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

MassHealth
Transmittal Letter PHY-167
July 2023

TO: Group Practices Participating in MassHealth

FROM: Mike Levine, Assistant Secretary for MassHealth

RE: *Physician Manual* (Revised Regulations at 130 CMR 433.000)

This letter transmits revisions to the Physician regulations at 130 CMR 433.000 to add CARES Program Services. It also adds Appendix M to the Physician Manual, which details the CARES Program Performance Specifications.

CARES Program Services: These regulations have been amended (see 130 CMR 433.485) to allow group practices to provide a new service known as "Coordinating Aligned, Relationship-centered, Enhanced Support (CARES) for Kids," a targeted case management service for the highest risk children and youth with medical complexities. CARES services will facilitate intensive support in care planning and coordination of services for eligible MassHealth members younger than 21 years of age.

These regulations are effective July 7, 2023.

MassHealth Website

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Questions

If you have questions about the information in this transmittal letter, please contact the MassHealth Customer Service Center at (800) 841-2900 or email provider@masshealthquestions.com.

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

Physician Manual

Pages iv, iv-a, vi, 4-43 through 4-52, and M-1 through M-12

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(The pages listed here are no longer in effect.)

Physician Manual

Pages iv, iv-a, vi, 4-43, and 4-44 — transmitted by Transmittal Letter PHY-154

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433.473: Clinical Nurse Specialist (CNS) Services.

(A) General. 130 CMR 433.473 applies specifically to clinical nurse specialists. In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to a physician also apply to a clinical nurse specialist (CNS), such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

(B) Conditions of Payment. The MassHealth agency pays a CNS or group practice for CNS services when

(1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);

(2) the CNS or group practice is not an employee or contractor of the hospital or other facility in which the CNS services were performed, or is not otherwise paid by the hospital or facility for their services;

(3) the CNS participates in MassHealth pursuant to the requirements of 130 CMR 433.473(C); and

(4) for an out of state CNS the requirements of 130 CMR 433.403(C) are met.

(C) Clinical Nurse Specialist Provider Eligibility. A CNS may enroll as a MassHealth provider. Any CNS applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency that he or she

(1) is licensed to practice as a CNS by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the CNS services are provided; and

(2) is a member of a group practice or is in a solo private practice.

(D) Consultation Between a Clinical Nurse Specialist and Physician. The MassHealth agency does not pay for a consultation between a CNS and a physician as a separate service.

(130 CMR 433.474 through 433.484 Reserved)

Part 4. *Additional Services*

433.485: CARES Program Services

(A) Introduction. The MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support for Kids program (CARES program) is a targeted case management service rendered CARES program providers certified in accordance with 130 CMR 433.485(D) to members younger than 21 years of age who satisfy the eligibility criteria in 130 CMR 433.485(C). The MassHealth agency pays for CARES program services provided by CARES program providers subject to restrictions and limitations in 130 CMR 433.485(A) through 433.485(H) and Appendix M.

(B) Definitions. The following terms used in 130 CMR 433.485(A) through 433.485(H) have the meanings given in 130 CMR 433.485(B) unless the context clearly requires a different meaning.

Comprehensive Assessment – a systematic, timely, and clearly documented screening process that provides the foundation for care coordination and the individual care plan. The assessment includes information and data from multiple sources and reflects key information about the member and their parent/guardian's needs and priorities.

Individual Care Plan (ICP) – a plan that specifies the goals and actions to address the medical, educational, social, behavioral, or other services needed by the member and their parent/guardian.

Local Education Agency – a public authority legally constituted by the state as an administrative agency to provide control of and direction for kindergarten through grade 12 public educational institutions.

Medical Complexity – a combination of multiorgan system involvement from chronic health condition(s) that often result in functional limitations, ongoing use of medical technology, and high resource need and use.

Natural Supports – include family, friends, neighbors, and self-help groups intentionally identified to support the member. This support system is an active component of the ICP to support the member and their parent/guardian.

Subspecialist – a provider who specializes in a narrow field of professional knowledge/skills within a medical specialty, such as pediatric congenital heart disease within the broad specialty of cardiology.

(C) Clinical Eligibility Criteria. To receive CARES program services, a member must:
(1) be younger than 21 years of age;
(2) not reside in a nursing facility or other inpatient facility for longer than six consecutive months at the time of seeking CARES program services; and
(3) satisfy:
(a) all of the eligibility criteria in 130 CMR 433.485(C)(3)(b)(1); and

(b) all of the eligibility criteria in either 130 CMR 433.485(C)(3)(b)(2) or 130 CMR 433.485(C)(3)(b)(3), as follows:

1. The member is a child or youth with special health needs who requires ongoing medical management by at least two pediatric subspecialists. At least one of the specialists must treat a medical condition that results in all of the following:

a. functional impairment (*e.g.*, need for assistance with activities of daily living) that substantially interferes with or limits the member's role/functioning in family, school, and community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the member in achieving or maintaining developmentally appropriate, social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.

b. at least one condition must be:

i. progressive, associated with persistent deteriorating health; or

ii. a chronic medical condition, expected to last at least a year and expected to: 1.) be episodically or continuously debilitating and 2.) require ongoing treatment for control of the condition that will use health care resources above the level of a healthy child; or

iii. a progressive or metastatic malignancy.

2. At the time the member begins receiving CARES program services, the member is at high risk for adverse health outcomes due to both of the following:

a. Demonstrated inability to coordinate multiple medical, social, and other services impacting medical condition, as evidenced by:

i. two or more unplanned emergency department visits within the past 180 days; or

ii. a documented pattern of multiple missed primary care physician (PCP) or subspecialty appointments; or

iii. chronic school absenteeism directly related to the member's medical conditions.

b. Demonstrated health-related social needs impacting the management of the member's medical condition. Social complexity/health-related social needs are defined by at least one of the following:

i. experiencing homelessness or housing insecurity;

ii. experiencing food insecurity;

iii. parent/caregiver experiencing employment instability;

iv. lacking access to basic resources such as heat, electricity, internet, transportation, education, and social connections; or

v. living in unsafe or violent conditions.

3. The member requires more than two continuous hours of skilled nursing services to remain safely at home.

(D) <u>Provider Requirements</u>.

(1) Payment for services described in 130 CMR 433.485(A) through 433.485(H) will be made only to group practices participating in MassHealth on the date of service that are

also certified by the MassHealth agency for the provision of CARES program services at or associated with that service location on the date of service.

(2) A group practice seeking to provide CARES program services must meet the requirements listed in 130 CMR 433.485(A) through 433.485(H). A separate application for certification as a CARES program provider must be submitted for each group practice that seeks to render such services. The application must be made on the form provided by the MassHealth agency and must be submitted to the MassHealth agency's physician program. The MassHealth agency may request additional information from the applicant to evaluate the applicant's compliance with 130 CMR 433.485(A) through 433.485(H). Through this certification, the applicant must, among other things:

(a) agree to enter into a written agreement with the MassHealth agency in which the applicant agrees to satisfy all of the requirements in 130 CMR 433.485(A) through 433.485(H);

(b) agree to establish, maintain, and comply with written policies and procedures to satisfy all the requirements in 130 CMR 433.485(A) through 433.485(H);

(c) agree to assess and annually reassess each member in its care in accordance with 130 CMR 433.485(E)(3)(a) and 130 CMR 433.485(F)(1)(a) to ensure that each such member satisfies, and continues to satisfy, the clinical eligibility criteria for receipt of CARES program services;

(d) agree to periodic inspections, by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 433.485(A) through 433.485(H);

(e) submit a written description of:

1. CARES program services offered by the applicant and its care objectives, and
2. how the applicant will fulfill the staffing requirements in 130 CMR 433.485(E);

(f) agree to participate in any CARES program provider orientation required by EOHHS;

(g) attest that it:

1. actively provides covered services to MassHealth members younger than 21 years of age with medical complexities; and
2. has the capacity to provide on-call care coordination to members assigned to the applicant 24 hours a day, 365 days per year;

(h) agree to provide any documentation, data, and reports as required by EOHHS;

(i) agree to subscribe to and participate in the statewide ENS (Event Notification Service) Framework described in 101 CMR 20.11: *Statewide Event Notification Service Framework*, including having the capacity to receive and send admission, discharge, and transfer messages, as that term is defined in 101 CMR 20.04: *Admission, Discharge, and Transfer Messages (ADTs)*;

(j) agree to establish and implement policies and procedures to increase the technological capabilities to share information among providers involved in members' care, including increasing Health Information Exchange (HIE) connections and enhancing digital systems interoperability;

(k) agree to use CMS required CEHRT (Certified Electronic Health Record Technology) criteria (2015 edition or subsequent editions) and updates to said criteria, to document and communicate clinical care information;

(l) agree to comply with the Office of the National Coordinator for Health Information Technology (ONC) guidance on USCDI (United States Core Data for Interoperability) for standardized health data exchange, or such other guidance and standards for health data exchange as specified by EOHHS;

(m) agree to submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the CARES program provider supported by documentation to demonstrate that the provider has adequate resources to finance the provision of services in accordance with 130 CMR 433.485(A) through 433.485(H); and

(n) agree to participate in any quality management and program integrity processes as required by the MassHealth agency.

(3) The MassHealth agency requires documentation from providers seeking to become CARES program providers. All required application documentation will be specified by the MassHealth agency and must be submitted and approved prior to participating as a CARES program provider in MassHealth.

(4) Based on the information provided in the certification application, the MassHealth agency will determine whether the applicant is certifiable as a CARES program provider. If the MassHealth agency determines that the applicant is not certifiable, the notice will contain a statement of the reasons for that determination and recommendations for corrective action so that the applicant may reapply for certification once corrective action has been taken.

(5) The certification is valid only for the group practice described in the application and is not transferable to any other provider. Any additional location established by the applicant at a satellite facility must obtain separate certification from the MassHealth agency in order to receive payment.

(E) CARES Team.

(1) The CARES program provider must establish a CARES team to meet the care coordination needs of members, including on call after-hours availability to assist as needed and to triage medical crises and emergencies. The CARES team must include a program director, senior care manager, care coordinator, and family support staff which may include a community health worker or peer, each of whom must satisfy the staff composition requirements specified in Appendix M. The CARES team must satisfy any other staff composition requirements specified in Appendix M. CARES team members may serve multiple roles for which they are qualified as long as the staffing responsibilities and programmatic requirements are met. In addition, care managers and supervisors serving on the CARES team must complete trainings as outlined in Appendix M. CARES program providers must establish policies and procedures relating to such trainings to ensure the completion of such trainings. CARES program providers must document compliance with training requirements for care managers and supervisors within three months of starting in that role.

(2) The CARES team is responsible for ensuring that needed medical, social, educational, and other CARES program services are accessed, coordinated, and delivered in a strength-based, individualized, member-driven, culturally informed, linguistically appropriate, and accessible manner. 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, 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.

(3) The CARES team must:

(a) conduct a comprehensive assessment of each member seeking CARES program services from the provider in order to determine that the member is clinically eligible to receive such services. The CARES team will conduct this comprehensive assessment in accordance with 130 CMR 433.485(F) and Appendix M.

(b) make referrals for and coordinate services on- and off-site. These services include, but are not limited to, making referrals for and coordinating the following services:

1. medical and behavioral health care.
2. home and community long-term services and supports, such as Durable Medical Equipment (DME) and Continuous Skilled Nursing (CSN) services. For members enrolled in the Community Case Management (CCM) program, the CARES team will serve as the lead care coordination entity and will work directly with the CCM case manager to coordinate DME, CSN, and other home health services.
3. health-related social needs, goods, and services, including, but not limited to, housing stabilization and support services, utility assistance, and nutritional assistance.
4. educational services and entitlements.
5. any state agency services for which the member may be eligible.

(c) 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.

(d) establish and maintain relationships with the member's health plan and any state or local agencies with which the member is involved, including, but not limited to, the Department of Children and Families (DCF), the Department of Developmental Services (DDS), the Department of Mental Health (DMH), the Department of Public Health (DPH), the Department of Transitional Assistance (DTA), the Department of Youth Services (DYS), and any Local Education Agency (LEA).

(e) support care coordination and facilitate collaboration through the establishment of regular case review meetings as specified in Appendix M.

(f) provide all CARES program services.

(F) Scope of Services. The CARES program provider must ensure that CARES program services are provided only by individuals serving on the CARES team who are qualified to render such services. Detailed service components are outlined in Appendix M.

(1) CARES program services must include at a minimum:

(a) a comprehensive assessment of the member at least once a year. These assessment activities include, but are not limited to:

1. taking the member's history, which must capture the full spectrum of medical, social, educational, and emotional needs;
2. identifying the member's needs and completing related documentation; and
3. gathering information from other sources such as the parent/guardian, medical providers, state agencies, social services providers, and educators, to complete the assessment or reassessment of the member.

(b) development of an ICP, which must be driven by the member and their parent/guardian, authorized health care decision maker, and other relevant providers, and it must be shared and included in transition of care communication with relevant providers, state agencies, and members of the care management team. The ICP must be in a form and format specified by the MassHealth agency and include:

1. goals and actions to address the medical, social, educational, and other services needed by the member;
2. a course of action to respond to the assessed needs of the member; and
3. an emergency plan;

(c) care coordination and family support activities such as, but not limited to:

1. 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 care manager must provide regular contact with the member and their parent/guardian (either face-to-face or by telehealth, in accordance with the preferences of the member and their parent/guardian);
2. providing a phone number and on-call capacity 24 hours a day, 365 days per year to respond to and triage any medical and care coordination related questions;
3. helping the parent/guardian/caregiver advocate for and access resources and services to meet the family's needs;
4. 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, in order to facilitate coordination;
5. coordinating with early intervention providers and school and early childhood education providers;
6. coordinating access to DME, home care needs, scheduling appointments, referrals to providers for needed medical services, and assistance with prior authorization;
7. coordinating goods and services related to health-related social needs;
8. providing ongoing support in maintaining MassHealth eligibility, accessing any eligible benefits through state agencies, and coordinating with primary insurance for members who have third-party coverage;
9. providing intensive support for transitions of care between different health and community settings and the member's home; and
10. performing any other activities as detailed in Appendix M.

(d) appropriate services to address identified needs and achieve goals specified in the ICP;

(e) intensive support for member transitions into adult care, beginning once the member reaches 16 years of age; and

(f) all monitoring and follow-up activities necessary to ensure that the ICP is implemented and adequately addresses the member's needs.

(2) A CARES program provider is responsible for providing any and all of the CARES program services described above to each member receiving CARES program services from that provider when medically necessary.

(G) Assignment and Removal of Assignment Procedures.

(1) To promote effective provision of targeted case management services and prevent duplication, a member seeking CARES program services may receive such services from only one CARES program provider at a time. To facilitate this requirement, a CARES program provider must, prior to rendering CARES program services to a member, check the Eligibility Verification System to determine whether the member has been assigned to another CARES program provider, in accordance with the process in Appendix M.

(a) If the member is assigned to another CARES program provider, the provider from whom the member seeks CARES program services must decline to provide such services to the member and refer the member to the CARES program to which they are assigned.

(b) If the member is not assigned to another CARES program provider, and if the member agrees to receive CARES program from the CARES program provider, the CARES program provider must assign the member to the CARES program provider in accordance with the process in Appendix M, including determining clinical eligibility and other education and information-sharing activities with the eligible member and parent/guardian.

(2) Removal of assignment. If a member no longer needs or is no longer eligible for CARES program services provided by the CARES program provider, the CARES program must follow the removal of assignment procedures as specified in Appendix M, including convening a meeting with the member and their family to develop an aftercare/transition plan.

(H) Payment.

(1) The MassHealth agency pays a CARES program provider for CARES program services only if the member receiving CARES program services is eligible to receive such services under 130 CMR 433.485(C).

(2) The MassHealth agency pays a CARES program provider for services in accordance with the applicable payment methodology and rate schedule established by EOHHS. Rates of payment for CARES program services include only those services described in 130 CMR 433.485(F), and do not cover or include any direct medical care.

(3) The MassHealth agency makes a single monthly payment for all CARES program services rendered by a CARES program provider to a member during that calendar month. In order to qualify for payment of the monthly fee, the CARES program provider must provide at least two of the CARES program services described above to that member during that calendar month, with at least one of those services including live interaction between the provider and the member and their parent/guardian, whether in person or via telehealth. A CARES program provider may not bill MassHealth the monthly fee for any calendar month in which the provider renders only one of the services described above to the member.

(4) Payment for the CARES program is subject to the conditions, exclusions, and limitations in 130 CMR 433.000 and 450.000: *Administrative and Billing Regulations*.

(5) The MassHealth agency does not pay for CARES program services rendered to a member by a CARES program provider during any period of time in which the member is assigned to another CARES program provider.

(6) If the member assigned to a CARES program provider is admitted to a nursing facility or other inpatient facility during the period of assignment, the MassHealth agency pays for

CARES program services rendered by that CARES program provider to that member for up to six consecutive months from the date of admission, subject to compliance with all applicable requirements in 130 CMR 433.485(A) through 433.485(H) and Appendix M. MassHealth will not pay for CARES program services rendered to any member who has resided in a nursing facility or other inpatient facility for more than six consecutive months.

REGULATORY AUTHORITY

130 CMR 433.000: M.G.L. c. 118E, §§7 and 12.

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MassHealth CARES Program Performance Specifications

The MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support (CARES) Kids program is a targeted case management (TCM) service that facilitates intensive support in care planning and coordination of services for MassHealth members younger than 21 years of age. The MassHealth CARES program provides 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, and ethnically and culturally competent, linguistically appropriate, and accessible manner. 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482 govern CARES program 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 program 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 program providers participating in MassHealth on the date of service. Provider types eligible for delivering CARES program services must be enrolled by MassHealth for the provision of TCM services at that location. CARES program 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 comply with Referral and Care Coordination sections of 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482. In doing so, the CARES team must establish referral relationships with members' pediatric specialty providers, primary care providers, behavioral health providers, MassHealth managed care entity, and any other entity, 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.

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 program provider must meet the requirements in the Staff Qualification and Responsibilities 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 the following staff composition requirements:

1. must have adequate staffing of qualified care managers and coordinators as defined in the Staff Qualifications and Responsibilities section to fully meet the care coordination needs of all members assigned to the provider's CARES program;
2. 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 care coordinator and care manager. 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;
3. must have at least one licensed registered nurse and one licensed social worker;
4. must ensure the availability of professional backup staff if coverage is required due to illness, vacation, or other reasons. All staff 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; and
5. 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 the following:
      1) development and implementation of the CARES program provider policies and procedures in 130 CMR 433.485, 130 CMR 405.477, and 130 CMR 410.482;

2) direction and supervision of all aspects of the CARES program, including any necessary IT integration;
3) oversight of all human resources and clinical functions of all CARES team staff;
4) oversight of fiscal administration of the CARES program including billing, budget preparation, and required program statistical and financial reports; and
5) required programmatic reporting as directed by the Executive Office of Health and Human Services (EOHHS).

2. Senior Care Manager

a. Qualifications

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

1) licensed in the state of Massachusetts as a registered nurse, a nurse practitioner, or a social worker, or has a master's degree in another relevant field with two years of experience working with the target population; and
2) 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:

1) ensuring the completion and periodic updating of the Comprehensive Assessment and Individual Care Plan as specified in the CARES Scope of Services section;
2) providing oversight of all care coordination, family support, and transition activities as specified in the CARES Scope of Services section;
3) providing oversight of all monitoring and follow-up activities as specified in the CARES Scope of Services section;
4) 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);
5) providing weekly individual supervision to care coordinators and ensuring regular supervision of other team members; and
6) providing ongoing training to care coordinators on medical aspects of the target population.

3. Care Coordinator

a. Qualifications

The CARES program provider must employ care coordinators that have the following qualifications:

1) a bachelor's degree from an accredited institution with one year of relevant experience with the target population; or
2) an associate's degree from an accredited institution with two years of relevant experience with the target population; or
3) a high school diploma or equivalent and a minimum of three years of relevant experience with the target population.

b. Responsibilities

Care coordinators are responsible for the following:

1) facilitating the development and periodic updating of the Comprehensive Assessment and Individual Care Plan as specified in the CARES Scope of Services section of this appendix;
2) providing care coordination, family support, and transition activities as specified in the CARES Scope of Services section;
3) providing monitoring and follow-up activities as specified in the CARES Scope of Services section;
4) 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);
5) 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
6) 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 program provider must employ family support staff who are strength-based and culturally and linguistically responsive paraprofessionals 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:

1) experience as a caregiver of a youth with special needs, preferably a youth with physical health needs; or
2) be a certified community health worker; or
3) have a bachelor's degree in a human services field from an accredited university and one year of relevant experience working with the target population; or
4) have 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; or
5) have 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 are responsible for the following:

1) providing family support to enable the member's parent/guardian to navigate the health care system with or on behalf of the member;
2) educating the member's parent/guardian about how to effectively navigate the 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;
3) helping with implementation of care plans; and
4) participating in all care planning meetings and processes for the member.

V. Provider and Staff Training

In addition to staff qualifications, the CARES team staff and supervisors are required to complete trainings outlined in this section. CARES program providers must have policies and procedures describing required trainings and how monitoring will occur to ensure completion of these requirements. CARES program providers must document compliance with training requirements for care managers and supervisors before the delivery of services by December 31, 2023, or within three months of employment, whichever comes later. CARES program providers may require additional trainings as they see necessary to deliver quality care management services.

A. The CARES program provider must provide initial and annual training to staff members who are responsible for the care of a member. Records of completed training must be kept on file and must be updated regularly by the CARES program provider. The initial training must be completed for new staff by December 31, 2023, or within three months of employment, whichever comes later, and must include, but is not limited to, the following topics:
    1. care coordination principles for children and families, including needs of populations with multiple co-occurring conditions;
    2. racial, cultural, and linguistic equity, including implicit bias; and
    3. privacy and confidentiality, including Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) compliance training.

B. In addition to those topics, care coordinator and family support staff members must complete training by December 31, 2023, or within three months of employment, whichever comes later, in the following topics:
    1. community-based resources, social service system, 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.

    Though formal training in the following topics is not required, CARES program provider should ensure all staff can demonstrate competencies in the following:

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

C. CARES program providers must provide access to and information regarding training opportunities that include:
   1. marketing CARES program care services;
   2. outreach and engagement strategies for members who are disengaged from care or have difficulty adhering to treatment recommendations, including individuals with histories of homelessness, criminal justice involvement, and transition-aged youth; and
   3. training on any state-required assessment tools.

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, and 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 comprehensive assessment at least once a year to determine the member and their parent/guardian's needs for any medical, educational, social, or other services to develop an Individual Care Plan (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 each member, and be accessible to the member and their parent/guardian.

   a. Comprehensive Assessment

   These assessment activities include, but are not limited to:

   1) taking the member's history, which must capture the full spectrum of medical, social, educational, and emotional needs;
   2) identifying the member's needs and completing related documentation; and
   3) 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.

   b. Periodic Reassessment

   1) 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 and

their parent/guardian's needs, conditions, and/or preferences have changed.

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

3) 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.

4) 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)

The ICP must:

1) be driven by the member and their parent/guardian, authorized health care decision-maker, and other relevant providers;

2) 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;

3) identify a course of action to respond to the assessed needs of the member and their parent/guardian, with concrete interventions and strategies and identified responsible persons;

4) be shared and included in transition of care communication with relevant providers, state agencies, and members of the care management team;

5) be developed in a form and format specified by MassHealth and shared with the member's PCP or PCP designee. The ICP must include:

   a) name and contact information for care manager(s), additional care team members as applicable, such as the member's PCP or PCP designee, specialists, school or early childhood supports, Community Case Management (CCM) and Continuous Skilled Nursing (CSN) supports, any community supports, and any state agency supports;

   b) health summary, which must include medical history and behavioral history as well as, but not limited to personal, educational, behavioral and social circumstances. The health summary must also include:

      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 Individualized Educational Plans (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); and

iv. health-related social needs (HRSN) supports, including but not limited supports and services related to housing, nutrition (e.g., SNAP/WIC), utility assistance, and transportation needs.

c) recommended action steps for each goal with associated responsible care team member and any related accessibility requirements;

d) upcoming medical and social service transitions, as well as strategies to support continuity of care during times of transition; and

e) 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), allergies, a list of 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:
   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 care manager 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);
   b. providing a dedicated phone number and on-call 24 hours a day, 365 days per year to respond and triage any medical questions, including but not limited to assisting with durable medical equipment (DME) needs or failures, helping access any other medical services as needed, and triaging medical crises and emergencies;
   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, Community Case Management (CCM) and Continuous Skilled Nursing (CSN) supports, and other state agencies (DCF, DDS, DESE, DMH, DPH, DTA, and DYS), in order to facilitate coordination;

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 Individualized Education Plans (IEPs) and 504 plans, providing family support with Individuals with Disabilities Education Act (IDEA) entitlements, and liaising with school nurses and other related staff to ensure continuity and quality of services between school and medical providers;
f. coordinating access to durable medical equipment (DME), home care needs, scheduling appointments, referrals to providers for needed medical services, and assistance with prior authorization;
g. coordinating goods and services related to health-related social needs (HRSN), 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 eligible benefits through state agencies, and coordinating with primary insurance for members who have third-party coverage; and
i. 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, 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 and privacy and 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. If both primary and subspecialty care are involved, discuss 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 and 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 the following conditions are met:

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 if 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 program provider must participate in any quality management and program integrity processes as required by MassHealth and EOHHS including, but not limited to, conducting member experience surveys and evaluations, making any requested data available, and providing access to visit the CARES program 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 program 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, 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 program 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 program 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 program provider must provide MassHealth or its designee any requested documentation for purposes of a member's medical necessity review for CARES program 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 member assignment 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 the CARES program as established in the Clinical Eligibility section;
- educate the member and their parent/guardian regarding the CARES program and care management services face-to-face, in person, or via telehealth;
- provide information about the member's rights and responsibilities when receiving CARES program 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 HIPAA requirements for sharing personal health information to 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 within 60 days upon referral or identification of the member;
- provide the member and their parent/guardian both a paper and electronic copy of the member's completed individual care plan 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; and
- provide the member and their parent/guardian a letter, via both certified mail and electronic transmission, if available, notifying enrollment in the MassHealth CARES program within 30 days of the enrollment effective date. The letter must include, at minimum, the enrollment effective date, the name of the CARES program provider, an overview of CARES services, the designated care manager's name and contact information, and a reminder that enrollment in the CARES program does not affect the member's benefits or enrollment in MassHealth or health plan.

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 program services. This may occur if one or more of the following circumstances exists:
   1. the member no longer meets the eligibility criteria for the CARES program;
   2. the chronic conditions that made the member eligible for the CARES program 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 program provider;

4. the member has service and support needs that can be met by parent/guardian and services without the intensive level of the CARES program;
5. the member/guardian/legally authorized representative and family are no longer interested in the CARES program;
6. the member is no longer eligible for MassHealth;
7. the member has moved out of Massachusetts; or
8. members who are 18 years of age or older, pregnant, parents, or married, and who are otherwise capable of consenting, may exercise independent choice to be unassigned

B. Before the removal of assignment from the CARES program, 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. date and reason for the removal of assignment and signed consent form from member, member's family. or legal guardian;
   2. 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. 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 program provider must provide the member and their parent/guardian a letter, via both certified mail and, if available, electronic transmission, notifying the termination of their enrollment in the MassHealth CARES program within 30 days of the termination date. The letter must include at minimum: effective termination date, the reason for the termination, the name of the CARES Program provider and contact information for any questions, and reminder that the termination of their enrollment in the CARES program does not affect the member's benefits or enrollment in MassHealth or health plan.