See 130 C.M.R. §§ 450.130, 520.039.

207 Who is exempt from copayments?

The following MassHealth members (with direct coverage) are not required to make copayments for any service:

- children under age 19;
- pregnant women;
- inpatients in nursing facilities, chronic disease hospitals, or ICF-MRs;
- individuals dually eligible for Medicare and MassHealth who are receiving home and community-based services instead of institutional care (new in 2012);
- hospice patients;
- MassHealth Limited members and EAEDC-Medical recipients; and
- American Indians and Alaska natives (new in 2011); and
- people who have met the annual copayment cap.

Premium Assistance: Family Assistance Premium Assistance and Basic/ Essential Premium Assistance members may be charged copayments under the terms of their employer-sponsored insurance. For children in Family Assistance Premium Assistance, the MassHealth agency will reimburse copayments incurred for well-child care, and after a family has spent more than 5 percent of its income on premiums and copayments for eligible children, the MassHealth agency will reimburse any additional costs for the year. However, the family must keep track of its costs and verify that costs have exceeded 5 percent of income; because of this very few families benefit from the 5 percent cap.

See 130 C.M.R. §§ 450.130, 520.037 (copay exemptions): Affordable Care Act § 3309 (dually eligible HCBS exemption); 130 C.M.R. § 505.005(B)(6) (Family Assistance 5 percent cap).

208 Which services do not require a copayment?

There is no copayment for the following services:

- family planning services and supplies,
- Medicare-covered services for individuals with Medicare and MassHealth Standard or the Senior Buy-In/QMB, and
- emergency services.

See 130 C.M.R. §§ 450.130, 520.037.

209 Will MassHealth members ever have to pay back MassHealth benefits?

In most cases members do not have to pay back MassHealth benefits, but there are some special circumstances in which the member or his or her estate may have to repay MassHealth:

- Members are required to assign to MassHealth their rights to third-party recovery in order to repay medical expenses from an insurance settlement or other recovery for a loss. See Part 14 for more information.
- Members who were provided money for premium assistance or direct reimbursement for transportation or other services may be required to repay money to which they were not entitled.
- If a member chooses to receive benefits pending an appeal from the termination of assistance and loses the appeal, the member is liable to repay the benefits paid pending appeal, however, in practice the MassHealth agency has not sought recovery from the member. 130 C.M.R. § 610.036(D).
- After the member's death, if he or she left an estate, the member's estate may be liable to repay MassHealth benefits received for services to someone age

55 or older. Estate recovery can be deferred until the death of a surviving spouse, minor child, or disabled adult child. There are also provisions to waive recovery on hardship grounds. 130 C.M.R. § 501.013.

- Someone who received Medicaid fraudulently may be court-ordered to repay the benefits received.
- An institutionalized individual of any age receiving nursing home level of care is also subject to estate recovery. *See* 130 C.M.R. §§ 515.011–515.012.

See 130 C.M.R. §§ 501.011–.013; Eligibility Operations Memo 09-16 (Sept. 15, 2009).