Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter NF-60
September 2013

TO: Nursing Facility Providers Participating in MassHealth

FROM: Kristin L. Thorn, Acting Medicaid Director

RE: *Nursing Facility Manual* (Integrated Care Organizations)

The Executive Office of Health and Human Services (EOHHS) and Centers for Medicare & Medicaid Services (CMS) have contracted with One Care plans (also known as integrated care organizations or ICOs) using a blended global financial arrangement to provide integrated, comprehensive medical, behavioral-health care, and long-term services and supports for those who are eligible for both Medicare and Medicaid ("dually eligible members") and who meet the specific criteria set forth below.

The purpose of the Duals Demonstration is to improve quality of care and reduce health disparities, improve health and functional outcomes, and contain costs for dually eligible members who participate in the Duals Demonstration by enrolling in a One Care plan. One Care plans are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

In order to be eligible to enroll in a One Care plan, a MassHealth member must meet all of the following criteria:

- be aged 21 through 64 at the time of enrollment;
- be eligible for MassHealth Standard as defined in 130 CMR 450.105(A) or MassHealth CommonHealth as defined in 130 CMR 450.105(E);
- be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001; and
- live in a designated service area of a One Care plan.

In addition, Duals Demonstration enrollees eligible for MassHealth Standard may elect to remain in the Duals Demonstration after age 65.

One Care plans will employ or contract with a network of providers that will deliver team-based integrated medical and behavioral-health care and long-term services and supports and will coordinate care across providers. The Interdisciplinary Care Team, led by a care coordinator and, if appropriate, an independent living and long-term services and supports coordinator, will arrange for the availability of care and services by specialists, hospitals, and providers of long-term services and supports and other community supports. The One Care plan will be the direct payer for all covered services.

Enrollment in a One Care plan for eligible members will start on or after October 1, 2013.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

These regulations are effective October 1, 2013.

NEW MATERIAL
(The pages listed here contain new or revised language.)

Nursing Facility Manual

Pages 4-3 through 4-6

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

Nursing Facility Manual

Pages 4-3 and 4-4 — transmitted by Transmittal Letter NF-35
Pages 4-5 and 4-6 — transmitted by Transmittal Letter NF-49

456.404: Requirements for Provider Participation: In State

To be eligible to participate in MassHealth, a nursing facility located in Massachusetts must

(A) be licensed by the Massachusetts Department of Public Health to operate such a facility;

(B) be certified by the Massachusetts Department of Public Health as meeting the federal requirements for participation in MassHealth under Title XIX of the Social Security Act; and

(C) participate in the Medicare program under Title XVIII of the Social Security Act to the extent required under 130 CMR 456.406.

456.405: Requirements for Provider Participation: Out of State

To be eligible to participate in MassHealth, an out-of-state nursing facility must

(A) be licensed by the appropriate state licensing authority to operate such a facility;

(B) be certified by the state survey agency in accordance with 42 U.S.C. 1396a(a)(33)(b);

(C) participate in the Medicare program under Title XVIII of the Social Security Act to the extent required under 130 CMR 456.406; and

(D) participate in the Medicaid program of its own state.

456.406: Medicare Certification Requirement

Nursing facilities must be certified for participation in the Medicare program pursuant to Title XVIII of the Social Security Act, as amended from time to time, and regulations promulgated thereunder. If a facility or institution has only one unit licensed to provide skilled-nursing care, then that unit must be Medicare certified. A facility with more than one unit licensed to provide skilled-nursing care may have one non-Medicare-certified unit. For a facility that was a MassHealth provider as of October 1, 1990, failure to comply with this requirement may result in an imposition of an administrative fine by the MassHealth agency, or may result in the facility's suspension from participation in MassHealth. For any facility applying to be a MassHealth provider after October 1, 1990, including facilities built after October 1, 1990, and facilities participating in MassHealth on October 1, 1990, that subsequently changed owners, failure to comply with this requirement will preclude such facility from participating in MassHealth.

456.407: Clinical Authorization of Nursing-Facility Services

(A) Clinical authorizations for nursing-facility services may be for a specified or indefinite length of stay. Authorizations for an indefinite length of stay may be subject to review by the MassHealth agency or its agent to ensure that conditions for payment continue to be met. New clinical authorizations are required when

(1) a member is transferred from one nursing facility to another nursing facility;
(2) a member who is hospitalized is to be admitted to a different nursing facility from the one the member resided in before the hospital admission;
(3) a member who has been hospitalized for over six months seeks to be readmitted to the nursing facility where the member resided before hospital admission; and
(4) a member has discharge potential as provided for in 130 CMR 456.411.

(B) The MassHealth agency notifies nursing facilities, hospitals, physicians, and home-health agencies of the identity of the agent responsible for authorizing nursing-facility services in accordance with 130 CMR 456.000.

(C) The referring medical provider must submit the request for authorization of nursing-facility services to the MassHealth agency or its agent on behalf of the member. For persons who become eligible for MassHealth while residing in a nursing facility, the facility itself must submit the request for authorization. The request for authorization of nursing-facility services must be submitted on the forms required by the MassHealth agency and must include documentation that available alternatives to institutionalization were considered and were deemed inadequate to meet the member's needs.

(D) If the MassHealth agency determines that a member is eligible for nursing-facility services, the MassHealth agency will issue a notice that contains the effective date of coverage and the patient-paid amount. This notice is confirmation to the facility that the MassHealth agency has authorized payment of nursing-facility services for the member.

456.408: Conditions for Payment

(A) The MassHealth agency pays for nursing-facility services if all of the following conditions are met.
(1) The MassHealth agency or its agent has determined that individuals aged 22 and older meet the nursing-facility services requirements of 130 CMR 456.409 or that the medical review team coordinated by the Department of Public Health has determined that individuals aged 21 or younger meet the criteria of 130 CMR 519.006(A)(4).
(2) The MassHealth agency or its agent has determined that community care is either not available or not appropriate to meet the individual’s needs.
(3) The requirements for preadmission screening at 130 CMR 456.410 have been met.

(B) The MassHealth agency pays for nursing-facility services beginning with the date of financial eligibility provided that the member shows that he or she was medically eligible for these services as of the date of financial eligibility. If the member was not medically eligible for nursing-facility services as of the first date of financial eligibility, the MassHealth agency will pay for these services beginning on the first date the member is medically eligible, provided that this date is after the first date of financial eligibility. A person may request a determination of medical eligibility at or after application for MassHealth.

(C) 130 CMR 456.408(A) and (B) do not apply to MassHealth members enrolled with a senior care organization (SCO). Enrollment in a SCO is voluntary and subject to change. Providers are responsible for verifying member status on a daily basis. For more information, see 130 CMR 450.117(D).

(D) 130 CMR 456.408(A) and (B) do not apply to MassHealth members enrolled with an integrated care organization (ICO). Continued enrollment in an ICO is voluntary and subject to change. Providers are responsible for verifying member status on a daily basis. For more information, see 130 CMR 450.117(J).

456.409: Services Requirement for Medical Eligibility

To be considered medically eligible for nursing-facility services, the member or applicant must require one skilled service listed in 130 CMR 456.409(A) daily or the member must have a medical or mental condition requiring a combination of at least three services from 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C).

(A) Skilled Services. Skilled services must be performed by or under the supervision of a registered nurse or therapist. Skilled services consist of the following:

(1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding;
(2) nasogastric-tube, gastrostomy, or jejunostomy feeding;
(3) nasopharyngeal aspiration and tracheostomy care, however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services;
(4) treatment and/or application of dressings when the physician has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions);
(5) administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema);
(6) skilled-nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the 24 hours; for example, for arteriosclerotic heart disease with congestive heart failure);
(7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety;
(8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter (a urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled-nursing care).However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled-nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection);
(9) gait evaluation and training administered or supervised by a registered physical therapist at least five days a week for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame. The member must require these services in an institutional setting;

(10) certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical-therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record);
(11) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications; and
(12) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame.

(B) Assistance with Activities of Daily Living. Assistance with activities of daily living includes the following services:
(1) bathing when the member requires either direct care or attendance or constant supervision during the entire activity;
(2) dressing when the member requires either direct care or attendance or constant supervision during the entire activity;
(3) toileting, bladder or bowel, when the member is incontinent of bladder or bowel function day and night, or requires scheduled assistance or routine catheter or colostomy care;
(4) transfers when the member must be assisted or lifted to another position;
(5) mobility/ambulation when the member must be physically steadied, assisted, or guided in ambulation, or be unable to propel a wheelchair alone or appropriately and requires the assistance of another person; and
(6) eating when the member requires constant intervention, individual supervision, or direct physical assistance.

(C) Nursing Services. Nursing services, including any of the following procedures performed at least three times a week, may be counted in the determination of medical eligibility:
(1) any physician-ordered skilled service specified in 130 CMR 456.409(A);
(2) positioning while in bed or a chair as part of the written care plan;
(3) measurement of intake or output based on medical necessity;
(4) administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions;
(5) staff intervention required for selected types of behavior that are generally considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers; or requiring a consistent staff one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental-health professional;
(6) physician-ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals);