An Introduction to MassHealth Long Term Services and Supports and Other Covered Services

For Use by ACOs, MCOs, and Community Partners

Updated: September 25, 2018

Contents

DISCLAIMER: This Guide is for informational purposes only. MassHealth aims to update this Guide periodically. However, ACOs, MCOs, Community Partners, and providers must refer to their MassHealth Contracts, regulations, bulletins, and provider manuals, as appropriate, for all applicable requirements for their respective programs and MassHealth services.

I. Introduction

MassHealth, the Commonwealth of Massachusetts' Medicaid Program, through its Office of Long-Term Services and Supports (OLTSS) provides a robust system of care for members of all ages who need services to enable them to live with independence and dignity in their daily lives, participate in their communities, and increase their overall quality of life. These services include the following Community-Based Long-Term Services and Supports (LTSS) and Facility-Based LTSS through the state plan, as well as Other Covered Services covered through the ACOs and MCOs:

> Community-Based Long-Term Services and Supports: Adult Day Health, Adult Foster Care, Continuous Skilled Nursing (may be provided by Independent Nurses or Home Health Agencies), Day Habilitation, Group Adult Foster Care, and Personal Care Attendant Program (PCA).
>
> Facility-Based Long-Term Services and Supports: Nursing Facility Services (over 100 days) and Chronic Disease Rehabilitation Hospital Services (over 100 days)
>
> Other Covered Services: Chronic Disease Rehabilitation Hospital Services (for the first 100 days), Nursing Facility services (for the first 100 days), Durable Medical Equipment (DME), Orthotics and Prosthetics, Oxygen and Respiratory Therapy, Hospice Services, Home Health Agency (except Continuous Skilled Nursing), and Therapies (including Physical Therapy, Occupational Therapy and Speech Therapy).

This Guide provides basic information about and gives context to the range of State Plan LTSS and Other Covered Services. MassHealth intends for this Guide to be a resource for care managers, care coordinators, and physician offices within Accountable Care Organizations (ACOs, including Accountable Care Partnership Plans, Primary Care ACOs, and MCO-Administered ACOs) and Managed Care Organizations (MCOs), as well as Community Partners (CPs), and providers as they serve MassHealth members who may benefit from LTSS or Other Covered Services.

This Guide focuses on MassHealth members who are under the age of 65, who are not dually-eligible for Medicare. These members may be enrolled in one of MassHealth's managed care options – an Accountable Care Partnership Plan, Primary Care ACO, MCO, or MassHealth's Primary Care Clinician Plan (the PCC Plan).

MassHealth regulations, provider bulletins, and provider manuals set forth detailed information and requirements related to State Plan LTSS and Other Covered Services. These are available online at

Provider Regulation: https://www.mass.gov/service-details/masshealth-provider-regulations

Provider Bulletins: https://www.mass.gov/masshealth-provider-bulletins

Provider Manual: http://www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/provider-manual/

Additional information about State Plan LTSS, Other Covered Services and other services that can support individuals in the community can be found at https://www.massoptions.org.

II. State Plan LTSS and Other Covered Services for MassHealth Members by Coverage Type

MassHealth members are eligible for a specific set of services based on their coverage type (see 130 CMR 450.105). The table below lists these services and member access to the services based on coverage type.

LTSS and Other Covered Services	MassHealth Standard	MassHealth CommonHealth	MassHealth Family Assistance	MassHealth Care Plus
Community- Based LTSS Services				
Adult Day Health	Yes	Yes	No	No
Adult Foster Care	Yes	Yes	No	No
Continuous Skilled Nursing (may be provided by Independent Nurses or Home Health Agencies)	Yes	Yes	No	No
Day Habilitation	Yes	Yes	No	No
Group Adult Foster Care	Yes	Yes	No	No
Personal Care Attendant Program	Yes	Yes	No	No
Facility-Based LTSS Services				
Nursing Facilities (over 100 days)	Yes	Yes	No	Yes
Chronic Disease and Rehabilitation Hospitals (over 100 days)	Yes	Yes	Yes	Yes
Other Covered Services				
Chronic Disease and Rehabilitation Hospital Services (for the first 100 days)	Yes	Yes	Yes	Yes
Durable Medical Equipment, Orthotics and Prosthetics, Oxygen and Respiratory Therapy	Yes	Yes	Yes	Yes
Home Health Agency (except Continuous Skilled Nursing)	Yes	Yes	Yes	Yes
Hospice Services	Yes	Yes	Yes	Yes
Nursing Facility Services (for the first 100 days)	Yes	Yes	No	Yes
Therapy Services (Physical Therapy, Occupational Therapy, Speech Therapy)	Yes	Yes	Yes	Yes

Note: Persons in Family Assistance with HIV will receive coverage for all medically necessary services.

In addition, MassHealth members must meet service eligibility and other requirements for each service, in order to be eligible to receive the service. Please see Section V below for more information.

III. State Plan LTSS and Other Covered Services for MassHealth Members by Plan Type: Who is Responsible for Authorizing and Covering the Specific Service

LTSS and Other Covered Services may be covered by a MassHealth member's managed care plan (i.e. a member's ACO or MCO) or by MassHealth directly. The table below summarizes who covers each LTSS and Other Covered Service based on the MassHealth member's health plan.

For LTSS and Other Covered Services covered by MassHealth directly, MassHealth's LTSS Third Party Administrator (TPA) is responsible for authorizing the service. This does not include, however, Continuous Skilled Nursing services or Facility-Based LTSS Services (Chronic Disease and Rehabilitation Hospitals (over 100 days) and Nursing Facility (over 100 days)). For such services, MassHealth will authorize such service through another designee.

For Other Covered Services covered by the MassHealth member's Accountable Care Partnership Plan or MCO, the member's plan is responsible for authorizing those services. All questions about these services, including service authorization requirements, should be directed to the member's health plan.

Services for MassHealth Members by coverage type:

LTSS and Other Covered Services	Who Covers this Service?	
	For Members Enrolled in an Accountable Care Partnership Plan or MCO	**For Members Enrolled in a Primary Care ACO or the PCC Plan, or Members in MassHealth fee-for-service**
Community-Based LTSS Services		
Adult Day Health	MassHealth covers this service directly	MassHealth covers this service directly
Adult Foster Care	MassHealth covers this service directly	MassHealth covers this service directly
Continuous Skilled Nursing (may be provided by Independent Nurses or Home Health Agencies[1])	MassHealth covers this service directly	MassHealth covers this service directly
Day Habilitation	MassHealth covers this service directly	MassHealth covers this service directly
Group Adult Foster Care	MassHealth covers this service directly	MassHealth covers this service directly
Personal Care Attendant Program	MassHealth covers this service directly	MassHealth covers this service directly
Facility-Based LTSS Services		
Chronic Disease and Rehabilitation Hospitals (over 100 days)	MassHealth covers for eligible members via MassHealth FFS	MassHealth covers for eligible members via MassHealth FFS
Nursing Facilities (over 100 days)	MassHealth covers for eligible members via MassHealth FFS	MassHealth covers for eligible members via MassHealth FFS
Other Covered Services		
Chronic Disease and Rehabilitation Hospitals (for the first 100 days)	The member's Accountable Care Partnership Plan or MCO covers this service	MassHealth covers this service directly
Durable Medical Equipment, Orthotics and Prosthetics, Oxygen and Respiratory Therapy	The member's Accountable Care Partnership Plan or MCO covers this service	MassHealth covers this service directly
Home Health Agency (except Continuous	The member's Accountable Care	MassHealth covers this service

[1] Note: The MCO serving MassHealth members in the Special Kids Special Care program covers Continuous Skilled Nursing as an MCO-covered service. As with other MCO-covered services, all questions about these services, including service authorization requirements, should be directed to the member's health plan.

Skilled Nursing)	Partnership Plan or MCO covers this service	directly
Hospice Services	The member's Accountable Care Partnership Plan or MCO covers this service	MassHealth covers this service directly
Nursing Facilities (for the first 100 days)	The member's Accountable Care Partnership Plan or MCO covers this service	MassHealth covers this service directly
Therapy Services (Physical Therapy, Occupational Therapy, Speech Therapy)	The member's Accountable Care Partnership Plan or MCO covers this service	MassHealth covers this service directly

IV. Connecting Members to Services

ACOs, MCOs, Community Partners, and providers may take the following steps to connect a MassHealth member with a LTSS or Other Covered Service:

1. Help the member choose a preferred service provider in their area.
    a. For Other Covered Services covered by a member's Accountable Care Partnership Plan or MCO, each plan will have information about the network of providers available to the member. For Other Covered Services that an Accountable Care Partnership Plan or MCO cover, please contact the health plan for information about in-network providers.
    b. For LTSS and Other Covered Services covered directly by MassHealth, including but not limited to all LTSS and Other Covered Services for members enrolled in a Primary Care ACO or the PCC Plan, members will have access to the full network of MassHealth providers. For LTSS and Other Covered Services covered directly by MassHealth, service providers can be located using the MassHealth provider directory: https://masshealth.ehs.state.ma.us/providerdirectory/.
2. Contact the service provider to determine if they are able to provide the service to the member (if provider is unable to serve the member, repeat Step 1).
3. The service provider will assess the member and submit an authorization request to the Accountable Care Partnership Plan, MCO or MassHealth LTSS TPA (or other MassHealth designee as applicable) depending on the service type requesting a level of care or amount and duration of the service (for more information see each service chart in Section V below).
4. The service provider will work with the member to shepherd the service authorization and medical necessity documentation through the authorization process (as required), with assistance from the member's prescribing provider or providers.
5. If a member disagrees with a decision about a prior authorization, the member has the right to appeal the decision made by the MassHealth, Accountable Care Partnership Plan or the MCO. Instructions on appealing a MassHealth decision can be found at https://www.mass.gov/how-to/how-to-appeal-a-masshealth-decision. For information about how to appeal an Accountable Care Partnership Plan or MCO decision, contact the health plan directly.
    a. The service provider will assist the member if the member's authorization request is not approved, or not approved for the requested amount. Any additional documentation should be submitted through the service provider.

V. Services in Detail

This section lists the services managed by OLTSS, including Community-Based LTSS Services, Facility-Based LTSS Services, and Other Covered Services:

- **Community- Based LTSS Services**
  - Adult Day Health
  - Adult Foster Care
  - Continuous Skilled Nursing
  - Day Habilitation
  - Group Adult Foster Care
  - Personal Care Attendants
- **Facility- Based LTSS Services**
  - Chronic Disease and Rehabilitation Hospitals (over 100 days)
  - Nursing Facilities (over 100 days)
- **Other Covered Services**
  - Chronic Disease and Rehabilitation Hospitals (for first 100 days)
  - Durable Medical Equipment, Orthotics and Prosthetics, Oxygen and Respiratory Therapy
  - Home Health Agency
  - Hospice Services
  - Nursing Facilities (for first 100 days)
  - Therapy Services (Physical Therapy, Occupational Therapy, Speech Therapy)

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ACOs, MCOs, Community Partners, and providers must refer to their MassHealth Contracts, regulations, bulletins, and provider manuals, as appropriate, for all applicable requirements for their respective programs and MassHealth services.

Community- Based LTSS Services

Adult Day Health

130 CMR 404.000

<table>
<tr><td>Service/Program Description</td><td colspan="2">Adult Day Health (ADH) services are provided to eligible MassHealth members who require skilled nursing services and/or assistance with ADLs in a structured community-based non-residential day setting.

ADH provides an organized program of nursing, therapy, personal care, case management, counseling, nutritional and other health related support services to MassHealth members who have physical, cognitive, or behavioral health impairments. Services provided to ADH members are based on an individual plan of care. Transportation of members to and from the ADH site is provided by ADH providers through their own transportation and/or contract with private carriers.</td></tr>
<tr><td>Members Who Might Benefit from Service/Program</td><td colspan="2">• Members with ADL needs who may have other formal or informal supports at home, who might benefit from support in a community-based structured setting during the day.
• Members with chronic conditions that could benefit from nursing oversight provided in a day setting.</td></tr>
<tr><td>MassHealth Coverage Types Eligible for Service/Program (See Section II above)</td><td colspan="2">• MassHealth Standard
• MassHealth CommonHealth</td></tr>
<tr><td rowspan="2">Who Covers this Service/Program? (See Section III above)</td><td><u>For members enrolled in an Accountable Care Partnership Plan or MCO</u></td><td><u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u></td></tr>
<tr><td>MassHealth covers this service directly</td><td>MassHealth covers this service directly</td></tr>
<tr><td>Who Authorizes this Service/Program? (See Section III above)</td><td colspan="2">For all members, MassHealth or its designee performs authorization activities.</td></tr>
</table>

Clinical Eligibility Requirements	**<u>For all MassHealth members</u>** To be clinically eligible for MassHealth payment of ADH services, a MassHealth member must meet all of the following criteria: (1) have a medical or mental dysfunction that involves one or more physiological systems and requires nursing care (The dysfunction does not have to be one that can be stabilized.); (2) require services in a structured adult day health setting; (3) have a personal physician; (4) require a health assessment, oversight, monitoring, or services provided by a licensed nurse; and (5) require one or both of the following: (a) assistance daily with one or more activities of daily living (see 130 CMR 404.407(C)); (b) or at least one skilled service (see 130 CMR 404.407(B)) **See 130 CMR 404.407 for complete clinical eligibility requirements** **Other Requirements** • Must be physician ordered/approved **Prior Authorization (PA)** • Will be subject to PA process in the near future
Other Factors to Consider	• ADH is typically provided Monday-Friday • An ADH program typically runs about 6 hours per day • ADH programs typically provide transportation services to and from the site for members attending the program
Non-Covered ADH Services and Services tat are considered duplicative of ADH	Situations in which ADH services are not covered for a member include when the member • Is a resident or at an inpatient status at a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities. Services that are considered duplicative of ADH and thus cannot be provided concurrent with the provision of ADH services include • HHA services provided during the time the member is at the ADH program • PCA services provided during the time the member is at the ADH program

Adult Foster Care

130 CMR 408.000

<table>
<tr><td>Service/Program Description</td><td colspan="2">Adult Foster Care (AFC) services provide 24-hour availability of assistance with personal care needs (i.e. assistance with ADLs and IADLs) by a live-in caregiver. AFC services include care management and nursing oversight of the delivery of the member's personal care needs delivered by the live-in caregiver. A MassHealth member receiving AFC services may live in their own home with an AFC caregiver or may live in the home of their AFC caregiver, who provides the AFC services.</td></tr>
<tr><td>Clinical Eligibility Requirements</td><td colspan="2"><u>For all MassHealth members</u>
Level of Care OR Functional Status Requirement
Member has a medical or mental condition that requires daily hands-on (physical) assistance or cueing and supervision throughout the entire activity in order for the member to successfully complete at least one of the following activities: bathing, dressing, toileting, transferring, mobility (ambulation), eating
See 130 CMR 408.416 for complete clinical eligibility requirements

Other Requirements
Must be Physician Ordered/Approved
Prior Authorization (PA)
Will be subject to PA process in the near future</td></tr>
<tr><td>MassHealth Coverage Types Eligible for Service/Program (See Section II above)</td><td colspan="2">• MassHealth Standard
• MassHealth CommonHealth</td></tr>
<tr><td rowspan="2">Who Covers this Service/Program? (See Section III above)</td><td><u>For members enrolled in an Accountable Care Partnership Plan or MCO</u></td><td><u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u></td></tr>
<tr><td>MassHealth covers this service directly</td><td>MassHealth covers this service directly</td></tr>
<tr><td>Who Authorizes this Service/Program? (See Section III above)</td><td colspan="2">For all members, MassHealth or its designee or designee performs authorization activities</td></tr>
<tr><td>Members Who Might Benefit from Adult Foster Care</td><td colspan="2">Members who would benefit from assistance with their personal care needs (ADLs & IADLS) delivered by a live-in caregiver.</td></tr>
<tr><td>Other Factors to Consider</td><td colspan="2">The live-caregiver cannot be a legally responsible relative (i.e. spouse of the member or parent of a minor member).</td></tr>
</table>

Non-Covered AFC Services and Services that are considered duplicative of AFC	Situations in which AFC services are not covered for a member include when the member • Is a resident or at an inpatient status at a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities. Services that are considered duplicative of AFC and thus cannot be provided concurrent with the provision of AFC services include: • PCA services • HHA Home Health Aide Services • Group Adult Foster Care Services

Continuous Skilled Nursing (may be provided by Independent Nurses or Home Health Agencies)

130 CMR 403.000 and 414.000

Service/Program Description	Continuous skilled nursing (CSN) is a nurse visit of more than 2 consecutive hours per visit provided to members in their home. CSN may be provided through a nurse employed or contracted by a Home Health Agency or by an independent nurse who independently enrolls as a provider in MassHealth to deliver CSN services. Members who need CSN also receive care management through MassHealth or its designee to ensure that such members are provided with a coordinated LTSS services plan that meets their needs.	
MassHealth Coverage Types Eligible for Service/Program (See Section II above)	• MassHealth Standard • MassHealth CommonHealth	
Who Covers this Service/Program? (See Section III above)	<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>	<u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u>
	MassHealth covers this service directly	MassHealth covers this service directly
Who Authorizes this Service/ Program? (See Section III above)	For all members, MassHealth or its designee performs authorization activities	
Clinical Eligibility Requirements	**<u>For all MassHealth members</u>** **Level of Care OR Functional Status Requirement** • Member requires medically necessary skilled nursing visits of more than two continuous hours per visit as determined by MassHealth or its designee **See 130 CMR 403.409(H) and 130 CMR 414.409(F) for complete clinical eligibility requirements** **Other Criteria** • Must be under the care of a physician **Prior Authorization (PA)** • CSN requires PA prior to the start of care	

Members Who Might Benefit from CSN	• Members whose medical needs require skilled nursing visits of more than two consecutive hours per visit in order to remain in the community
Other Factors to Consider	• Members determined eligible to receive CSN are assigned a clinical manager to provide care coordination and care management
Non-Covered CSN Services	Situations in which CSN services are not covered for a member include when the member: • Is a resident or at an inpatient status at a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities

Day Habilitation

130 CMR 419.000

Service/Program Description	Day Habilitation (DH) services are designed to provide adult members with intellectual or developmental disabilities with a structured, goal-oriented program to raise and/or prevent the worsening of the members' level of functioning, and to facilitate independent living and self-management in the community. Services provided at DH include skilled nursing services and health care supervision, developmental skills training, therapy services (including PT, OT, ST and behavior management), and assistance with ADLs.	
MassHealth Coverage Types Eligible for Service/Program (See Section II above)	• MassHealth Standard • MassHealth CommonHealth	
Who Covers this Service/Program? (See Section III above)	<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>	<u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u>
	MassHealth covers this service directly	MassHealth covers this service directly
Who Authorizes this Service/ Program? (See Section III above)	For all members, MassHealth or its designee performs authorization activities	
Clinical Eligibility Requirements	**<u>For all MassHealth members</u>** **Level of Care OR Functional Status Requirement** • Member must have an intellectual or developmental disability; and • Member must need and can benefit from DH services designed to maintain or improve independent functioning **See 130 CMR 419.434 for complete clinical eligibility requirements** **Other Criteria** • Must be under the care of a physician **Prior Authorization (PA)** • Will be subject to PA process in the near future	

Members Who Might Benefit from Day Habilitation	• Members with ID/DD who have skilled service needs and/or who could benefit from a structured day setting that promotes and facilitates independent living and self-management in the community.
Other Factors to Consider	• DH is typically provided Monday-Friday • A DH program typically runs 6 hours per day
Non-Covered DH Services and Services that are considered duplicative of DH	Situations in which DH services are not covered for a member include when the member: • Is a resident or at an inpatient status at a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities, except if the service is recommended as a specialized service pursuant to PASRR Services that are considered duplicative of DH and thus cannot be provided concurrent with the provision of DH services include: • PCA services provided during the time the member is at the DH site • HHA Services provided during the time the member is at the DH site

Group Adult Foster Care

Service/Program Description	The Group Adult Foster Care (GAFC) Program provides assistance with personal care. Personal care provided under GAFC consists of the provision of assistance with Activities of Daily Living (ADLs), as well as care management and nursing oversight of the provided personal care. GAFC services are provided by a direct care worker employed or contracted by the GAFC provider. GAFC services are provided in a member's home, which must be a GAFC qualified setting.	
MassHealth Coverage Types Eligible for Service/Program (See Section II above)	• MassHealth Standard • MassHealth CommonHealth	
Who Covers this Service/Program? (See Section III above)	<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>	<u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u>
	MassHealth covers this service directly	MassHealth covers this service directly
Who Authorizes this Service/ Program? (See Section III above)	For all members, MassHealth or its designee performs authorization activities	
Clinical Eligibility Requirements	**<u>For all MassHealth members</u>** **Level of Care OR Functional Status Requirement** • Require assistance with one or more of the following activities of daily living (ADLs): bathing, dressing, toileting, eating, transfers and ambulation. **Other Requirements** • Must be Physician Ordered/Approved	
Members Who Might Benefit from Group Adult Foster Care	• Members who might benefit from some ADL assistance at home, but who generally do not require more than 2 hours a day of ADL support.	

Non-Covered GAFC Services and Services that are considered duplicative of DH	Situations in which GAFC services are not covered for a member include when the member: • Is a resident or at an inpatient status at a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities or certain other residential facilities subject to state licensure or certification. Services that are considered duplicative of GAFC and thus cannot be provided concurrent with the provision of GAFC include: • PCA services • AFC services • HHA Home Health Aide services

Personal Care Attendant Program

130 CMR 422.000

Service/Program Description	The Personal Care Attendant (PCA) Program is a self-directed personal care program that provides assistance with personal care needs (i.e. assistance with ADLs and IADLs) by a PCA that is employed by the member (referred to as "consumer" in the context of PCA services). Consumers or their surrogates are the employer of the PCAs and are responsible for recruiting, hiring, training, firing, and supervising their PCAs. Consumers select a personal care management (PCM) agency that evaluates a consumer's need for PCA services, develops a PCA service agreement, and provides intake/orientation and skills training to the member or his or her surrogate regarding employer responsibilities.	
MassHealth Coverage Types Eligible for Service/Program (See Section II above)	• MassHealth Standard • MassHealth CommonHealth	
Who Covers this Service/Program? (See Section III above)	<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>	<u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u>
	MassHealth covers this service directly	MassHealth covers this service directly
Who Authorizes this Service/ Program? (See Section III above)	For all members, MassHealth or its designee performs authorization activities	

Clinical Eligibility Requirements	**<u>For all MassHealth members</u>** **Level of Care OR Functional Status Requirement** • The member's disability is permanent or chronic in nature and impairs the member's functional ability to perform ADLs and IADLs without physical assistance • The member requires physical assistance with two or more of the following ADLs: mobility, including transfers; taking medications; bathing/grooming; dressing or undressing; range-of-motion exercises; eating; and toileting **See 130 CMR 422.403(C) for complete clinical eligibility requirements** **Other Criteria** • Must be Physician Ordered/Approved • Member must appoint a surrogate to perform his/her employer tasks if they are assessed as requiring a surrogate to manage their PCA services **Prior Authorization (PA)** • Requires PA prior to the start of care
Members Who Might Benefit from PCA	• Members who require assistance with two or more ADL and IADLs to live independently in the community
Other Factors to Consider	• PCA services are self-directed, and often provided in the member's home but may be provided elsewhere in the community at the direction of the member. The member decides how, where and when their PCA services are performed. • A member's PCA cannot be a legally responsible relative (e.g. spouse of the member or parent of a minor member) • A member's PCA cannot be the member's surrogate
Non-Covered PCA Services and Services that are considered duplicative of PCA	Situations in which PCA services are not covered for a member include: • When the member is a resident or at an inpatient status at a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities • During the hours in which the member is in attendance at a DH program • During the hours in which the member is in attendance at an ADH program • Assistance in the form of cueing, prompting, or supervision is not covered Services that are considered duplicative of PCA and thus cannot be provided concurrent with the provision of PCA include: • Adult Foster Care • Group Adult Foster Care • Home health aide services provided by a Home Health Agency

Facility-based Long-Term Services and Supports

Long-term (over 100 days) Chronic Disease and Rehabilitation Hospitals

130 CMR 435.000

<table>
<tr><td>Service/Program Description</td><td colspan="2">Chronic disease and rehabilitation (CDR) hospitals provide a wide array of inpatient services to members that require a CDR level of care provided in an inpatient setting as defined in 130 CMR 435.409 and 435.410.

Chronic disease services include, but are not limited to oncology, complex medical management, HIV and AIDS care, complex wound management, post medical-surgical problems, and heart failure.</td></tr>
<tr><td>MassHealth Coverage Types Eligible for Service/Program (See Section II above)</td><td colspan="2">• MassHealth Standard
• MassHealth CommonHealth
• MassHealth Family Assistance
• MassHealth CarePlus</td></tr>
<tr><td rowspan="2">Who Covers this Service/Program? (See Section III above)</td><td><u>For members enrolled in an Accountable Care Partnership Plan or MCO</u></td><td><u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u></td></tr>
<tr><td>MassHealth covers for eligible members via MassHealth FFS</td><td>MassHealth covers for eligible members via MassHealth FFS</td></tr>
<tr><td>Who Authorizes this Service/ Program? (See Section III above)</td><td colspan="2">For all members, MassHealth or its designee performs authorization activities</td></tr>
<tr><td>Clinical Eligibility Requirements</td><td colspan="2"><u>For all MassHealth members</u>

Level of Care OR Functional Status Requirement

• Services must be medically necessary (a member must require a CDR level of care)

See 130 CMR 435.409 and 435.410 for complete clinical eligibility requirements

Clinical Authorization

• CDR Hospital services require clinical authorization</td></tr>
<tr><td>Members Who Might Benefit from CDRH Services</td><td colspan="2">• Members who require intensive inpatient hospital level medical and nursing services, hospital level intensive interdisciplinary rehabilitative services or hospital level management of complex clinical needs.</td></tr>
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Long-term (over 100 days) Nursing Facilities

130 CMR 456.000

<table>
<tr><td>Service/Program Description</td><td colspan="2">Nursing Facilities (NFs) provide short-term and long-term skilled nursing services for eligible MassHealth members who require a nursing facility level of care, as defined by 130 CMR 456.409.</td></tr>
<tr><td>MassHealth Coverage Types Eligible for Service/Program (See Section II above)</td><td colspan="2">• MassHealth Standard
• MassHealth CommonHealth
• MassHealth CarePlus</td></tr>
<tr><td rowspan="2">Who Covers this Service/Program? (See Section III above)</td><td><u>For members enrolled in an Accountable Care Partnership Plan or MCO</u></td><td><u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u></td></tr>
<tr><td>MassHealth covers for eligible members via MassHealth FFS</td><td>MassHealth covers for eligible members via MassHealth FFS</td></tr>
<tr><td>Who Authorizes this Service/ Program? (See Section III above)</td><td colspan="2">For all members, the MassHealth agency or its designee performs authorization activities</td></tr>
<tr><td>Clinical Eligibility Requirements</td><td colspan="2"><u>For all MassHealth members</u>
Level of Care OR Functional Status Requirement
• Members must be clinically eligible to receive NF services, i.e. the member must require at least one skilled service daily or require a combination of nursing services and activities supporting activities of daily living, pursuant to 130 CMR 456.409.
See 130 CMR 456.409 and 410 for complete clinical eligibility requirements
Other Criteria
• Members are eligible for nursing facility care only if MassHealth (or its agent) determines that community care is not available or cannot meet their needs
Clinical Authorization
• Nursing facility services require clinical authorization</td></tr>
<tr><td>Other Factors to Consider</td><td colspan="2">Prior to admission and annually thereafter, all individuals, regardless of payer source are required to undergo a Pre-Admission Screening and Resident Review (PASRR) assessment to determine whether they have an intellectual disability, developmental disability, or major mental illness, and to determine whether nursing facility admission is appropriate and whether specialized services are required. This function is performed by the state and pursuant to federal requirements under 42 U.S.C. 1396r(e)(7).</td></tr>
<tr><td>Members Who Might Benefit from Nursing Facilities</td><td colspan="2">• Members who require a nursing facility level of care and choose a facility setting.
• Members who require skilled services performed by or under the supervision of an RN or therapist (e.g., intravenous feeding, observation and evaluation of an unstable medical condition, positioning in bed or a chair as part of the care plan or administration of medication) in a facility setting.</td></tr>
</table>

Other Covered Services

Chronic Disease and Rehabilitation Hospitals (for the first 100 days of admission)

130 CMR 435.000

<table>
<tr><td>Service/Program Description</td><td colspan="2">Chronic disease and rehabilitation (CDR) hospitals provide a wide array of inpatient services to members that require a CDR level of care provided in an inpatient setting as defined in 130 CMR 435.409 and 435.410.

Conditions served by the rehabilitation unit include, but are not limited to stroke, amputee, head injury, spinal cord injury, pulmonary or physical medicine, and rehabilitation.

Chronic disease services include, but are not limited to oncology, complex medical management, HIV and AIDS care, complex wound management, post medical-surgical problems, and heart failure.</td></tr>
<tr><td>MassHealth Coverage Types Eligible for Service/Program (See Section II above)</td><td colspan="2">• MassHealth Standard
• MassHealth CommonHealth
• MassHealth Family Assistance
• MassHealth CarePlus</td></tr>
<tr><td rowspan="2">Who Covers this Service/Program? (See Section III above)</td><td><u>For members enrolled in an Accountable Care Partnership Plan or MCO</u></td><td><u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u></td></tr>
<tr><td>The member’s Accountable Care Partnership Plan or MCO covers this service</td><td>MassHealth covers this service directly</td></tr>
<tr><td rowspan="2">Who Authorizes this Service/ Program? (See Section III above)</td><td colspan="2"><u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>

<u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u></td></tr>
<tr><td>The member’s Accountable Care Partnership Plan or MCO authorizes this service</td><td>MassHealth or its designee authorizes this service</td></tr>
<tr><td>Clinical Eligibility Requirements</td><td colspan="2"><u>For members enrolled in a Primary Care ACO, the PCC Plan, or in MassHealth fee-for-service:</u>
Level of Care OR Functional Status Requirement
• Services must be medically necessary (a member must require a hospital level of care)
See 130 CMR 435.409 for complete clinical eligibility requirements
Clinical Authorization
• CDR Hospital services require clinical authorization

<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>
For members enrolled in ACO Partnership Plans and MCOs, contact the ACO or MCO for service information and authorization.</td></tr>
<tr><td>Members Who Might Benefit from CDRH Services</td><td colspan="2">• Members who require intensive inpatient hospital level medical and nursing services, hospital level intensive interdisciplinary rehabilitative services or hospital level management of complex clinical needs.</td></tr>
</table>

Other Factors to Consider	• Members who do not require a hospital level of rehabilitation or chronic disease management may benefit from either a service which provides a lower level of inpatient care (NFs) or provides a lower level of care at home or in the community (Home Health Agency or PCA).

Durable Medical Equipment

130 CMR 409.000

Service/Program Description	MassHealth provides members with medically necessary equipment, accessories, or supplies that can be appropriately used in a home setting. For members who reside in nursing facilities, the MassHealth DME program covers certain customized mobility equipment and support surfaces. For members who are inpatients at an intermediate care facility, acute hospital or chronic disease and rehabilitation hospital, MassHealth covers customized mobility equipment. The DME program also covers repair of DME, including repairs to necessary backup equipment. To meet the federal definition of DME, items or supplies must be primarily and customarily used for a medical purpose; generally not useful in the absence of disability, illness or injury; and able to withstand repeated use over an extended period. Medical supplies are made to fulfill a medical purpose and are consumable or disposable. Examples of DME and medical supplies include Absorbent products Ambulatory equipment (e.g. crutches and canes) Bath and toilet equipment and supplies Compression devices Enteral and parenteral nutrition and nutritional supplements Glucose monitors and diabetic supplies Home infusion equipment and supplies Hospital beds and accessories Mobility equipment and seating systems Ostomy supplies Patient lifts Personal emergency response systems Augmentative and alternative communication devices (such as speech generating devices) Support surfaces
Members Who Might Benefit from DME	• Member medical needs are specific to the DME or medical supplies. • Some medical needs that may correlate to DME or medical supplies include ○ Incontinence (Absorbent products) ○ Mobility impairments (Ambulatory, Mobility, and Bath and toilet equipment and supplies) ○ Wound care (Hospital beds and accessories, Support surfaces) ○ Type 1 or Type 2 Diabetes (Glucose monitors and diabetic supplies) ○ Intellectual or Developmental Disability, including Acquired or Traumatic Brain Injury (Augmentative and alternative communication devices) ○ Circulatory or support needs (Compression devices)

<table>
<tr><td>MassHealth Coverage Types Eligible for Service/Program (See Section II above)</td><td colspan="2">• MassHealth Standard
• MassHealth CommonHealth
• MassHealth Family Assistance
• MassHealth CarePlus</td></tr>
<tr><td rowspan="2">Who Covers this Service/Program? (See Section III above)</td><td><u>For members enrolled in an Accountable Care Partnership Plan or MCO</u></td><td><u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u></td></tr>
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The member’s Accountable Care Partnership Plan or MCO authorizes this service</td><td><u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u>

MassHealth’s designee authorizes this service</td></tr>
<tr><td>Clinical Eligibility Requirements</td><td colspan="2"><u>For members enrolled in a Primary Care ACO, the PCC Plan, or in MassHealth fee-for-service</u>
Level of Care OR Functional Status Requirement
• DME or medical supplies must be medically necessary
See 130 CMR 409 for complete clinical eligibility requirements

Other Criteria
• Prescription and letter of medical necessity required for purchase or rental of DME

Prior Authorization (PA)
• Most DME and medical supplies require prior authorization by MassHealth or its designee
• Many supplies have maximum allowable units within defined periods. Members may request PA for additional medically necessary units

<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>
For members enrolled in ACO Partnership Plans and MCOs, contact the ACO or MCO for service information and authorization.</td></tr>
<tr><td>Other Factors to Consider</td><td colspan="2">• DME providers and prescribers are responsible for ensuring that all DME and medical supplies are appropriate and cost effective, given the member’s medical need for which the DME or medical supplies are prescribed.</td></tr>
<tr><td>Non-Covered Services</td><td colspan="2">• Devices that are experimental or investigational in nature are not covered
• Manual wheelchairs and medical supplies are not covered for members residing in nursing facilities.
• Medical supplies and non-customized DME are not covered for members who are inpatients at an intermediate care facility, acute hospital or chronic disease and rehabilitation hospital.</td></tr>
</table>

Orthotics and Prosthetics

130 CMR 442.000 and 428.000

<table>
<tr><td>Service/Program Description</td><td colspan="2">• MassHealth provides medically necessary orthotics and prosthetic devices, including shoes, braces, artificial limbs, and splints to members living at home and in nursing facilities. Orthotics and Prosthetics programs cover the purchase, customization, fitting, repair, replacement, and adjustment of an orthosis or prosthetic or component part.
• For members who reside in nursing facilities or are inpatients at an intermediate care facility, MassHealth covers certain orthotics and prosthetics. For members who are inpatients at an acute hospital or chronic disease and rehabilitation hospital, MassHealth covers orthotics and prosthetics prescribed in anticipation of discharge.</td></tr>
<tr><td>MassHealth Coverage Types Eligible for Service/Program (See Section II above)</td><td colspan="2">• MassHealth Standard
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<tr><td>Clinical Eligibility Requirements</td><td colspan="2"><u>For members enrolled in a Primary Care ACO, the PCC Plan, or in MassHealth fee-for-service:</u>
Level of Care OR Functional Status Requirement
• Services must be medically necessary
• Some devices require a specific diagnosis, e.g., diabetes
See 130 CMR 422 and 130 CMR 428 for complete clinical eligibility requirements
Other Criteria
• Members are limited to two pairs of shoes during a 12 month time period
• Orthotics and prosthetics require a written prescription from a physician, a licensed podiatrist or an independent nurse practitioner.
Prior Authorization
• Some orthotic and prosthetic devices require prior authorization

<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>
For members enrolled in ACO Partnership Plans and MCOs, contact the ACO or MCO for service information and authorization.</td></tr>
</table>

Members Who Might Benefit from O&P	• Member medical needs are specific to the orthotic or prosthetic device
Non-Covered Services	• Non-medical orthotic or prosthetic devices and those that are experimental or investigational in nature

Oxygen and Respiratory Therapy

130 CMR 427.000

Service/Program Description	MassHealth provides oxygen and respiratory equipment services including the purchase, rental and repair of equipment and supplies used in the treatment of pulmonary diseases. Oxygen therapy is the administration of oxygen in concentrations greater than that in the ambient air to treat the signs and symptoms of tissue hypoxia resulting from abnormal blood oxygen levels. Equipment includes, but is not limited to, comprehensive oxygen delivery systems, including gaseous and liquid oxygen, oxygen generating equipment, stand, cart, walker or stroller, supply reservoir, and regulator with flow gauge. Respiratory therapy is treatment that maintains or improves the ventilatory function of the respiratory tract. Equipment includes the complete respiratory therapy device and its related delivery-system accessories, such as regulator, humidification and heating units, and filters. For members who reside in nursing facilities, MassHealth covers certain oxygen and respiratory equipment. For members who are inpatients at an acute hospital or chronic disease and rehabilitation hospital, MassHealth covers oxygen and respiratory equipment prescribed in anticipation of discharge.	
MassHealth Coverage Types Eligible for Service/Program (See Section II above)	• MassHealth Standard • MassHealth CommonHealth • MassHealth Family Assistance • MassHealth CarePlus	
Who Covers this Service/Program? (See Section III above)	<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>	<u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u>
	The member's Accountable Care Partnership Plan or MCO covers this service	MassHealth covers this service directly
Who Authorizes this Service/Program? (See Section III above)	<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>	<u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u>
	The member's Accountable Care Partnership Plan or MCO authorizes this service	MassHealth's designee authorizes this service

Clinical Eligibility Requirements	**<u>For members enrolled in a Primary Care ACO, the PCC Plan, or in MassHealth fee-for-service</u>** **Level of Care OR Functional Status Requirement** • Oxygen and respiratory therapy must be medically necessary **See 130 CMR 427 for complete clinical eligibility requirements** **Other Criteria** • Prescription and letter of medical necessity required. **Prior Authorization (PA)** • Prior authorization is required for: ○ The purchase and repair of some oxygen/respiratory therapy equipment require prior authorization by MassHealth or its designee The rental of oxygen/respiratory therapy delivery systems, suction apparatus, nebulizers, intermittent positive pressure breathing machines, and equipment that is not covered by one of the service codes payable by MassHealth require prior authorization by MassHealth or its designee. **<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>** For members enrolled in ACO Partnership Plans and MCOs, contact the ACO or MCO for service information and authorization**.**
Members Who Might Benefit from Oxygen or Respiratory Therapy	• Members whose needs are specific to the oxygen or respiratory equipment that addresses those needs. • Some medical needs that may correlate to oxygen and respiratory supplies include: ○ members who require the treatment of severe lung diseases (for example, chronic bronchitis, emphysema, and interstitial lung disease) that cause hypoxemia and where oxygen therapy can reasonably be expected to correct the patient's hypoxemia (Oxygen Therapy Equipment) ○ infants at high risk for sudden death (Apnea Monitor)
Non-Covered Oxygen and Respiratory Services	• For members who reside in nursing facilities, MassHealth does not cover standby or pro re nata (PRN) oxygen. For are inpatients at an intermediate care facility, MassHealth does not cover oxygen or respiratory equipment. • MassHealth does not cover equipment that is primarily and customarily non-medical.

Home Health Agency (except Continuous Skilled Nursing)

130 CMR 403.000

Service/Program Description	Home Health Agency services include nursing visits, home health aide services, physical therapy, speech therapy and occupational therapy services to MassHealth members provided in their home.
MassHealth Coverage Types Eligible for Service/Program (See Section II above)	• MassHealth Standard • MassHealth CommonHealth • MassHealth Family Assistance • MassHealth CarePlus

<table>
<tr><td rowspan="2">Who Covers this Service/Program? (See Section III above)</td><td><u>For members enrolled in an Accountable Care Partnership Plan or MCO</u></td><td><u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u></td></tr>
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<tr><td>The member’s Accountable Care Partnership Plan or MCO authorizes this service</td><td>MassHealth’s designee authorizes this service</td></tr>
<tr><td>Clinical Eligibility Requirements</td><td colspan="2"><u>For members enrolled in a Primary Care ACO, the PCC Plan, or in MassHealth fee-for-service</u> Level of Care OR Functional Status Requirement
• Services must be medically necessary and require the skilled intervention or treatment of a licensed nurse or therapist, as applicable.
See 130 CMR 403.409 and 403.410 for complete clinical eligibility requirements
Other Criteria
• MassHealth members can only receive Home Health Agency services if they are under the care of a physician who certifies that services are medically necessary and establishes an individual plan of care. The plan of care must document that the physician conducted a face-to-face encounter with the member no more than 90 days before or 30 days after the start of Home Health Agency services.
Prior Authorization (PA)
• For most services, prior authorization is required after a certain number of visits within a specified period.
• Prior authorization is required whenever the services provided exceed one or more of the following prior authorization requirements:
o Skilled nursing visits after 30 visits in a 90-day period
o Medication administration visits after 30 visits in a 90-day period
o Home Health aide units after 240 units (15-minute units) in a 90-day period
o Physical therapy after 20 visits in a 12-month* period
o Occupational therapy after 20 visits in a 12-month* period
o Speech therapy after 35 visits in a 12-month* period
o *The 12-month period for PT, OT and ST begins with the first visit.
<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>
For members enrolled in ACO Partnership Plans and MCOs, contact the ACO or MCO for service information and authorization.</td></tr>
<tr><td>Members Who Might Benefit from Home Health Agency</td><td colspan="2">• Members who need skilled services from a licensed nurse or therapist to support their ability to reside in the community.</td></tr>
</table>

Non-Covered HHA Services and Services that are considered duplicative of HHA	Situations in which HHA services are not covered for a member include: • When the member is a resident or at an inpatient status at a hospital, nursing facility, or intermediate care facility for people with intellectual disabilities. • Hours in which the member is in attendance at an ADH program or DH program. The following services are considered duplicative of home health aide services and thus HHA home health aide services are not covered when the member is receiving: • PCA services • AFC services • GAFC services

Hospice Services

130 CMR 437.000

Service/Program Description	Hospice is an all-inclusive benefit that uses an interdisciplinary team to meet all the member's medical needs related to terminal illness. The hospice model of care is based on a coordinated program employing an interdisciplinary team to meet the special needs of terminally ill members, including physical, psychosocial, spiritual, and emotional needs such as nursing; medical social services; physician; counseling; physical, occupational and speech language therapy; homemaker/home health aide services; medical supplies, drugs and durable medical equipment and supplies, short term general inpatient care, short term respite care, and room and board in a nursing facility provided, however, that the 100 day limitation on institutional care services shall not apply to an Enrollee receiving Hospice services.	
MassHealth Coverage Types Eligible for Service/Program (See Section II above)	• MassHealth Standard • MassHealth CommonHealth • MassHealth Family Assistance • MassHealth CarePlus	
Who Covers this Service/Program? (See Section III above)	For members enrolled in an Accountable Care Partnership Plan or MCO	For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service
	The member's Accountable Care Partnership Plan or MCO covers this service	MassHealth covers this service directly
Who Authorizes this Service/ Program? (See Section III above)	For members enrolled in an Accountable Care Partnership Plan or MCO	For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service
	The member's Accountable Care Partnership Plan or MCO authorizes this service	MassHealth's designee authorizes this service

Clinical Eligibility Requirements	**<u>For members enrolled in a Primary Care ACO, the PCC Plan, or in MassHealth fee-for-service</u> Level of Care OR Functional Status Requirement** • Must be certified as terminally ill **See 130 CMR 437.412 for complete clinical eligibility requirements** **Hospice Election** • Members voluntarily elect Hospice Services using a hospice election form and must be certified by a physician as being terminally ill (life expectancy of six months of less). The effective date of the Hospice Services benefit may not be earlier than the date the member or member's representative signed the hospice election form. **<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>** For members enrolled in ACO Partnership Plans and MCOs, contact the ACO or MCO for service information and authorization.
Members Who Might Benefit from Hospice Services	• Medically eligible members with a life expectancy of six months or less who express a desire to elect this service
Other Factors to Consider	When electing Hospice Services, members over the age of 21 waive all MassHealth benefits related to the member's terminal illness, except for • PCA services if used to implement the plan of care to the extent typically completed by a member's family, and • Physician services provided by the member's attending physician. Nursing Facility residents who are clinically eligible for Hospice may choose to receive Hospice Services from a Hospice provider and continue to reside in the nursing facility.

Nursing Facilities for the first 100 days of Admission

130 CMR 456.000

Service/Program Description	Nursing Facilities (NFs) provide short-term and long-term skilled nursing services for eligible MassHealth that require a nursing facility level of care, as defined by130 CMR 456.409.
MassHealth Coverage Types Eligible for Service/Program (See Section II above)	• MassHealth Standard • MassHealth CommonHealth • MassHealth CarePlus

<table>
<tr><td rowspan="2">Who Covers this Service/Program? (See Section III above)</td><td><u>For members enrolled in an Accountable Care Partnership Plan or MCO</u></td><td><u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u></td></tr>
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<tr><td>The member’s Accountable Care Partnership Plan or MCO authorizes this service</td><td>MassHealth or its designee authorizes this service</td></tr>
<tr><td>Clinical Eligibility Requirements</td><td colspan="2"><u>For members enrolled in a Primary Care ACO, the PCC Plan, or in MassHealth fee-for-service</u>

Level of Care OR Functional Status Requirement:

• Members must be clinically eligible to receive NF services, i.e. the member must require at least one skilled service daily, or require a combination of nursing services and services supporting activities of daily living, pursuant to 130 CMR 456.409.

See 130 CMR 456.409 and 410 for complete clinical eligibility requirements

Other Criteria

• Members are eligible for nursing facility care only if MassHealth (or its agent) determines that community care is not available or cannot meet their needs.

Clinical Authorization

• Nursing facility services require prior authorization.

<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>
For members enrolled in ACO Partnership Plans and MCOs, contact the ACO or MCO for service information and authorization.</td></tr>
<tr><td>Other Factors to Consider</td><td colspan="2">Prior to admission and annually thereafter, all individuals, regardless of payer source are required to undergo a Pre-Admission Screening and Resident Review (PASRR) assessment to determine whether they have an intellectual disability, developmental disability, or major mental illness, and to determine whether nursing facility admission is appropriate and whether specialized services are required. This function is performed by the state and pursuant to federal requirements under 42 U.S.C. 1396r(e)(7).</td></tr>
<tr><td>Members Who Might Benefit from Nursing Facilities</td><td colspan="2">• Members who require a nursing facility level of care and choose a facility setting.
• Members who require skilled services performed by or under the supervision of an RN or therapist (e.g., intravenous feeding, observation and evaluation of an unstable medical condition, positioning in bed or a chair as part of the care plan or administration of medication) in a facility setting.</td></tr>
</table>

Therapy Services (Physical Therapy, Occupational Therapy, Speech Therapy)

130 CMR 403.417

<table>
<tr><td>Service/Program Description</td><td colspan="2">Independent therapists, rehabilitation centers, or speech and hearing centers deliver Physical Therapy (PT), Occupational Therapy (OT), and Speech/Language Therapy (ST). Therapy services, including diagnostic evaluation and therapeutic intervention, are designed to improve, develop, correct, rehabilitate, and to maintain function, or to prevent the worsening of functions that have been lost, impaired, or reduced because of acute or chronic medical conditions, congenital anomalies, or injuries.</td></tr>
<tr><td>MassHealth Coverage Types Eligible for Service/Program (See Section II above)</td><td colspan="2">• MassHealth Standard
• MassHealth CommonHealth
• MassHealth Family Assistance
• MassHealth CarePlus</td></tr>
<tr><td rowspan="2">Who Covers this Service/Program? (See Section III above)</td><td><u>For members enrolled in an Accountable Care Partnership Plan or MCO</u></td><td><u>For members enrolled in a Primary Care ACO or the PCC Plan, or members in MassHealth fee-for-service</u></td></tr>
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<tr><td>The member’s Accountable Care Partnership Plan or MCO authorizes this service</td><td>The MassHealth TPA authorizes this service</td></tr>
</table>

Clinical Eligibility Requirements	**<u>For members enrolled in a Primary Care ACO, the PCC Plan, or in MassHealth fee-for-service</u>** **Level of Care OR Functional Status Requirement** • Services must be medically necessary and a therapist must obtain a written referral from a physician or nurse practitioner before beginning services. **See 130 CMR 403.417 for complete clinical eligibility requirements** **Other Criteria** • MassHealth covers only one individual therapy visit and one group therapy session per member per day. **Prior Authorization (PA)** • Prior authorization is required after 20 PT visits; 20 OT visits; or 35 ST visits in a 12-month period. The 12-month period for physical therapy, occupational therapy, and speech therapy begins with the first visit. **<u>For members enrolled in an Accountable Care Partnership Plan or MCO</u>** For members enrolled in ACO Partnership Plans and MCOs, contact the ACO or MCO for service information and authorization.
Members Who Might Benefit from a Therapy Service	• Members with PT, OT, or Speech needs.

VI. Additional Information

Philosophies Giving Context to How Members Use LTSS and Other Covered Services

Each person is different and follows an individual philosophy for how they intend to meaningfully live and manage their care. The preferred approach is to actively seek member input to better understand the member's goals and priorities in order to develop a person-centered and person-directed approach to the member's care and services to ensure the member has access to the full benefits of community living and receives services in a way that helps achieve their goals. The information in the paragraphs below offer brief descriptions of philosophies and social constructs that inform daily life for some individuals with LTSS needs.

Independent Living Philosophy

The federal Administration for Community Living (ACL) draws its definition of independent living philosophy from the text of the Rehabilitation Act of 1973, "a philosophy of consumer control, peer support, self-help, self-determination, equal access, and individual and system advocacy, in order to maximize the leadership, empowerment, independence, and productivity of individuals with disabilities, and the integration and full inclusion of individuals with disabilities into the mainstream of American society." Independent living centers articulate this by explaining that individuals with disabilities are the best experts on their own needs, having crucial and valuable perspective to contribute. Individuals are deserving of equal opportunity to decide how to live, work, and take part in their communities, particularly in reference to services that powerfully affect their day-to-day lives and access to independence. To learn more, visit ACL at https://www.acl.gov/programs/aging-and-disability-networks/centers-independent-living or the National Council on Independent Living at https://www.ncil.org/about/aboutil/

Social Model of Disability

The social model of disability has been developed by people with disabilities in response to the medical model and the impact it has had on their lives. UNICEF, in its guide to the UN Convention on the Rights of Persons with Disabilities, defines the social model of disability as recognizing that disability is a social construct that results from an environment that can be inaccessible for certain individuals. This model also emphasizes that societal change is needed for full inclusion of all individuals, including changes to existing rules, attitudes, and infrastructure.

Recovery Model

The experience of recovery is different for each individual. In 2011, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) developed the following working definition of recovery from mental illness and/or substance use disorders: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

SAMHSA has delineated four major dimensions that support a life in recovery:

- Health—overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being
- Home—having a stable and safe place to live
- Purpose—conducting meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- Community—having relationships and social networks that provide support, friendship, love, and hope
  For more information visit https://www.samhsa.gov/recovery

Substance Use Practice Improvement Resources

The Massachusetts Department of Public Health Bureau of Substance Abuse Services actively promotes best practices in prevention, treatment and recovery systems of care and has articulated a set of principles which inform practice. Each guide contains summaries, with embedded links, of research and resources.
http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html

VII. MassHealth Resources

The following resources may be useful as background, training, and operational support at the following websites:

Payment and Care Delivery Reform Information

MassHealth's ACOs are designed to emphasize care coordination, member-centric care, and to align financial incentives. It has created this page to help providers better understand these payment and care delivery changes.
https://www.mass.gov/payment-care-delivery-innovation-pcdi-for-providers

MassHealth LTSS and Other Covered Services Provider Portal and Prior Authorization

LTSS and Other Covered Service providers will benefit from a Provider Portal dedicated to LTSS and other covered services providers, found at www.masshealthltss.com. The portal provides, in one dedicated, easy-to- access location, information for LTSS and Other Covered Service providers delivering services to eligible members. It will also provide access to 24/7 provider-training webinars, quick reference guides, and helpful links to Mass.gov resources, organized by service type.

Programs Managed by MassHealth OLTSS

Programs managed by MassHealth OLTSS each have a MassHealth Provider Manual, which is available online at
http://www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/provider-manual/

This MassHealth provider manual consists of both generic (all provider) pages and provider-specific pages. A quick reference for the most commonly requested information in the MassHealth provider manuals can be found here at https://www.mass.gov/service-details/how-to-read-your-provider-manual

Provider Rates and billing codes can be found at http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html (community programs) and http://www.mass.gov/eohhs/gov/laws-regs/hhs/hospitals-nursing-homes-and-rest-homes.html (nursing homes).

MassHealth Medical Necessity criteria for services subject to prior authorization can be found at the following page. Please note that Accountable Care Partnership Plans and MCOs have their own medical necessity guidelines.They can be found at https://www.mass.gov/lists/masshealth-guidelines-for-medical-necessity-determination

Additional Resources for Providers

More information is available here:
www.mass.gov/masshealth-for-providers

MassOptions

MassOptions is a service of the Massachusetts Executive Office of Health and Human Services (EOHHS), which includes a partnership with a strong statewide network including agencies in communities throughout Massachusetts that have experience working with elders, individuals with disabilities, caregivers and families such as those associated with the Aging and Disability Resource Consortia (ADRC) and state agencies that provide services to improve access to community Long-term services and supports. MassOptions provides information about and connections to MassHealth and state agency community services and supports for elders, individuals with disabilities, caregivers, and family members.

MassOptions includes a website with helpful information about MassHealth and state agency services, and a hotline with trained specialists who are available to give personalized attention and information, as well as a connection to the appropriate community resource or organization.

The MassOptions website is available at https://www.massoptions.org and has an online chat feature. Trained specialists can be contacted by calling the toll free number at 1-844-422-6277 or by chat online at the MassOptions website 7 days a week from 8am to 8pm.

Locating Other LTSS Sources

Some members may have goals or needs that exceed the options available under MassHealth, or they may have goals or needs that are better met through LTSS provided by another source. MassOptions is a resource for members and providers to locate the appropriate state agency or community based organization that can provide access to services and supports for members, including assistance with social determinants of health.

Trained specialists can be reached by phone or through the online chat feature described above to discuss other potential sources of support. An extensive resource guide with state agency, local, and specialized organization contacts are available organized by the following support types:

Career, Training and Employment

Care Management

Caregiver Supports

Community Life

Coordinated Care Programs

Day Services

Emergency Services

Employment Opportunity Resources

Equipment and Supplies

Financial Assistance

Food Pantries and Nutrition Programs

Health and Therapeutic Services

Housing Services

In-Home Supports

Legal Resources

Mental Health

Municipal and Specialized Organizations

Personal Care Services

Protective Services

Substance Abuse Services

Transition Assistance

Transportation