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4. Program Regulations

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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)

~~REGULATORY AUTHORITY~~

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

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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) Provider Requirements.

- (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 that 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

(nk) 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 care 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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