

Appendix M of the Physician Manual
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 protect 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) 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) providing family support to enable the member’s parent/guardian to navigate the health care system with or on behalf of the member;
- 3) 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;
- 4) helping with implementation of care plans; and
- 5) 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 and within three months of employment. 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 within three months of hire 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 within three months of hire 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 shall 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.

- 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.