MassHealth CARES Service Performance Specifications

MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support (CARES) for Kids is a targeted case management (TCM) service that facilitates intensive support in care planning and coordination of services for MassHealth Standard and CommonHealth members younger than 21 years of age. MassHealth CARES services provide a single point of accountability for ensuring that necessary medical, educational, social, or other services are accessed, coordinated, and delivered in a strength-based, individualized, member-driven, ethnically and culturally competent, linguistically appropriate, and accessible manner. 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482 govern CARES services under MassHealth. Qualified CARES providers are expected to comply with all requirements in these performance specifications.

I. Clinical Eligibility Criteria

A member must satisfy the requirements in the "Clinical Eligibility Criteria" sections of 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482 for receipt of CARES services.

II. Provider Requirements

Payment for services described in 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482 will be made only to CARES providers participating in MassHealth on the date of service. Provider types eligible for delivering CARES services must be enrolled by MassHealth for the provision of TCM services at that location. CARES providers must agree to comply with all of the provisions outlined in the "Provider Requirements" sections of 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482.

III. Referral Practices and Relationships

The CARES team must establish referral relationships with members' pediatric specialty providers; primary care providers; behavioral health providers; MassHealth managed care entities; and any other entity, state or local agency, system, or provider as needed for the treatment of a member in the provider's care, as determined by the member's CARES team. As a part of establishing these referral relationships, a CARES provider must have standardized processes for referrals to ensure continuity of care; exchange of relevant health information, such as test results and records; and avoidance of service duplication. This process must also contain follow-up provisions to ensure that the referral is completed successfully.

Further, the CARES team must support care coordination and facilitate collaboration through the establishment of regular case review meetings, which must include all members of the interdisciplinary team and the member and their parent/guardian on a schedule determined by the CARES team in consultation with the member and their parent/guardian. The CARES team may utilize technology conferencing tools including audio, video, and web-deployed solutions when security protocols and precautions are in place to safeguard protected health information (PHI).

IV. Staff Qualifications and Responsibilities

The CARES provider must meet the requirements in the "CARES Team" sections of 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482. Further, the CARES program provider must satisfy the staff composition requirements in the following sections.

A. Staff Composition

The CARES team must satisfy all of the following staff composition requirements.

1. The team must have adequate staffing of qualified senior care managers, care coordinators, and family support staff members as defined in the "Staff Qualifications and Responsibilities" section of this appendix to fully meet the care coordination needs of all members assigned to the provider for CARES services.

    a. To determine whether a CARES provider has adequate staffing of qualified senior care managers, care coordinators, and family support staff members to fully meet care coordination needs of all members assigned to it for CARES services, each CARES provider must submit a staffing plan that includes the following information for every member of the CARES team: name; role on the CARES team (program director, senior care manager, care coordinator, or family support staff); credentials, percent of their time they will spend supporting CARES services; and the approximate number of enrolled members they will be supporting in their role.

        i. Staffing plans must be submitted annually or whenever there is a staffing change to the CARES team, which ever comes earlier.

        ii. If MassHealth determines that staffing is inadequate to fully meet the care coordination needs of all members assigned to the provider for CARES services, MassHealth may implement sanctions or deny claims for inability to render the service in accordance with the regulations.

b. The team must have a senior medical professional (medical doctor, doctor of osteopathic medicine, nurse practitioner, or physician assistant) available during normal business hours to provide consultation services to the senior care managers and care coordinators. The senior medical professional must be available to provide phone or face-to-face consultation to CARES team members within one business day of a request.

2. The team must have at least one licensed registered nurse and at least one licensed social worker. The CARES team will be considered to include a clinical social worker as long as the provider's CARES program has regular access to a social worker that is directly employed by the provider's organization and working in a clinical role.

3. The team must ensure the availability of professional backup staff if coverage is required due to illness, vacation, or other reasons. All staff members providing backup coverage must possess an equal or greater level of licensure and certification required for each position and must meet all other requirements of regular staff members.

4. The team must ensure programmatic capacity for responding to and triaging urgent/emergent clinical needs, as identified by a member or their parent/guardian, including maintaining telehealth capacity and after-hours on-call capacity.

B. Staffing Qualifications and Responsibilities

MassHealth will pay for TCM services only when they are furnished by those program staff members designated in 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482.

1. Program Director

a. Qualifications

The program director must be a medical doctor, doctor of osteopathic medicine, nurse practitioner, or physician assistant with at least five years of clinical experience, at least two of which must be with the target population. At least one of those years must have been spent in an administrative role.

b. Responsibilities

The program director must ensure that the CARES team meets all requirements in 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482, including

i. development and implementation of the CARES provider policies and procedures in 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482;

ii. direction and supervision of all aspects of CARES services, including any necessary information technology (IT) integration;

iii. oversight of all human resources and clinical functions of all CARES team staff;

iv. oversight of fiscal administration of CARES services, including billing, budget preparation, and required program statistical and financial reports; and

v. required programmatic reporting as directed by the Executive Office of Health and Human Services (EOHHS).

2. Senior Care Manager

a. Qualifications

The CARES provider must employ senior care managers who have the following qualifications.

i. Senior care managers must be licensed in the state of Massachusetts as a registered nurse, a nurse practitioner, or a social worker, or must have a master's degree in another relevant field with two years of experience working with the target population in a direct service capacity; and

ii. At least one senior care manager must be a licensed social worker, registered nurse, or nurse practitioner.

b. Responsibilities

Senior care managers are responsible for the implementation of all aspects of the "CARES Scope of Services" section of this appendix, including

i. ensuring the completion and periodic updating of the Comprehensive Assessment and Individual Care Plan (ICP) as specified in the "CARES Scope of Services" section;

ii. providing oversight of all care coordination, family support, and transition activities as specified in the "CARES Scope of Services" section;

iii. providing oversight of all monitoring and follow-up activities as specified in the "CARES Scope of Services" section;

iv. possibly serving as the main and "first line" contact for the member and their parent/guardian, providing regular contact (either face to face or by telehealth as determined by member and their parent/guardian);

v. providing weekly individual supervision to care coordinators and ensuring regular supervision of other team members; and

vi. providing ongoing training to care coordinators on medical aspects of the target population.

3. Care Coordinator

a. Qualifications

The CARES provider must employ care coordinators that have

i. a bachelor's degree from an accredited institution with one year of relevant experience with the target population in a direct service capacity; or

ii. an associate's degree from an accredited institution with two years of relevant experience with the target population in a direct service capacity; or

iii. a high school diploma or equivalent and a minimum of three years of relevant experience with the target population in a direct service capacity.

b. Responsibilities

Care coordinators are responsible for

i. facilitating the development and periodic updating of the Comprehensive Assessment and ICP as specified in the "CARES Scope of Services" section of this appendix;

ii. providing care coordination, family support, and transition activities as specified in the "CARES Scope of Services" section;

iii. providing monitoring and follow-up activities as specified in the "CARES Scope of Services" section;

iv. possibly serving as the main and "first line" contact for the member and their parent/guardian, providing regular contact (either face to face or by telehealth as determined by the member and their parent/guardian);

v. maintaining linkages and a working relationship with local providers of all services in order to facilitate referrals from these providers and to ensure care is properly coordinated for the member and their parent/guardian; and

vi. providing all services listed in the "CARES Scope of Services" section in partnership with the CARES team.

4. Family Support Staff

a. Qualifications

The CARES provider must employ family support staff members who are strength-based and culturally and linguistically responsive paraprofessionals and who practice under the supervision of a care coordinator or care manager. They must have experience navigating child- and family-serving systems and supporting family members who are involved with the child- and family-serving systems and have, at minimum, one of the following qualifications.

i. Experience as a caregiver of a youth with special needs, preferably a youth with physical health needs

ii. Being a certified community health worker

iii. A bachelor's degree in a human services field from an accredited university and one year of relevant experience working with the target population in a direct service capacity

iv. An associate's degree in a human service field from an accredited school and one year of experience working with children/adolescents/transition-age youth

v. A high school diploma or GED and a minimum of two years of experience working with children/adolescents/transition-age youth

b. Responsibilities

Family support staff members are responsible for

i. providing family support to enable the member's parent/guardian to navigate the health care system with or on behalf of the member;

ii. educating the member's parent/guardian about how to effectively navigate child-serving systems for themselves and about the existence of informal/community resources available to them, and facilitating the parent/guardian's access to these resources;

iii. helping with implementation of care plans; and

iv. participating in all care planning meetings and processes for the member.

V. Provider and Staff Training

In addition to staff qualifications, the CARES team members are required to complete trainings outlined in Section V. CARES providers must have policies and procedures describing required trainings and how monitoring will occur to ensure completion of these requirements. CARES providers must document compliance with training requirements for all CARES team members (program director, senior care manager, care coordinator, and family support staff). CARES providers may require additional trainings as they deem it necessary to deliver quality care management services.

A. The CARES provider must provide training to all CARES team members (program director, senior care manager, care coordinator, and family support staff). The CARES provider must keep records of completed training on file and update them regularly. The training must be completed within three months of employment or within three months of any updates to these requirements that are relevant to a team member's role on the CARES team, whichever comes later, and must include

1. care coordination principles for children and families, including needs of populations with multiple co-occurring conditions; and

2. racial, cultural, and linguistic equity, including implicit bias.

B. In addition to those topics, senior care managers, care coordinators, and family support staff members must complete training within three months of employment or within three months of any updates to these requirements that are relevant to their role on the CARES team, whichever comes later, in

1. community-based resources, social service systems, and state agency resources;

2. educational systems, including training on individualized education plans (IEPs) and 504 plans; and

3. shared plan of care development, including learning from and building partnerships with families, with a life course framework.

MassHealth may implement other trainings or technical assistance that it deems necessary or appropriate for participating providers, including on an individual provider basis if determined necessary by MassHealth.

Though formal training in the following topics is not required, CARES providers should ensure that all staff members can demonstrate competencies in

- motivational interviewing;
- trauma-informed care;
- health and medical complexity literacy; and
- transition and referral processes.

VI. CARES Scope of Services

The CARES team is responsible for ensuring that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, member-driven, ethnically and culturally competent, linguistically appropriate, and accessible manner. The CARES team must provide, at minimum, the following services to all members assigned to the provider's case management program.

A. Comprehensive Assessment, Individual Care Plan, and Periodic Reassessment

1. The CARES team must perform a person-centered comprehensive assessment of each member seeking CARES services at least once a year to determine the member's and their parent/guardian's needs for any medical, educational, social, or other services to develop an ICP. The comprehensive assessment must be completed concurrently with the development of an ICP within 60 days of initial intake of the member. The CARES team must convene and facilitate care planning meetings to develop a member-centered ICP, using the information collected during the comprehensive assessment. The ICP must be developed in collaboration with the member and their parent/guardian, be unique to the member, and be accessible to the member and their parent/guardian.

a. Comprehensive Assessment

These assessment activities include, but are not limited to, the following.

i. Taking the member's history, which must capture the full spectrum of medical, social, educational, and emotional needs as well as self-identified strengths, weaknesses, interests, choices, care goals, personal goals, and (as applicable) advance directive status and guardianship status.

ii. Identifying the member's needs and completing related documentation.

iii. Gathering information from other sources such as the parent/guardian, medical providers, state agencies, social service providers, and educators to form a complete assessment of the member.

iv. Ensuring that the comprehensive assessment takes place in a location that meets the member's needs.

v. Keeping records of the comprehensive assessment in the member's medical record, communicating them to the member and their parent/guardian, and sharing them with the member's providers as appropriate.

b. Periodic Reassessment

After the initial comprehensive assessment, a reassessment is to be conducted at least once every year to ensure the member continues to meet eligibility requirements and to determine whether the member's and their parent/guardian's needs, conditions, and/or preferences have changed.

i. Reassessments should also occur when there are significant changes in the member's health and functional status, life circumstances, or social service needs.

ii. Any needed changes that are identified should be updated in the ICP. The member and their parent/guardian, along with appropriate service providers, state agencies, and other members of the care team, must be consulted during reassessment of needs.

(1) The process for updating the ICP must include

(a) determining the enrollee's progress toward goals;

(b) reassessing the enrollee's health status;

(c) reassessing the enrollee's goals;

(d) monitoring the enrollee's adherence to the ICP;

(e) documenting recommendations for follow-up;

(f) making necessary changes in writing, as necessary, to reflect these activities;

(g) ensuring that the enrollee signs or otherwise approves the updates to the ICP; and

(h) notifying the Enrollee's primary care provider (PCP) or PCP designee of the update.

iii. If there are no significant changes to the member's needs, the care manager should perform an abbreviated evaluation of the member's current status including rescreening for risk factors and document the evaluation.

c. The Individual Care Plan (ICP)

i. The ICP must be driven by the member and their parent/guardian, authorized health care decision-maker, and other relevant providers.

ii. The ICP must specify the goals and actions to address the medical, social, educational, and other services needed by the member and their parent/guardian, outlined in the "Care Coordination Activities" section.

iii. The ICP must identify a course of action to respond to the assessed needs of the member and their parent/guardian, with concrete interventions and strategies, identified responsible persons, and potential barriers to meeting goals.

iv. The ICP must be shared and included in transition of care communication with relevant providers, state agencies, and members of the care management team.

v. The ICP must be signed or otherwise approved by the member or the member's parents/guardians.

(1) The CARES provider shall establish and maintain policies and procedures to ensure that a member or their parents/guardians can sign, or otherwise convey approval of, the ICP when it is developed or modified. Such policies and procedures shall include all of the following.

(a) Informing members or their parents/guardians of their right to approve of the ICP.

(b) Providing mechanisms for the member or their parent/guardian to sign, or otherwise convey approval of, the ICP, including a process for allowing electronic signature, which may be used to meet this requirement. Such mechanisms shall meet the member's or their parent/guardian's accessibility needs.

(c) Documenting the member's or their parent/guardian's verbal approval of the ICP in the member's medical record, including a description of the accommodation need that does not permit the member or their parent/guardian to sign the ICP. If there is no accommodation need, the provider shall document why it could not obtain a signature and shall obtain a signature from the member or their parent/guardian within three months of the verbal approval.

vi. The ICP must be developed in a form and format specified by MassHealth and shared with the member's PCP or PCP designee. The ICP must include all of the following.

(1) Name and contact information for care manager(s) and additional care team members as applicable, such as the member's PCP or PCP designee, specialists, school or early childhood personnel who support the member's care, the MassHealth Community Case Management (CCM) Program clinical manager, continuous skilled nursing (CSN) agencies and nurses, and any community-based organization or state agency personnel who support the member's care.

(2) Health summary, which must include, but is not limited to, medical history; behavioral history; and personal, educational, and social circumstances. The health summary must also include all of the following.

i. A list of current services the member is receiving to meet current needs or conditions identified from the comprehensive assessment or from other screenings or assessments.

ii. Long- and short-term clinical, functional (e.g., need for assistance with activities of daily living [ADLs]), developmental, and social goals—which are specific, achievable, and time-specific—as well as aspirational (e.g., long-term hopes).

iii. Educational needs, which must include any required supports for member to be successful in school, including but not limited to information on IEPs, 504 plans, and any school-based related services (e.g., physical, occupational, and speech therapy; behavioral health supports; and nursing services for medical care or assistance with activities of daily living).

iv. Health-related social needs (HRSN) supports, including but not limited to supports and services related to housing, nutrition (e.g., Supplemental Nutrition Assistance Program [SNAP]/Women, Infants, & Children Nutrition Program [WIC]), utility assistance, and transportation needs.

v. Member's strengths, interests, preferences, and cultural considerations.

vi. The right to an appeal of any denial, termination, suspension, or reduction in services, or any other change in providers, services, or medications included in the ICP.

vii. Information on the availability of and access to ombudsman services.

(3) Recommended action steps for each goal with the associated responsible care team member and any related accessibility requirements.

(4) Upcoming medical and social service transitions, as well as strategies to support continuity of care during times of transition.

(5) An emergency plan, to be accessed by emergency medical technicians (EMTs) and emergency department (ED) providers as needed. The emergency plan includes a list of medications, needed accommodations (e.g., local anesthesia for intravenous access), and allergies, as well as providers most involved in the member's care and their contact information.

B. Care Coordination and Family Support Activities

1. Using the ICP, the CARES team must partner with the member and their parent/guardian to obtain needed services by doing the following.

   a. Having a designated CARES team member (either a care coordinator or a senior care manager) serve as the primary and "first line" contact for the member and their parent/guardian. The designated CARES team member must provide regular contact with the member and their parent/guardian (either face to face or by telehealth as determined by the member and their parent/guardian).

      i. Regular contact should include proactive review of previous and current needs, including but not limited to (as applicable) current health status, durable medical equipment (DME) requirements, medication access for refills, social and educational needs, and any other barriers to completing referrals that were previously made.

ii. Having a designated CARES team member (either a care coordinator or a senior care manager) serve as the primary contact for the member and their parent/guardian on its own cannot count as one of the two minimum monthly CARES services required for payment, but proactive review of the previous or current needs with the member and/or their parent/guardian can count as a qualifying CARES service.

b. Providing a dedicated phone number and being on call 24 hours a day, 365 days per year to respond and triage any medical questions, including but not limited to assisting with DME needs or failures, helping access any other medical services as needed, and triaging medical crises and emergencies.

   Providing a phone number 24 hours a day, 365 days per year, is not a distinct activity that can count as one of the two minimum monthly CARES services that must be rendered to receive the monthly payment.

c. Helping the parent/guardian advocate for and access resources and services to meet the family's needs. This may include, but is not limited to, assisting with the identification and development of natural supports and access to support groups, faith groups, and community supports that will help the parent/guardian address the member's needs.

d. Maintaining effective, coordinated, and communicative relationships with designees from the member's care team, such as primary care physicians, health systems, specialty providers, dental providers, behavioral health providers, CCM and CSN supports, and other state agencies (the Department of Children and Families [DCF], Department of Developmental Services [DDS], Department of Elementary and Secondary Education [ESE], Department of Mental Health [DMH], Department of Public Health [DPH], Department of Transitional Assistance [DTA], and Department of Youth Services [DYS]), in order to facilitate coordination.

   As a part of maintaining effective, coordinated, and communicative relationships specifically with the MassHealth CCM Program and DCF, CARES providers will be required to share the name and contact information of the CARES designated care coordinator with a member's MassHealth CCM Program clinical manager and/or DCF case manager if applicable.

e. Coordinating with early intervention providers and school and early childhood education providers, including, but not limited to, attending team meetings and participating in the development of IEPs and 504 plans, providing family support with Individuals with Disabilities Education Act (IDEA) entitlements, and liaising with school nurses and other related staff members to ensure continuity and quality of services between school and medical providers.

f. Coordinating access to DME, home care needs, appointment scheduling, referrals to providers for needed medical services, and assistance with prior authorization. Scheduling appointments with a provider within the CARES team does not count as a CARES service.

g. Coordinating goods and services related to HRSNs, including, but not limited to, housing stabilization and support services, utility assistance, and nutritional assistance.

h. Providing ongoing support in maintaining MassHealth eligibility, accessing any benefits for which the member is eligible through state agencies, and coordinating with primary insurance for members who have third-party coverage, as well as providing intensive support for transitions of care between different health and community settings and the member's home, such as directly participating in discharge planning and on-site presence in acute settings.

C. Transition to Adulthood

The CARES team must provide intensive support for member transitions into adult care, with initial discussions and supports beginning once the member reaches 12 to 14 years of age and more intensive supports beginning once the member reaches 16 years of age, which includes, but is not limited to,

1. developing and regularly updating a plan for transition of care, including the member's goals and prioritized actions; medical summary and emergency care plan; and, if needed, a condition fact sheet and legal documents;

2. helping the member identify an adult clinician(s) and providing linkages to insurance resources, self-care management information, and community support services, including long-term community services and supports, and providing referrals to other community services/supports accordingly;

3. determining the need for decision-making supports for the member, including possible need for guardianship, and making referrals to legal resources;

4. preparing the member and parent/guardian for an adult approach to care, including legal changes in decision-making, privacy, consent, self-advocacy, and access to information; and

5. as the member approaches age 21, planning with the member and parent/guardian for optimal timing of transfer from pediatric to adult care (including, if both primary and subspecialty care are involved, discussion of optimal timing for each).

D. Monitoring and Follow-up Activities

1. Monitoring and follow-up activities are necessary to ensure that the ICP is implemented and adequately addresses the member's needs. This can be accomplished with the member, their parent/guardian, and other members of the care team and conducted at least once every six months, or as often as necessary to determine whether

   a. services are being furnished in accordance with the individual's care plan;

   b. services in the care plan are adequate; and

   c. changes in the needs or status of the individual are reflected in the care plan.

2. Follow-Up after Referral

   a. When a member is referred for services, the CARES team must follow up with the member or service provider to determine whether services were received and whether the services met the member's needs.

   b. The follow-up must occur as quickly as indicated by the assessed need, not to exceed 30 days from the scheduled date of the referral service. If a 30-day follow-up cannot be made with the member due to an unexpected circumstance, the reason must be documented in the member's file.

   c. Additionally, if a 30-day follow-up cannot be made due to the referral being set to take place more than 30 days out from the initial referral, it must be documented in the member's case notes.

VII. Quality Management, Utilization, and Reporting Requirements

A. A CARES provider must participate in any quality management and program integrity processes required by MassHealth and EOHHS, including, but not limited to, conducting member experience surveys and evaluations, submitting development plans to MassHealth, making any requested data available, and providing access to visit the CARES provider's place of business upon request. MassHealth or EOHHS may implement any such required processes via MassHealth bulletin, transmittal letter, or other written issuance.

B. A CARES provider must review and report on the comprehensive assessment or periodic reassessment of the member's needs as specified in the "Comprehensive Assessment, Individual Care Plan, and Periodic Reassessment" section of this appendix, to determine whether services are being provided in accordance with the ICP, whether the services in the ICP are adequate, and whether there are changes in the member's and their parent/guardian's needs or status and, if so, adjust the ICP as necessary. Information gathered through the comprehensive assessment or periodic reassessment reviews should inform overall program planning as needed.

C. A CARES provider must submit requested documentation to MassHealth or its designee for purposes of utilization review and provider review and audit, within MassHealth's or its designee's time specifications. The CARES provider must provide MassHealth or its designee with any supporting documentation the MassHealth agency or its designee requests, in accordance with M.G.L. c. 118E, § 38, and 130 CMR 450.000: *Administrative and Billing Regulations*.

D. A CARES provider must provide MassHealth or its designee with any requested documentation for purposes of a member's medical necessity review for CARES services. The requested documentation must be submitted to MassHealth or its designee within MassHealth's or its designee's time specifications.

VIII. Member Assignment Procedures

The CARES provider must satisfy all of the requirements in the "Assignment and Removal of Assignment Procedures" sections of 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482, in addition to the following activities.

- Conduct and document evaluations to determine eligibility for CARES services as established in the "Clinical Eligibility Criteria" section of 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482.
- Educate the member and their parent/guardian regarding CARES services and care management services face to face, in person, or via telehealth.
- Provide information about the member's rights and responsibilities when receiving CARES services.
- Inform the member and parent/guardian of their right to choose among CARES providers and other TCM services.
- Obtain and document signed release-of-information forms meeting Health Insurance Portability and Accountability Act (HIPAA) requirements for sharing personal health information with other providers, schools, MassHealth, any other health plans, and other necessary parties to ensure effective care coordination and communication.

- If the member/parent/caregiver consents to receive CARES services, complete a comprehensive assessment and create an ICP in partnership with the member and their parent/guardian as specified in the "CARES Scope of Services" section of this appendix within 60 days upon referral or identification of the member.

- Provide the member and their parent/guardian with both a paper and an electronic copy of the member's completed ICP in English and in the member and their parent/guardian's primary language (or language of choice) within 60 days of referral or identification of the member.

- Provide the member and their parent/guardian with a letter, via both registered mail and electronic transmission, if available, notifying them of their enrollment in MassHealth CARES services within 30 days of the enrollment effective date. The letter must include, at minimum, the enrollment effective date, the name of the CARES service provider, an overview of CARES services, the designated care manager's name and contact information, and a reminder that enrollment in CARES services does not affect the member's benefits or enrollment in MassHealth or their health plan.

- If a member is enrolled in the CCM program, notify their CCM clinical manager of the member's enrollment in CARES, and give the clinical manager the name and contact information for the member's designated care manager.

IX. Member Removal of Assignment Procedures

A. The removal of assignment procedures can begin if a member no longer needs, or is no longer eligible for, CARES services. This may occur if one or more of the following circumstances exists.

1. The member no longer meets the eligibility criteria for CARES services.

2. The chronic conditions that made the member eligible for CARES services no longer require being managed and or maintained.

3. All parties concur the member has met the goals of their ICP and is stable enough to no longer require the services of a CARES provider.

4. The member has service and support needs that can be met by a parent/guardian and services without the intensive level of CARES services.

5. The member/guardian/legally authorized representative and family are no longer interested in CARES services.

6. The member is no longer eligible for MassHealth.

7. The member has moved out of Massachusetts.

8. The member is 18 or older, pregnant, a parent, married, or otherwise capable of consenting and has chosen to be unassigned.

B. Before the removal of assignment from CARES services, the CARES team must convene to develop an aftercare/transition plan for the member and their family. The aftercare/transition plan must include, at a minimum,

1. the date and reason for the removal of assignment and a signed consent form from the member or the member's family or legal guardian;

2. a summary of treatment/care recommendations and documentation of ongoing strategies and resources to assist the member and their parent/guardian in sustaining necessary supports post-removal of assignment;

3. identification of any referrals to other appropriate service providers for any health or social services required by the member;

4. a list of services that are in place post-removal of assignment and providers arranged to deliver each service; and

5. a list of prescribed medications, dosages, and possible side effects and ongoing treatments, including DME usage and any therapies.

C. The CARES provider must provide the member and their parent/guardian with a letter, via registered mail or, if available, electronic transmission, notifying them of the termination of their enrollment in MassHealth CARES services within 30 days of the termination date. The letter must include, at minimum, the effective termination date, the reason for the termination, the name of the CARES provider and contact information for any questions, and reminder that the termination of their enrollment in CARES services does not affect the member's benefits or enrollment in MassHealth or their health plan.