

Integrating MassHealth Long-Term Services and Supports: Considerations for ACOs and MCOs

OCTOBER 2017



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ACKNOWLEDGEMENTS

The authors would like to thank the following people for their input and insight towards the development of this report: senior staff from the Executive Office of Health and Human Services, senior staff from potential accountable care organizations and long-term services providers, senior staff from disability advocacy organizations, senior staff from home care organizations, and others.

Design: Madolyn Allison

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I. INTRODUCTION AND CONTEXT

MassHealth, Massachusetts' Medicaid program, is the largest payer of long-term services and supports (LTSS) in the Commonwealth and administers a number of LTSS programs, some in conjunction with other state agencies.¹ Only 14 percent of MassHealth enrollees, or about 251,000 people, utilize LTSS, yet they account for over 30 percent of all MassHealth spending, or about \$4.5 billion annually.² Individuals who utilize LTSS span the population—nearly half are elderly, and a third are non-elderly adults and children with disabilities. They have diverse and complex care needs and often face serious issues finding safe, affordable housing and transportation to medical appointments and overcoming other social barriers to care.³

Massachusetts and the nation as a whole are beginning to grapple with how to improve access to quality care for individuals who require LTSS while simultaneously containing costs. States are increasingly covering LTSS through managed care arrangements,⁴ and the new Medicaid managed care regulations released by the Centers for Medicare and Medicaid Services (CMS) acknowledge this shift by adding for the first time specific protections for beneficiaries in managed LTSS programs.⁵ In addition, states continue to shift care away from institutional settings and into home- and community-based settings, which individuals and their families vastly prefer. In fact, home- and community-based services (HCBS) now account for 70 percent of all MassHealth LTSS expenditures.⁶

In November 2016, CMS approved a Section 1115 waiver extension request for MassHealth to implement program-wide delivery system and payment reforms over the next five years. One of the waiver's five goals is to "improve integration of physical health, behavioral health, LTSS, and health-related social needs."⁷ To accomplish this goal, the waiver creates a Medicaid Accountable Care Organization (ACO)-based delivery system that offers three different ACO models—Accountable Care Partnership Plan, Primary Care ACO, and Managed Care Organization (MCO)—Administered ACO—with varying degrees of financial risk and reliance on the existing MCO infrastructure, which the state will retain.⁸

1 Other agencies include the Department of Developmental Services, Department of Veterans Services, Executive Office of Elder Affairs, Massachusetts Commission for the Blind, Massachusetts Commission for the Deaf and Hard of Hearing, Massachusetts Rehabilitation Commission, Department of Mental Health, and Department of Public Health/Bureau of Substance Abuse Services.

2 Massachusetts Medicaid Policy Institute. *Long-Term Services & Supports: Opportunities for MassHealth*. December 2015. Available online at www.bluecrossfoundation.org/sites/default/files/download/publication/Manatt_MMPI_ChartPack_FINAL_v05.pdf.

3 Ibid.

4 In 2015, 22 states operated managed LTSS programs, up from six states in 2009, and 11 additional states were planning to implement a program. National Association of States United for Aging and Disabilities. *State of the States in Aging and Disability: 2015 Survey of State Agencies*.

5 Centers for Medicare & Medicaid Services. *Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) Implementation Dates*. April 2016. Available online at www.medicare.gov/medicaid/managed-care/downloads/implementation-dates.pdf.

6 Mission Analytics Group and New Editions Consulting. *Innovations in the Balancing Incentive Program: Massachusetts*. February 2017. Available online at www.medicare.gov/medicaid/ltss/balancing/incentive/index.html.

7 MassHealth. *The MassHealth 1115 Waiver Summary*. November 2016. Available online at www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/ma-1115-waiver-summary.pdf.

8 The Massachusetts Medicaid Policy Institute. *The MassHealth Waiver 2016–2022: Delivering Reform*. January 2017. Available online at www.bluecrossmafoundation.org/publication/masshealth-waiver-2016%E2%80%932022-delivering-reform.

Roughly 68,000 adults under age 65 and children who use LTSS in Massachusetts will be eligible to enroll in ACOs and MCOs.^{9,10} Those who choose to enroll in these delivery systems will access a comprehensive array of physical health and behavioral health services and a limited number of LTSS currently covered by the MCOs, such as short-term nursing facility services, home health services, durable medical equipment, and therapies. All other LTSS will be provided on a fee-for-service (FFS) basis outside the ACOs and MCOs until Year 3 or 4 of the waiver. All ACOs and MCOs, however, are required to work with competitively procured LTSS community partners (CPs) throughout the five-year waiver to identify people with the highest LTSS needs and actively manage their care.¹¹

By Year 3 or 4 of the waiver, all ACOs and MCOs also are anticipated to assume financial responsibility for the full array of LTSS authorized by the Medicaid state plan. For the first few years, a new LTSS third-party administrator (TPA) will support the ACOs by performing LTSS utilization management, data analytics, quality reporting, and other functions in conjunction with MassHealth.¹² The TPA will continue these functions for Primary Care ACOs even after they assume financial responsibility for LTSS, as the Primary Care ACO networks are based on the Primary Care Clinician (PCC) plans' FFS provider network. However, the Partnership Plan and MCO-Administered ACOs will assume the TPA's functions when they assume financial responsibility for LTSS.¹³

This brief prioritizes issues for consideration as ACOs and MCOs plan to integrate and fully manage comprehensive LTSS. These result from lessons learned from managed LTSS programs in other states and interviews with key stakeholders in Massachusetts. Descriptions of the current MassHealth LTSS programs and providers are provided in the appendix to help readers understand the scope and type of services that will eventually be included in ACO total cost of care (TCOC) responsibilities and MCO capitation rates. Figure 1 illustrates the state plan LTSS that will be integrated into ACOs and MCOs over the course of the waiver, as well as the MassHealth coverage types eligible for these services.

9 Note that this figure underestimates the total ACO-eligible population of LTSS users, because home- and community-based services (HCBS) waiver populations are excluded from these figures but will be ACO eligible; their HCBS waiver benefits will not be within ACO cost accountability. Massachusetts Executive Office of Health and Human Services. *LTSS TPA RFR—Attachment B Data Book*. May 2016. Available online at www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-16-1039-EHS01-EHS01-00000008526.

10 Dual-eligible members, or those eligible for both MassHealth and Medicare, are excluded from ACOs and MCOs and are primarily covered through fee-for-service (FFS) Medicaid. They may elect to enroll in managed care through Senior Care Options (SCO), Programs of All-inclusive Care for the Elderly (PACE), and One Care, which MassHealth intends to expand.

11 Note that ACOs and MCOs are also required to work with competitively procured Behavioral Health (BH) CPs to provide comprehensive care management for certain high-need members.

12 Massachusetts Executive Office of Health and Human Services. *Long-Term Services and Supports Third-Party Administrator: Frequently Asked Questions*. May 2017. Available online at www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/masshealth-innovations/third-party-administrator-for-ltss.html.

13 The Massachusetts Medicaid Policy Institute. *The MassHealth Waiver 2016–2022: Delivering Reform*. January 2017. Available online at www.bluecrossmafoundation.org/publication/masshealth-waiver-2016%E2%80%932022-delivering-reform.

FIGURE 1. MASSHEALTH STATE PLAN LTSS—SERVICE DESCRIPTION OVERVIEW

SERVICE	CURRENTLY IN MCO CONTRACTS AND WILL BE IN AGO PARTNERSHIP CONTRACT DAY 1	SERVICE TO BE ADDED IN YEAR 3 OR 4	MASSHEALTH ELIGIBILITY			
			STANDARD	CARE PLUS	COMMONHEALTH	FAMILY ASSISTANCE
Adult day health		•	•		•	
Adult foster care/ group adult foster care		•	•		•	
Chronic disease and rehabilitation inpatient hospital services	1st 100 days	Post 100 days	•	•	•	•
Chronic disease and rehabilitation outpatient hospital services	•		•	•	•	•
Day habilitation		•	•		•	
Durable medical equipment/medical supplies	•		•	•	•	•
Home health	•		•	•	•	•
Independent nurse services/continuous skilled nursing		•	•		•	
Nursing facility	1st 100 days	Post 100 days	•	•	•	
Orthotics and prosthetics	•		•	•	•	•
Oxygen/respiratory therapy equipment	•		•	•	•	•
Personal care attendant (including the Transitional Living Program)		•	•		•	
Therapies (physical, occupational, and speech)	•		•	•	•	•

These services, described further in the appendix, focus on programs that include personal care services that address people's daily living needs, involve some level of care coordination or care management, and come from a diverse group of often small providers. Such services include nonmedical services for complex populations and may be very different from the medical services ACOs and MCOs are accustomed to providing. Service descriptions are limited to institutional and community LTSS covered under the Medicaid state plan that will be integrated into ACOs and MCOs and do not include LTSS covered under the state's 1915(c) waivers or paid for by other state or federal sources.¹⁴ In addition, the appendix does not include non-emergency medical transportation, hospice, or early intervention, which are sometimes viewed as LTSS.

For each service, the appendix includes:

- A description of the service
- Eligibility requirements, which members utilize the service, and how they access it
- Organizations that provide the service
- Payment method and rates
- Funding trends
- Relevant regulations and statutes

¹⁴ Some members with Medicaid-only coverage currently enrolled in MassHealth Home- and Community-Based Services (HCBS) waiver programs will be eligible to enroll in ACOs, but ACOs will not be responsible for providing or paying for these services, which include homemaker, respite, assistive technology, home modification, and other services and supports. In addition, some MassHealth members may currently benefit from LTSS provided and paid for by other state agencies supported by state or federal funding that is not Medicaid, such as the state home care program or the federal Rehabilitation Services Administration.

II. CONSIDERATIONS FOR ACOS AND MCOS

As mentioned above, MassHealth will not hold ACOs and MCOs financially accountable for most LTSS during the first few years of the waiver extension. However, MassHealth does expect these entities to identify and coordinate enrollees' comprehensive care needs—including LTSS—as part of the needs assessment, care plan development, and interdisciplinary care team processes they will conduct for certain members beginning in Year 1 of the waiver.¹⁵ ACOs and MCOs must contract with LTSS CPs to support these care management activities for 20,000 to 25,000 high-need LTSS enrollees.^{16,17} ACOs and MCOs will rely on LTSS CPs to share their deep LTSS subject matter expertise; to act as liaisons between LTSS and other providers; to provide information and referrals, patient navigation, and LTSS options counseling services to enrollees and their families; and to participate in the development of the LTSS portion of the person-centered care plan, care transitions, and care coordination.¹⁸ While LTSS CPs will participate in the care planning process, ultimate responsibility for conducting the assessment and determining the LTSS care plan will fall to the ACO or MCO. Some stakeholders expressed concern that the LTSS CP—given its expertise regarding LTSS—was not tasked with performing the LTSS assessment, while other stakeholders felt that the entity ultimately financially responsible for the total cost of care (TCOC) should be given responsibility for the assessment and care planning as currently planned.

LTSS CPs, which the state selected in the summer of 2017, include Aging Services Access Points (ASAPs), Independent Living Centers (ILCs), other community-based organizations with LTSS expertise, and partnerships among these entities.¹⁹

There is some debate among stakeholders about whether the delay in fully carving in LTSS unnecessarily preserves silos in the care delivery system. Some see the phased carve-in as a “missed opportunity” to immediately address enrollees' quality of care and care experience, as well as achieve cost efficiencies. For example, stakeholders note that personal care attendants (PCAs) closely observe individuals in their homes and communities and from this vantage point can identify risks for falls and help address individuals' social support needs, obviating the need for more costly services such as emergency department or inpatient hospital use. Additionally, delaying carving in most LTSS deters ACOs and MCOs from considering investing in LTSS that could help keep people in the community. On the other hand, some stakeholders believe the phased-in approach gives ACOs and MCOs time to prepare for the LTSS carve-in and gain experience assessing and managing the care of those with LTSS needs. The LTSS CPs will be particularly vital to coordinating access to comprehensive services from the outset of the program—because MassHealth has decided to delay the

15 Massachusetts Executive Office of Health and Human Services. *MassHealth Delivery System Restructuring Open Meeting*. October 2016. Available online at www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/1610-open-public-meetings.pdf. Note that only those members identified by MassHealth as having high BH or complex LTSS needs and/or other special health care needs will receive these services.

16 Massachusetts Executive Office of Health and Human Services. *Delivery System Reform Implementation Council Presentation: Meeting #2*. June 22, 2017.

17 Members with co-occurring behavioral health (BH) and LTSS needs will be offered BH CPs who will also support care coordination for LTSS needs since members may only be assigned to a single CP. In addition to the 20,000 to 25,000 high-need LTSS enrollees supported by LTSS CPs, MassHealth will fund BH CP supports for up to 35,000 high-need BH enrollees, including some individuals who also have high-need for LTSS.

18 Massachusetts Executive Office of Health and Human Services. *Long-Term Services and Supports Community Partners*. December 2016. Available online at www.commbuys.com/bsa/external/bidDetail.sdo?bidId=BD-17-1039-EHS01-EHS01-11586&parentUrl=activeBids.

19 Listing of the eight entities that have been selected as LTSS CPs is available online at www.mass.gov/eohhs/gov/newsroom/press-releases/eohhs/masshealth-selects-26-community-partners.html.

carve-in of PCAs and other community-based LTSS—and will continue to play a critical role in providing active and appropriate care management throughout the program. ACOs and MCOs should view the CPs as ongoing active partners in care management for people with LTSS needs.

As ACOs and MCOs prepare to assume financial accountability for LTSS by Year 3 or 4 of the program, they must develop and continue to build internal capabilities and expertise to serve individuals with LTSS needs, which likely will require adjustments to their care delivery models, operational protocols, and financial/rate development models. These organizations may need to adapt enrollment protocols, clinical care (e.g., utilization management, prior authorization) and continuity of care policies, network adequacy standards, provider credentialing and contracting processes, information technology systems, and grievance and appeals rules.²⁰ In addition, organizations will need to ensure they are in compliance with the new federal Medicaid Managed Care rules' LTSS-specific requirements.²¹ Before LTSS are fully carved in, MassHealth will conduct a “comprehensive state readiness review” to demonstrate that the ACO or MCO has built these capabilities and can assume responsibility for these services without negatively impacting its members.²² This likely will align with the readiness review process for the One Care program, a health insurance program for individuals ages 21–64 who are eligible for both MassHealth and Medicare.²³

Among all of the changes ACOs and MCOs will need to make to successfully integrate LTSS populations and services, stakeholders identified the following priorities for ACOs and MCOs as they begin working with CPs and prepare to take on full responsibility for LTSS.

1. CULTURAL COMPETENCY

Stakeholders identified the historical divide between medical and nonmedical models of care for those with LTSS needs as the single biggest barrier to successfully integrating care. Long-standing administrative, purchasing, provider, and delivery system silos have effectively created two parallel yet separate systems of care for people who have LTSS and non-LTSS care needs. Managed care entities and their contracted medical providers need to first understand the disability rights movement and culture, and then be able to deliver culturally competent care that respects the diversity in clinical and functional care needs, language, communication styles, beliefs, and behaviors of LTSS populations. Doing so will help break down barriers between silos, build trust and facilitate communication and information-sharing among the medical and nonmedical provider communities, and enable ACOs and MCOs to effectively coordinate comprehensive services for these members.

Culturally Competent Care

Culturally competent care is defined as care that respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviors.

Source: Agency for Healthcare Research and Quality (AHRQ). *CAHPS Cultural Competence Item Set*. Available online at www.ahrq.gov/cahps/surveys-guidance/item-sets/cultural/index.html.

20 Massachusetts Executive Office of Health and Human Services. *Section 1115 Demonstration Project Amendment and Extension Request*. July 2016. Available online at www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/20160716-masshealth-1115-demonstration-extension-request.pdf.

21 For more information see www.manatt.com/Insights/Newsletters/Medicaid-Update/A-New-Focus-on-Managed-Long-Term-Services-and-Supp.

22 Massachusetts Executive Office of Health and Human Services. *Section 1115 Demonstration Project Amendment and Extension Request* — Section 4.3.1.3.

23 Centers for Medicare and Medicaid Services. *Medicare-Medicaid Plans Readiness Review Letter*. November 2012. Available online at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Mass_RR_memo.pdf.

In 2008, Massachusetts articulated its vision for providing care for those with LTSS needs as working to “empower and support people with disabilities and elders to live with dignity and independence in the community by expanding, strengthening, and integrating systems of community-based long-term supports that are person-centered, high in quality, and provide optimal choice.”²⁴ The state’s action plan to implement this vision is known as the *Community First Olmstead Plan* and clearly outlines six strategies to “maximize the extent to which elders and people with disabilities are able to live successfully in their homes and communities.”²⁵

According to some stakeholders, this vision and overall goal of delivering person-centered and culturally competent care is not always fully understood or appreciated by the medical community or managed care entities that employ medical models of care, potentially resulting in suboptimal care. The medical community often seeks to treat the individual first using clinical interventions that may not be aligned with the individual’s preferences and goals and may not be particularly cost effective. For example, despite state law requiring the state to offer pre-admissions counseling on home and community based service options prior to admission in a long-term care facility stakeholders report such counseling may not always be provided. Pre-admissions counseling could help divert people from nursing facilities.²⁶ It is imperative that ACOs and MCOs understand and embrace care philosophies for individuals with disabilities, such as independent living and consumer-directed personal care services; train staff and providers appropriately; and communicate with members using culturally appropriate methods and materials. Person-centered care principles must be incorporated into the member assessment and care plan development processes, and interdisciplinary care teams must include both medical professionals and nonmedical individuals selected by the member (e.g., family members, PCAs, LTSS CP representatives) in order to make conflict-free decisions that are directed by and in the best interest of the member’s ultimate care goals.

Members with LTSS often have broad care needs that extend beyond typical medical interventions and include the need to access social supports. ACOs and MCOs will have to work with CPs and the community to incorporate nonmedical interventions into members’ care management, which will provide higher quality care and may even produce cost savings.

2. CARE MANAGEMENT AND UTILIZATION MANAGEMENT

A second key consideration for ACOs and MCOs is how these entities will develop and implement person-centered care management processes, particularly during care transitions, for individuals with LTSS. To avoid confusion, duplication of services, and substandard care for the member, ACOs and MCOs need to clearly define care management roles and responsibilities in their member and provider materials and at the beginning of the care management

Informed Choice for LTSS Care Planning

The LTSS Community Partner (CP) Model Contract specifies that members must be provided with care options as part of their LTSS care planning process.

Section 2(c) states that a member’s CP Care Coordinator must inform the Assigned or Engaged Enrollee about his or her options for specific LTSS services and programs and providers that may meet the member’s identified LTSS needs when developing or updating the LTSS Care Plan. In performing this function, the CP Care Coordinator must document that the member was informed of multiple service options available to meet his or her needs, as appropriate, and that at least two providers per service option, where applicable, were recommended.

Source: Massachusetts Executive Office of Health and Human Services. *LTSS Community Partner (CP) RFR—Attachment A: LTSS CP Model Contract, Section 2(c)*. December 2016. Available online at www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-11586&external=true&parentUrl=bid.

²⁴ Massachusetts Executive Office of Health and Human Services. *The Community First Olmstead Plan: A Summary*. 2008. Available online at www.mass.gov/eohhs/docs/eohhs/olmstead/olmstead-plan-summary.pdf.

²⁵ *Ibid.*

²⁶ See M.G.L. Chapter 118E, section 9.

process for each party involved, including the ACO/MCO, CPs, providers, family members, and the member themselves. Organizations will need to be flexible to accommodate individual needs and preferences, but establishing a baseline care management model will create a necessary foundation and clarity for all involved in the process. Stakeholders noted that ensuring the right people and parties are involved in care planning from the beginning is critical, and this can only be achieved if there is clear understanding and expectations of specific roles and responsibilities.

Establishing clear roles and responsibilities includes acknowledging the important role of nonmedical providers in the care management process, particularly during care transitions. For example, PCAs can act as key members of the care team by ensuring continuity of care when a member is admitted to and discharged from the hospital, providing valuable insight into the member's preferences, and recognizing when nonmedical issues arise (e.g., loss of safe and affordable housing, fall hazards) that threaten a return to the hospital. Similarly, family caregivers can provide valuable insight into the member's desires and needs due to their ongoing relationships. ACOs and MCOs need to establish clear roles for these care team members, as doing so may actually keep members from requiring care in institutional settings unnecessarily.

While all of these providers' and caregivers' input is valuable, the care provided should ultimately meet the member's goals and preferences to the extent possible. Options counseling can provide information about all of the services and resources available to members and ensure the member and/or the family understands the available options, makes an informed care choice, and determines the next steps themselves.²⁷ LTSS CPs will be required to inform members of available options for specific LTSS services and programs as part of their care planning process²⁸ and can be valuable partners in care management, but ACOs and MCOs will need to ensure they have person-centered care models, staff and provider trainings, information technology (IT) for health information exchange, and protocols in place that effectively engage LTSS CPs in the care management process.

Similarly, ACOs and MCOs will need to consider how to adjust and structure their clinical policies for individuals requiring LTSS, including utilization management and prior authorization. ACOs and MCOs will rightly be focused on ensuring that members access only medically necessary, non-duplicative, and appropriate services, but stakeholders urged that the organizations recognize the benefit in investing in LTSS that could reap long-term clinical, functional, and financial results and not only prioritize near-term cost control measures. LTSS can be provided over weeks, months, or even years, and ACOs and MCOs need to consider which services can help keep members in the community and out of costlier settings—even if doing so involves higher up-front costs.

3. TECHNOLOGY

Stakeholders agreed that providing successful care management to individuals with LTSS needs often involves robust information sharing, including electronic medical records (EMRs) and quality reporting. ACOs and MCOs will need to navigate the complicated and expensive world of health information technology and health information exchange to establish clear and secure lines of communication with providers and CPs. ACOs and MCOs will need to assess gaps in communication and technology, which are commonplace among small LTSS

²⁷ Massachusetts Executive Office of Health and Human Services. *Options Counseling Program*. Available online at www.mass.gov/elders/service-orgs-advocates/options-counseling/options-counseling-program.html.

²⁸ Massachusetts Executive Office of Health and Human Services. *LTSS Community Partner (CP) RFR—Attachment A: LTSS CP Model Contract, Section 2(c)*. December 2016. Available online at www.commbuys.com/bsso/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-11586&external=true&parentUrl=bid.

providers, who may still use paper records and fax communications, and decide what they will require and support. Some questions ACOs and MCOs will need to answer are:

- How might Delivery System Reform Incentive Program (DSRIP) funds for infrastructure and capacity building be most effectively leveraged?
- Should ACOs and MCOs encourage CPs to build their own capacity or access EMRs through the ACO or MCO?
- How might IT platforms be standardized to promote efficiencies in communication across entities?
- Should ACOs and MCOs have set minimum data capabilities to ensure seamless communication and data sharing among providers?
- How will ACOs and MCOs handle the enormous variability in technological capabilities across LTSS providers and LTSS CPs?
- How might the lessons learned and data and technological supports developed by the TPA be transitioned to the ACOs and MCOs in Year 3 or 4 of the waiver when Partnership ACOs and MCOs take on full responsibility for LTSS.

4. WORKFORCE

The LTSS workforce largely consists of direct care workers, such as home health aides, PCAs, and nursing assistants, and unpaid family caregivers. Both the direct care workforce and informal caregivers are overworked and undersupported. In addition, community based organizations also report challenges recruiting and retaining case managers and other staff who will be critical to supporting integration and coordination of services. As ACOs and MCOs prepare to care for those with LTSS needs, they must acknowledge and consider how to tap into and support the existing LTSS workforce, which is widely viewed as inadequate to meet the growing demand for these services. ACOs and MCOs may need to work with their contracted LTSS providers to help address low wages and promote clear career paths for direct caregivers and to better support family caregivers both financially and emotionally.

III. CONCLUSION

MassHealth has clearly signaled that integration and coordination of LTSS with other health care services is integral to furthering its health care delivery system's reform, and the new waiver is a sign that both the state and the federal government are prepared to make significant financial and infrastructure investments to achieve greater integration. ACOs and MCOs will be given three to four years to prepare to fully manage this new population and should take this lead time to ensure they are ready to fully care for their members. Doing so will not only provide better and more appropriate care for members, but also help ACOs and MCOs—and ultimately the state—contain costs.

APPENDIX: MASSHEALTH STATE PLAN LTSS—SERVICE DESCRIPTIONS

Below are detailed descriptions of the MassHealth state plan LTSS listed in alphabetical order. Some of these services are already covered by MCO contracts and will be included in ACO-Partnership contracts from Day 1, and others will be integrated into the ACOs and MCOs by Year 3 or 4 of the waiver extension period.

Services in current MCO contracts and will be in ACO-Partnership contract from Day 1

- Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital Services
- Durable Medical Equipment/Medical Supplies
- Home Health
- Nursing Facilities (1st 100 days)
- Orthotics and Prosthetics
- Oxygen/Respiratory Therapy Equipment
- Therapies—Physical, Occupational, and Speech (Outside of the Home Health Setting)

Services to be added in Year 3 or 4 of the waiver extension

- Adult Day Health
- Adult Foster Care/Group Adult Foster Care
- Day Habilitation
- Independent Nurse Services/Private Duty Nursing
- Nursing Facilities (post 100 days)
- Personal Care Attendant Program (including the Transitional Living Program)

Data on spending, members utilizing the services, and providers are from the LTSS TPA request for responses.²⁹ The information includes FFS members only and does not include information from Senior Care Options (SCO), Program of All-inclusive Care for the Elderly (PACE), One Care, MCO, and 1915(c) waivers.

Glossary of Terms

Activities of daily living (ADL): Everyday functions and activities individuals usually do without help. ADL functions include bathing, continence, dressing, eating, toileting, and transferring.²⁸

Instrumental activities of daily living (IADL): Activities that are instrumental to the care of the member's health and are performed by a PCA, such as meal preparation and clean-up, housekeeping, laundry, shopping, maintenance of medical equipment, transportation to medical providers, and completion of paperwork required for the member to receive personal care services.²⁹

Medical necessity: A service is “medically necessary” if:

- (1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and
- (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007.³⁰

29 Massachusetts Executive Office of Health and Human Services. *Long-Term Services and Supports Third-Party Administrator*. May 2016. Available online at www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-16-1039-EHS01-EHS01-00000008526.

30 For more information see www.mass.gov/ocabr/docs/doi/consumer/lc-care-report/appendix-g-2008.pdf.

31 For more information see www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-personalcare.pdf.

32 For more information see www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-allprovider.pdf.

ADULT DAY HEALTH*

Description of the service

Adult day health (ADH) is a program of services provided at a community-based program setting open at least eight hours a day typically on Monday through Friday. Transportation to and from the program is arranged and paid for by the program.

The general goal of the services is to provide an organized program of nursing services and supervision, maintenance therapy services, and socialization. Examples of services provided include:

- Nursing services such as medication administration, education in hygiene, monitoring of health status, and reporting changes in condition to the member's physician
- Therapy services such as occupational, physical, and speech/language services
- Assistance with ADLs
- Nutritional and dietary services
- Individual and group counseling by a social worker
- Therapeutic activities
- Case management if no other agency is acting as coordinator of services for that member

There are currently two levels of care that sites may provide:

1. Basic—for those members who require at least one skilled service daily and/or daily assistance with at least one ADL.
2. Complex—for members who require at least one skilled service daily or at least three services from the skilled nursing facility (SNF) regulations.

ADH center sites serve as the central location for providing services to enrollees of PACE. PACE is a fully integrated model of health care for persons age 55 and older.

Eligibility for the service, how members access it, and who uses it

Only MassHealth Standard or CommonHealth members who are at least 18 years of age and require assistance with at least one ADL are eligible for ADH services.

ADH services must be ordered by a physician, and the member must have a medical or mental dysfunction that:

- Involves one or more physiological systems and requires nursing care
- Requires services in a structured ADH setting that has a personal physician
- Requires a health assessment, oversight, monitoring, or services provided by a nurse

Organizations that provide the service and workforce

The Department of Public Health certifies the capacity of the site or the number of clients a provider may serve on average on a daily basis.

There were 160 ADH providers during 2015, up from 142 in 2012.

Payment method and rate

ADH center programs are paid a daily rate of \$58.83 for the basic level of care and \$74.50 for the complex level of care (101 CMR 310.00).

In addition, providers are reimbursed for transportation at a weighted-average one-way rate established by the ADH provider and approved by MassHealth.

Funding trends

Nearly \$105 million was spent on ADH for over 8,600 members in 2015, up from \$94 million for over 8,400 members in 2012.

Relevant sources

- Adult Day Health Manual:
www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-adultdayhealth.pdf
- 101 CMR 310.00:
www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-310-adult-day-health.pdf
- Adult Day Health Licensure:
www.mass.gov/courts/docs/lawlib/104-105cmr/105cmr158.pdf
- 105 CMR 158.026:
www.mass.gov/courts/docs/lawlib/104-105cmr/105cmr158.pdf

* On August 25, 2017, MassHealth proposed changes to the adult day health regulations. As of the date of publication, final regulations have not yet been promulgated.

ADULT FOSTER CARE/GROUP ADULT FOSTER CARE

Description of the service	<p>Adult foster care (AFC) is a program of services, including 24-hour supervision, assistance with ADLs and IADLs and other personal care as needed, nursing services and oversight, and care management, that are provided in a member's home or in an AFC caregiver's private residence.</p> <p>An AFC caregiver cannot be a family member, such as a spouse, parent or adoptive parent of a minor child, or any legally responsible relative of the member, and the caregiver's residence must meet certain accessibility, health and safety, and occupancy standards to be considered a qualified setting for AFC payment purposes.</p> <p>Group adult foster care (GAFC) services are AFC-like services provided in an assisted living residence (ALR) or a supported housing complex for seniors and/or people with disabilities.</p>
Eligibility for the service, how members access it, and who uses it	<p>Only MassHealth Standard or CommonHealth members are eligible for services. Members must be at least 16 years of age to be eligible for AFC services.</p> <p>To be clinically eligible for AFC services, the member must have a medical or mental condition that requires either daily physical assistance or cueing and supervision with at least one ADL (Level I AFC), or requires physical assistance with three ADLs or physical assistance with two ADLs and management of behaviors (e.g., wandering, verbal or physical abuse, or resisting care) that require caregiver intervention (Level II AFC).</p> <p>To be clinically eligible for GAFC services, the member must require hands-on assistance or supervision and cueing through the entire ADL task with at least one ADL.</p> <p>A clinical assessment and approval from MassHealth or its designee is required.</p> <p>An eligible MassHealth member must have a written order for AFC services from a physician and a clinical assessment from an AFC provider's multidisciplinary professional team (e.g., registered nurse and AFC care manager) that AFC services are medically necessary before MassHealth will pay for the services. The AFC provider must obtain prior authorization before the first date of service delivery and annually thereafter, upon significant change.</p>
Organizations that provide the service and workforce	<p>AFC services are provided by an AFC caregiver, a registered nurse, and an AFC care manager, who are all under contract to an AFC provider.</p> <p>AFC providers, such as elder services agencies, ARCs, and other organizations, train and pay the AFC caregiver a monthly stipend. (Note: caregivers are not employees of the AFC provider.) The registered nurse and AFC care manager form a multidisciplinary professional team, which supervises and provides oversight of the AFC caregiver.</p> <p>In 2015, MassHealth contracted with 90 AFC providers, up from 57 in 2012, and 197 GAFC providers.*</p>
Payment method and rate	<p>Payment for AFC services includes a one-time pre-admission intake and assessment rate of \$242.38, plus a per diem or daily rate of \$47.74 for Level I AFC services and \$82.06 for Level II AFC services. MassHealth payment for AFC services does not cover room and board. With some exceptions, MassHealth only pays for AFC services on days that the member receives services.</p> <p>Payment for GAFC services is at a per diem rate of \$40.33 per member.</p>
Funding trends	<p>MassHealth spent \$220 million on AFC services for over 10,000 members in 2015, up from \$132 million for 7,000 members in 2012.</p> <p>MassHealth spent \$84 million on GAFC services for nearly 8,000 members in 2015, down from \$89 million for over 9,000 members in 2012.</p>
Relevant sources	<ul style="list-style-type: none">• Adult Foster Care Manual: www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-adultfostercare.pdf• Group Adult Foster Care Manual: www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/provider-manual/group-adult-foster-care-manual.html• 101 CMR 351.00: www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-351.pdf

* MassHealth has had a moratorium on enrollment for Adult Foster Care providers since April 1, 2017.

CHRONIC DISEASE AND REHABILITATION INPATIENT AND OUTPATIENT HOSPITAL SERVICES

Description of the service

Chronic disease and rehabilitation (CDR) hospitals provide a wide array of inpatient and outpatient services. Conditions eligible for rehabilitation include, but are not limited to, stroke, amputee, head injury, spinal cord injury, pulmonary or physical medicine, and rehabilitation.

Chronic services include, but are not limited to, oncology, complex medical management, HIV and AIDS care, complex wound management, post medical-surgical problems, and congestive heart failure.

MassHealth explicitly outlines a number of services that cannot be reimbursed (see 130 CMR 410.405), including, but not limited to:

- Nonmedical services
- Cosmetic surgery
- Infertility treatment
- Certain mental health services such as vocational rehab or recreational services
- Certain pharmacy services such as obesity drugs, cough and cold preparations, and drugs related to infertility
- Certain vision care services such as extended-wear contact lenses or invisible bifocals

Eligibility for the service, how members access it, and who uses it

MassHealth Standard, CarePlus, CommonHealth, and Family Assistance members are eligible for CDR inpatient and outpatient hospital services.

The screening program for CDR inpatient and outpatient services applies to all in-state and out-of-state chronic disease and rehabilitation hospitals except those participating in a managed care program for all inpatients (see 130 CMR 435.402). The screening program described in 130 CMR 435.408 is intended to ensure that medical and nursing services are medically necessary. The MassHealth agency pays for chronic disease and rehabilitation hospital services only when the MassHealth agency or its agent determines, pursuant to a screening, that such services are medically necessary and authorizes such services prior to admission or conversion.

Outpatient prior authorization is required for:

- Non-emergency services provided to a member by an out-of-state hospital outpatient department (50+ miles from state border)
- More than 20 occupational therapy visits or 20 physical therapy visits within a 12-month period, including group therapy visits
- More than 35 speech/language therapy visits in a 12-month period, including group therapy visits

Organizations that provide the service and workforce

A chronic disease or rehabilitation hospital must be licensed and participate in both Medicaid and Medicare.

- Prior authorization is required for out-of-state chronic disease or rehabilitation hospitalization. Out-of-state hospitals must:
 - Be located in CT, ME, NH, NY, RI, or VT and be within 50 miles of the state border, and provide services to a member who lives near the border
 - Provide services to a member who is authorized to live out of state
 - Provide services that are not available from comparable resources in Massachusetts

Acute and non-acute hospital outpatient departments in Massachusetts must be licensed, possess a signed provider agreement for participation in MassHealth, and participate in Medicare.

MassHealth contracted with 18 outpatient hospitals in 2015 and has done so every year since 2012.

MassHealth contracted with 15 inpatient chronic disease and rehabilitation hospitals in 2015.

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CHRONIC DISEASE AND REHABILITATION INPATIENT AND OUTPATIENT HOSPITAL SERVICES *(continued)*

Payment method and rate

In-state hospitals for services are paid according to rates established in the signed provider agreement with MassHealth. Out-of-state hospitals are generally paid the lowest of:

- The rate of payment established under the other state's Medicaid program
- The MassHealth rate of payment for the service or comparable service in Massachusetts
- The MassHealth rate of payment for a comparable provider in Massachusetts

Acute and non-acute hospital outpatient departments are paid according to the rate of payment established for each hospital in the signed MassHealth provider agreement. For non-acute departments, MassHealth pays only for charges contained in the charge book and will pay no more than said charges except when specific rates have been established for specific services or programs (e.g., adult day health services).

Payment limitations to both acute and non-acute departments include that MassHealth will not pay for outpatient services if a member is an inpatient at the same or a different hospital on the same day. However, if a member receives outpatient services at one facility and is admitted as an inpatient to another facility on the same day, MassHealth will pay both hospitals for services.

MassHealth only pays for emergency outpatient services on the day the member is discharged from the hospital.

Hospitals may only bill for the all-inclusive per diem rate for the day a member is admitted as an inpatient through an emergency or outpatient department. MassHealth will not pay for services provided by the emergency or outpatient department on the admitting day.

Funding trends

MassHealth spent \$17.4 million on outpatient hospitals in 2015 for over 9,000 members, up from \$13.6 million for just over 8,100 members in 2012.

Relevant sources

- Chronic Disease and Rehabilitation Outpatient Hospital Manual:
www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-cdroutpatienthosp.pdf
- 130 CMR 435.000 (Chronic Disease and Rehabilitation Inpatient Services):
www.mass.gov/courts/docs/lawlib/116-130cmr/130cmr435.pdf
- Chronic Disease and Rehabilitation Inpatient Hospital Manual:
www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-chronicdiseaserehab.pdf
- 130 CMR 410.000 (Outpatient Hospital Services):
www.mass.gov/courts/docs/lawlib/116-130cmr/130cmr410.pdf

DAY HABILITATION

Description of the service

Day habilitation is a structured, goal-oriented program of medically oriented, therapeutic, and habilitation services for members with developmental disabilities. The purpose of the program is to raise or maintain members' levels of functioning and facilitate independent living and self-management in their communities.

Services include:

- Nursing services and health care supervision, including administration of medication, education in hygiene and health concerns, monitoring health status, and oversight of maintenance therapy
- Developmental skills training in the following areas of development: self-help, sensorimotor, communication, social, independent living, affective, and behavioral
- Therapy services including speech/language, occupational, physical, and behavior management
- Assistance with ADLs

Eligibility for the service, how members access it, and who uses it

Only MassHealth Standard and CommonHealth members are eligible for day habilitation services.

To receive day habilitation program services, members must have a developmental disability and must need and be expected to benefit from day habilitation services designed to improve their level of independent functioning. The services must be medically necessary as determined by MassHealth, prescribed in a day habilitation service plan, and authorized by the member's physician or primary care clinician. If the member resides in a nursing facility, day habilitation services must be recommended as a result of a pre-admission screening and annual resident review.

In limited circumstances, day habilitation services may be provided in a nursing facility, including when the member is so medically fragile that transport to a day habilitation program presents a significant risk.

The member must have had a comprehensive evaluation by the referring provider, including an assessment of his or her social skills and medical, mental, functional, and developmental status. In addition, a home assessment must have been conducted that includes a family history and description of the member's adaptation to the home environment.

For payment a severity profile must be completed by the provider annually and whenever there is a significant change in the member's functional level.

The site must complete a service needs assessment that determines the member's level of functioning, needs, and strengths and includes specific recommendations regarding the following areas of need: habilitation, medical, social, occupational, psychological, and behavioral. This assessment is used to inform the development of a day habilitation service plan.

Organizations that provide the service and workforce

Day habilitation providers must operate at least five days a week for at least six hours per day. They must be accredited by the Commission on Accreditation of Rehabilitation Facilities or the Accreditation Council for Developmental Disabilities.

A day habilitation program with 28 or fewer participants must have no fewer than four health-care professionals on its interdisciplinary team.

For sites with more than 28 participants, there must be one full-time-equivalent professional for every seven additional participants.

The interdisciplinary team must include a nurse, and other team members can include a speech therapist, an occupational therapist, a physical therapist, a developmental specialist, a behavioral specialist, a psychologist, or a rehabilitation counselor.

One staff person must be designated as the administrator, one the program director, and one a health care supervisor who must be a registered nurse who is employed at least three-quarters time.

There were 169 providers during 2015, up slightly from 166 in 2012.

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DAY HABILITATION *(continued)*

Payment method and rate

Payment rates for day habilitation services provided by a community program are divided into three categories reflecting a high, intermediate, or low level of member function, and are billed in 15- minute increments.

- Low need = \$2.87 per 15 minutes
- Intermediate need = \$3.24 per 15 minutes
- High need = \$4.24 per 15 minutes

Payments for services provided in a nursing facility vary depending on the required staffing ratio, and are also billed in 15 minute increments:

- 1:1 staff-to-member ratio = \$7.43 per 15 minutes
- 1:2 or 1:3 staff-to-member ratio = \$4.12 per 15 minutes

A per-trip payment of \$3.65 is also allowed for non-emergency transportation if used to serve four or more individuals in a nursing facility.

In addition, certain clients may need supplemental services in the form of additional staff assistance to enable their participation in the day habilitation program.

- Program aide (direct care/program staff I) \$15.54/hour
- Direct care/program staff II \$17.42/hour
- Licensed practical nurse (LPN) and registered nurse (RN) hourly rate per home health rates at 101 CMR 350.00 (formerly 114.3 CMR 50.00)

Vocational skills and sheltered workshops are nonreimbursable.

Funding trends

More than \$165 million was spent on day habilitation services for over 9,900 members in 2015, up from \$143 million for just over 8,400 members in 2012.

Relevant sources

- Day Habilitation Program Manual:
www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-dayhabprogram.pdf
- 101 CMR 348.00:
www.mass.gov/eohhs/docs/eohhs/regs/101-cmr-348.pdf
- 139 CMR 419.000:
www.mass.gov/courts/docs/lawlib/116-130cmr/130cmr419.pdf

DURABLE MEDICAL EQUIPMENT/MEDICAL SUPPLIES

Description of the service

Durable medical equipment (DME) is equipment made primarily for a medical purpose and intended for repeated use over an extended period of time.

Medical supplies are made to fulfill a medical purpose and are non-reusable and disposable. Examples of DME and medical supplies include:

- Absorbent products
- Ambulatory equipment such as crutches and canes
- Compression devices
- Speech augmentative devices
- Enteral and parenteral nutrition and nutritional supplements
- Home infusion equipment and supplies
- Glucose monitors and diabetic supplies
- Mobility equipment and seating systems
- Personal emergency response systems
- Ostomy supplies
- Support surfaces
- Hospital beds and accessories
- Patient lifts
- Bath and toilet equipment and supplies (e.g., commodes, grab bars, tub benches)

Eligibility for the service, how members access it, and who uses it

MassHealth Standard, CarePlus, CommonHealth, and Family Assistance members are eligible for DME and medical supplies.

The member must have a prescription and letter of medical necessity for the purchase or rental of DME. In some cases, the prescription must be made by a specific kind of medical professional. MassHealth has issued specific medical necessity criteria for some types of DME, and for others, the provider must adhere to the current local coverage determination policy developed by CMS. In some cases, diagnostic test results may be part of the documentation for demonstrating medical necessity.

MassHealth regulations specifically detail coverage for augmentative and alternative communication devices and personal emergency response systems.

There are limited circumstances under which MassHealth will pay for DME and/or medical supplies for members residing in nursing facilities, acute, chronic disease and rehabilitation, and psychiatric hospitals, or intermediate care facilities for individuals with intellectual disabilities.

MassHealth covers the repair of DME, including repairs to medically necessary backup DME. For example, MassHealth will pay for a manual wheelchair and its repairs for a member with a power mobility system. But it will pay for the replacement of a member's mobility system only when the cost of repairing or modifying the system would exceed the value of the system or when the member's physical condition has changed enough to render the existing mobility system ineffective.

Prior authorization is required in addition to a prescription for some DME, and generally repairs costing more than \$1,000 require prior authorization.

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DURABLE MEDICAL EQUIPMENT/MEDICAL SUPPLIES *(continued)*

Organizations that provide the service and workforce

DME providers must have a service facility available to members during regular business hours and must participate in the Medicare program as a DME provider, unless the provider supplies only personal emergency response systems or absorbent products. DME providers may not accept prescriptions from any prescribing provider who has a financial interest in the DME provider.

The provider must ensure that all DME is the most cost effective, given the medical need for which it is prescribed.

DME providers are responsible for instructing the member or the member's caregiver in the appropriate use of DME. And DME providers are responsible for ensuring that all DME is free from defects and is in proper working condition, including prompt amelioration, repair, or replacement of DME subject to recall. DME providers must respond to members' complaints about their DME within two business days.

There were 90 providers of one or more types of DME and/or medical supplies services during 2015, down from 106 in 2012.

Payment method and rate

Rates for most DME and medical supplies are specified in 114.3 CMR 22.00. In some cases, MassHealth will accept a quote from a DME provider for an item that does not have a rate established if the equipment has not yet been purchased.

Funding trends

More than \$49 million was spent on DME and medical supplies for 54,000 members during 2015, up from \$46 million for over 50,000 members in 2012.

Relevant sources

- Durable Medical Equipment Manual:
www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-durablemedical.pdf
- 114.3 CMR 22.00:
www.mass.gov/courts/docs/lawlib/111-115cmr/114-3cmr22.pdf

HOME HEALTH

Description of the service Home health services include intermittent skilled nursing, continuous skilled nursing (more than two hours of continuous care),* the services of a home health aide (personal care and other health-related services), and physical/occupational/speech-language therapy** provided by or through a home health agency in an eligible MassHealth member's home or community.

Eligibility for the service, how members access it, and who uses it MassHealth Standard, CarePlus, CommonHealth, and Family Assistance Direct Coverage members are eligible for home health services. Eligible members must reside in a non-institutional setting, which can include a homeless shelter or other temporary residence or community setting.

MassHealth members can only receive home health services if they are under the care of a physician who certifies that services are medically necessary and establishes an individual plan of care. The plan of care must document that the physician conducted a face-to-face encounter with the member no more than 90 days before or 30 days after the start of home health services. The physician must not be on the staff of or under contract to the home health agency.

Prior authorization is required for all home health services, based on a determination of medical necessity. Requests must be submitted by the home health agency and accompanied by the physician's clinical documentation and individual plan of care. Prior authorization is required for:

- Any continuous skilled nursing services
- More than 30 skilled nursing visits in a 90-day period
- More than 240 home health aide units (15-minute units) in a 90-day period
- More than 20 physical therapy visits in a 12-month period
- More than 20 occupational therapy visits in a 12-month period
- More than 35 speech/language therapy visits in a 12-month period

Note: the 12-month period for physical therapy, occupational therapy, and speech/language therapy begins with the first visit.

For members ages 60 and over, home health agencies must complete an ASAP referral reform upon assessment and reassessment for services or for discharge from services. The agency must forward the completed form to Executive Office of Elder Affairs and keep a copy in the member's record.

Organizations that provide the service and workforce The home health agency may provide home health services directly or, in certain circumstances, through contracts with other providers, such as a hospital, nursing facility, another home health agency, or hospice. In either circumstance, the home health agency must submit the claims for services to MassHealth.

Home health agencies employ or contract the services of licensed registered nurses, licensed practical nurses, home health aides, and physical, occupational, and speech/language therapists to provide home health services.

There were more than 190 home health agencies in 2015, up from just over 140 in 2012.***

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* Continuous skilled nursing services are available only for complex-care members whose medical needs are such that they require a nurse visit of more than two continuous hours of nursing services to remain in the community. These services can be provided through a nurse employed or contracted by a home health agency or by an independent nurse who independently enrolls as a provider in MassHealth to deliver services. More detail on continuous skilled nursing services is provided in the section on independent nurse services/private duty nursing.

** Physical, occupational, and speech/language therapy services can also be provided outside a home health setting by independent therapists, rehabilitation centers, and speech and hearing centers. These services are described in the section on physical, occupational, and speech/language therapies.

*** MassHealth has had a moratorium on new home health providers since February 2016.

HOME HEALTH *(continued)*

Payment method and rate

MassHealth pays different rates for different services provided in the home health setting. For example, as of July 14, 2017, MassHealth generally pays:

- \$89.21 for the first 30 calendar days of skilled nursing visits (this goes down to \$69.59 for each subsequent individual—not the first individual—for the first 30 calendar days when two or more individuals in the same household are receiving a nursing visit during the same period)
- \$69.59 for skilled nursing visits on or after 31 days (this same rate is paid for visits on or after 31 days when two or more individuals in the same household are receiving a nursing visit in the same period)
- \$59.14 for oral, intramuscular, or subcutaneous medication administration
- \$68.30 per visit for physical therapy services
- \$72.88 per visit for speech/language therapy services
- \$71.20 per visit for occupational therapy services
- \$28.99 for office services provided on an emergency basis
- \$6.10 per 15-minute unit for home health aide services

MassHealth does not pay for home health services in hospitals, nursing facilities, intermediate care facilities for persons with developmental disabilities, or any other institutional facility providing medical, nursing, rehabilitative, or related care.

Funding trends

MassHealth spent nearly \$500 million on home health services for over 33,000 members in 2015, up from \$195 million for 23,000 members in 2012.

Relevant sources

- Home Health Agency Manual:
www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-homehealthagency.pdf
- 101 CMR 350.00 (formerly 114.3 CMR 50.00):
www.mass.gov/courts/docs/lawlib/101-103cmr/101cmr350.pdf

INDEPENDENT NURSE SERVICES/CONTINUOUS SKILLED NURSING

Description of the service	<p>Independent nurse services or private duty nursing (PDN) is the provision of continuous skilled nursing services by an independent practitioner (e.g., an RN or LPN) to members with complex care needs in their home or community. Continuous skilled nursing is a nurse visit of more than two continuous hours of services.</p>
Eligibility for the service, how members access it, and who uses it	<p>Only MassHealth Standard and CommonHealth members with complex-care needs are eligible for independent nurse/private duty nursing services. Members with complex-care needs are those whose medical needs, as determined by MassHealth or its designee (currently the University of Massachusetts Medical School [UMMS]), are such that they require a nurse visit of more than two continuous hours of nursing services to remain in the community.</p> <p>Prior authorization from MassHealth is required for independent nurse/private duty nursing services. To be clinically eligible for these services, there must be a:</p> <ul style="list-style-type: none">• Clearly identifiable, specific medical need for a nursing visit of more than two continuous hours• Need for services that require the skills of an RN or LPN• Medical necessity for services to treat an illness or injury <p>MassHealth automatically assigns a clinical care manager to each eligible MassHealth member. Care management includes service coordination with independent nurses (or with home health agencies for continuous nursing services provided in a home health setting) to ensure that complex-care members are provided with a coordinated community LTSS service plan, to avoid duplicative services, and to ensure that MassHealth pays for only medically necessary nursing and other community LTSS. The UMMS clinical care manager conducts an in-person visit to determine medical necessity for the services and, if the member is eligible, conducts a comprehensive needs assessment, service authorization, discharge planning support, service coordination, and follow-up and reassessment.</p>
Organizations that provide the service and workforce	<p>Private duty nurse services are provided by an RN or LPN who independently enrolls as a provider in MassHealth to provide continuous skilled nursing services.</p> <p>MassHealth currently contracts with 348 independent nurses to provide these services, up from 218 in 2015.</p>
Payment method and rate	<p>MassHealth pays for continuous nursing services per unit of service in 15-minute increments, and rates vary based on:</p> <ul style="list-style-type: none">• Whether a home health agency or an independent nurse is providing the care (agency rates are slightly higher)• The number of patients served (1–3)• Whether the nurse is working regular/“straight” time or overtime• Whether the service is provided on a weekday, night/weekend, or holiday• Whether the nurse is an RN or LPN <p>For example, for an individual practitioner, a single patient, straight-time hour, the per-unit (15-minute) rates effective July 14, 2017 are:</p> <ul style="list-style-type: none">• \$10.52 RN Services, weekday• \$11.25 RN Services, nights/weekends• \$15.07 RN Services, holidays• \$8.76 LPN Services, weekday• \$9.39 LPN Services, nights/weekends• \$12.62 LPN Services, holidays
Funding trends	<p>In 2015, MassHealth spent \$97 million on private duty nursing services for just over 900 members, up from \$77 million for just under 800 members in 2012.</p>
Relevant sources	<ul style="list-style-type: none">• Independent Nurse Manual: www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-independentnurse.pdf• 101 CMR 350.00 (formerly 114.3 CMR 50.00): www.mass.gov/courts/docs/lawlib/101-103cmr/101cmr350.pdf

NURSING FACILITIES

Description of the service	<p>Nursing facilities provide short-term and long-term skilled nursing services for individuals with medical, psychological, and physical diagnoses that require 24-hour nursing care.</p> <p>MassHealth-covered nursing facility services include:</p> <ul style="list-style-type: none">• Skilled services that must be performed by or under the supervision of an RN or therapist (e.g., intravenous feeding, observation and evaluation of an unstable medical condition)• Assistance with ADLs• Nursing services, such as positioning in bed or a chair as part of the care plan or administration of medication <p>Residents can also choose to receive hospice services and continue to reside in the nursing facility if the facility is serviced by a hospice provider. MassHealth will pay for hospice room and board and medical leave of absence, as long as the member remains in the facility.</p>
Eligibility for the service, how members access it, and who uses it	<p>MassHealth Standard, CarePlus, and CommonHealth members are eligible for nursing facility services if they require at least one skilled service or a combination of at least three ADLs and nursing services (with at least one of the three being a nursing service).</p> <p>Members are only eligible for nursing facility care if MassHealth (or its agent) determines that community care is not available or cannot meet their needs. Prior to admission to a nursing facility, eligible members must be screened to determine whether they have a major mental illness, retardation, or developmental disabilities.</p> <p>Clinical authorizations for services may be for a specified or indefinite length of stay, and authorizations for indefinite stays may be subject to review. New clinical authorizations are required when a member:</p> <ul style="list-style-type: none">• Is transferred from one nursing facility to another• Switches facilities after a hospital admission• Is readmitted to the same nursing facility following a hospital stay of six months or more• Has discharge potential
Organizations that provide the service and workforce	<p>In-state nursing facilities must be licensed by the Department of Public Health, be certified by the Department of Public Health, and participate in Medicare.</p> <p>Out-of-state facilities must be licensed by the appropriate authority, certified by the state survey agency, and participate in Medicare.</p> <p>MassHealth contracted with 403 nursing facility service providers in 2015, down from 422 in 2012.</p>
Payment method and rate	<p>MassHealth pays for nursing facility services based on per diem rates that align with the member's needs, as set forth by the Center for Health Information and Analysis (CHIA). Nursing facilities must complete a Management Minutes Questionnaire to determine the member's needs, and then they may bill MassHealth for each member according to the member's assigned management minutes category.</p> <p>In 2015, there were six payment groups arrayed on total management minutes, which measures care intensity:</p> <ul style="list-style-type: none">• 0–30 management minutes: \$14.45• 30.1–110: \$39.54• 110.1–170: \$68.38• 170.1–225: \$96.34• 225.1–270: \$117.67• 270+: \$146.39 <p>The Massachusetts standard payment calculation consists of three core cost centers: nursing, other operating, and capital. Other provisions exist to address pediatrics, state-owned and municipal facilities, and unique circumstances. Please refer to 101 CMR 206.00: Standard Payments to Nursing Facilities for additional provisions and current rates.</p>

(continued)

NURSING FACILITIES *(continued)*

Funding trends MassHealth spent \$1.4 million on nursing facility services in 2015 for over 39,000 members, down from \$1.5 million for just over 40,500 members in 2012.

Relevant sources

- Nursing Facility Manual:
www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-nursingfac.pdf
- 101 CMR 206.00:
www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-206.pdf

ORTHOTICS AND PROSTHETICS*

Description of the service The orthotics program provides medically necessary orthotics devices, including, but not limited to, shoes, braces, and splints. This also includes the design and application of an external appliance to support a paralyzed muscle, which promotes a specific motion to correct musculoskeletal deformities.

Included are purchase, customization, fitting, repair, replacement, and adjustment of an orthosis or component part. Orthotics also includes pedorthic services, i.e. the design, manufacture, modification, and fitting of orthopedic or diabetic shoes, including foot orthoses, prosthetic fillers, and orthotic and pedorthic appliances for use from the ankle and below.

The prosthetics program provides customization, fitting, repair, replacement, and adjustment of a prosthesis or component part.

Eligibility for the service, how members access it, and who uses it MassHealth Standard, CarePlus, CommonHealth, and Family Assistance members are eligible for orthotics and prosthetics. Age restrictions may apply, but no age restriction applies to shoe or shoe inserts for those with severe diabetic foot disease.

The purchase of orthotic and prosthetic equipment requires a written prescription signed by a licensed physician or independent nurse practitioner.

Prior authorization is required for some orthotics and some prosthetics.

MassHealth pays for orthotic and prosthetic equipment for members residing in the community, in nursing facilities, intermediate care facilities for individuals with an intellectual disability, and rest homes.

Organizations that provide the service and workforce Providers must primarily engage in the business of providing orthotics services or prosthetic or prosthetic repair services, be a Medicare provider, be certified by the American Board for Certification in Orthotics, Prosthetics and Pedorthics or the Board of Certification/Accreditation International. If the provider intends to solely provide breast prostheses and accessories, the provider must employ at least one full-time mastectomy fitter.

The provider must ensure that all orthotics or prosthetic services and supplies are clean, in proper working condition, functional, free from defects, and new and unused at the time of purchase. The provider must ensure that all orthotic services are the most cost effective, given the medical need for which they are prescribed and the member's physical limitations.

There were 19 providers of orthotics during 2015, and the number of providers has remained steady since 2012. There were 37 providers of prosthetics during 2015, down from 40 in 2012.

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* On December 13, 2016, MassHealth proposed changes to the prosthetics regulations that make technical changes to certain regulation citations. As of the date of publication, final regulations have not yet been promulgated.

ORTHOTICS AND PROSTHETICS* *(continued)*

Payment method and rate

MassHealth pays providers of orthotics and prosthetics at the lower end of the provider's usual and customary charge to the public or the schedule of allowable fees set by the state (see 130 CMS 442.420(a)). If a rate has not been set, providers can request individual consideration based on an adjusted acquisition cost (see 130 CMR 442.421 and 130 CMR 428.421).

Payment covers fitting, instructing the member in use, cost of component parts and accessory equipment, repairs due to normal wear and tear within 90 days, and adjustments to the prosthesis, orthosis, or pedorthic device and any component made during fitting for 90 days from the date of delivery when such adjustments are not necessitated by change in the member's functional abilities.

MassHealth covers all repair services on an individual consideration basis. The provider is liable for the quality of the workmanship and parts and for ensuring the repaired equipment is in working condition. All manufacturer warranties must be exhausted before submitting claims for repairs.

Funding trends

More than \$2.7 million was spent on orthotics for just over 4,400 members in 2015, up from \$1.6 million for just over 3,000 members in 2012.

More than \$5.6 million was spent on prosthetics for over 10,500 members during 2015, up from \$5.1 million for over 9,000 members in 2012.

Relevant sources

- Orthotics Manual:
www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-orthotics.pdf
- Orthotics and Prosthetics Payment and Coverage Guidelines Tool:
www.mass.gov/eohhs/docs/masshealth/mh-paymnt-coverage-guideline-tools/mhpgt-ort-prt.pdf
- Prosthetics Manual:
www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-prosthetics.pdf
- 101 CMR 334.00:
www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-334-00-prosthetics-orthotics.pdf

* On December 13, 2016, MassHealth proposed changes to the prosthetics regulations that make technical changes to certain regulation citations. As of the date of publication, final regulations have not yet been promulgated.

OXYGEN/RESPIRATORY THERAPY EQUIPMENT

Description of the service	<p>Oxygen and respiratory therapy equipment services include the purchase, rental, and repair of oxygen and respiratory therapy equipment and supplies used in the treatment of pulmonary diseases.</p> <p>Oxygen therapy is the administration of oxygen in concentrations greater than that in the ambient air to treat the signs and symptoms of tissue hypoxia resulting from abnormal blood oxygen levels. Equipment includes, but is not limited to, comprehensive oxygen delivery systems, including gaseous and liquid oxygen, oxygen-generating equipment, stand, cart, walker or stroller, supply reservoir, and regulator with flow gauge.</p> <p>Respiratory therapy is treatment that maintains or improves the ventilatory function of the respiratory tract. Equipment includes the complete respiratory therapy device and its related delivery-system accessories, such as regulator, humidification and heating units, and filters.</p>
Eligibility for the service, how members access it, and who uses it	<p>MassHealth Standard, CarePlus, CommonHealth, and Family Assistance members are eligible to receive oxygen and respiratory therapy equipment services and must use these services in their home.</p> <p>The oxygen and respiratory therapy equipment provider must obtain a written prescription from a licensed physician or independent nurse practitioner dated within 90 days of the initial date of service for providers to be paid for these services.</p> <p>Prior authorization is required for:</p> <ul style="list-style-type: none">• The purchase of oxygen/respiratory therapy equipment costing more than \$35; gaseous or liquid oxygen; and repair services costing more than \$35• The rental of oxygen/respiratory therapy delivery systems, suction apparatus, nebulizers, intermittent positive pressure breathing machines, and equipment that is not covered by one of the service codes payable by MassHealth (see Subchapter 6 of the Oxygen and Respiratory Therapy Equipment Manual) <p>The prior authorization request must include documentation of the medical necessity for the item or service and an invoice that reflects the provider's adjusted acquisition cost—the price a provider pays to a supplier for the equipment, excluding shipping, handling, and insurance costs.</p> <p>Before approving the prior authorization request, MassHealth may also require the prescriber to submit an assessment of the recipient's pulmonary disability and to describe the specific therapeutic goals of the requested service.</p>
Organizations that provide the service and workforce	<p>Providers must be accredited by the Joint Commission as oxygen and medical equipment providers. In general, these providers furnish DME, medical and surgical supplies, customized equipment, oxygen or respiratory therapy equipment, mobility systems, intravenous and enteral therapy equipment, and related supplies and services.</p> <p>MassHealth contracts with 20 oxygen/respiratory therapy equipment and repair providers. Contracted providers have remained steady around 20 since 2012.</p>
Payment method and rate	<p>Payment to providers of oxygen and respiratory therapy equipment varies based on whether the equipment is purchased, rented, or being repaired, and whether the recipient receives Medicare Part B benefits (see 130 CMR 427.423-.427).</p>
Funding trends	<p>MassHealth spent \$1.9 million on oxygen and respiratory therapy equipment and supplies for over 3,000 members in 2015. Program spending and enrollment has remained relatively steady, at around \$2 million and 3,000 members, since 2012.</p>
Relevant sources	<ul style="list-style-type: none">• Oxygen and Respiratory Therapy Equipment Manual: www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-oxygen.pdf• 114.3 CMR 22.00: www.mass.gov/eohhs/docs/eohhs/eohhs-regs/114-3-22.pdf

PERSONAL CARE ATTENDANT PROGRAM (INCLUDING THE TRANSITIONAL LIVING PROGRAM*)

Description of the service

Personal care attendant (PCA) services are physical assistance with ADLs and IADLs provided by a PCA for the purpose of assisting the member to achieve independent living. The PCA program includes personal care management, a fiscal intermediary, and PCA services.

Members or their surrogates are the employer of the PCAs and are responsible for recruiting hiring, training, firing, and supervising their PCAs.

Members select a personal care management (PCM) agency that evaluates a member's need for PCA services, develops a PCA service agreement, and provides intake/orientation and skills training to the member or his or her surrogate regarding employer responsibilities.

The PCM is responsible for assessing if a member needs a surrogate to perform PCA management tasks that the member cannot perform him or herself. A surrogate may be the member's legal guardian, a family member, or another person. A surrogate cannot also be the member's PCA or an employee or contractor of either the member's fiscal intermediary or PCM agency.

PCM agencies select a fiscal intermediary to act as an employer agent for members by processing payment checks, withholding and paying all required employer taxes, union dues, and fees, and purchasing workers' compensation.

Most PCA services are provided in the member's home, but some members receive them in a Transitional Living Program. Normally, payment to a PCA is handled through a fiscal intermediary. However, payment under the Transitional Living Program is handled differently—the transitional living provider collects activity forms on which the PCA records hours, and then the provider pays the member or surrogate, who pays the PCA directly.

Eligibility for the service, how members access it, and who uses it

Only MassHealth Standard and CommonHealth members are eligible to receive personal care services.

A MassHealth member must have a permanent or chronic disability that impairs the member's functional ability to perform ADLs and IADLs without physical assistance. The member must require physical assistance with two or more ADLs.

Assistance in the form of cueing, prompting, or supervision is not covered, and PCA is not covered while the member is a resident of a nursing facility or inpatient facility or during the time a member is receiving day habilitation, adult day health, adult foster care, or group adult foster care services.

The PCM agency or transitional living provider, when applicable, conducts an initial evaluation that is performed by an occupational therapist and an RN. This evaluation documents the member's need for PCA services. MassHealth then conducts prior approval review of the request.

The PCM agency or provider of transitional living services must request prior authorization from MassHealth as a prerequisite to payment for services.

Organizations that provide the service and workforce

A PCA cannot be a family member (defined as a spouse, a parent of a minor, or any legally responsible relative), a foster parent, or a person acting as a surrogate to the member.

There were 34 organizations supporting member access to PCA services in 2015, including 25 PCM agencies (five of which are independent living centers), four fiscal intermediaries, and two providers that provide PCA through the Transitional Living Program.

(continued)

* The Transitional Living Program is a structured group-living environment for persons with severe disabilities who demonstrate an aptitude for independent living but who can clearly benefit from functional skills training and supervised experience in management of health care, PCA services, and community activity in gaining the ability and confidence necessary for independent living.

PERSONAL CARE ATTENDANT PROGRAM (INCLUDING THE TRANSITIONAL LIVING PROGRAM*) (continued)

Payment method and rate

PCM agencies are paid different rates for their different functions. Below are rates as of January 1, 2017:

- Intake and orientation — \$103.80 per member per month for up to three consecutive months
- Functional skills training — \$50.64 per member per month
Note: this functional skills training payment was increased temporarily to \$52.74 for the months of October, November, and December of 2016 to account for additional training in management of PCA overtime requirements.
- Initial evaluation and assessment — \$227.83 per session
- Reevaluation and assessment — \$130.94 per session

Fiscal intermediaries are paid based on a contract selected via a request for response, as opposed to on rates set by state regulation.

PCAs are currently paid at a class rate of \$16.00 an hour (of which \$14.12 is the gross wage component). Wage increases have been negotiated with the union to increase the class rate hourly wage up to \$16.52 (of which \$14.46 is the gross wage component), effective July 1, 2018.

In November 2016, MassHealth updated the PCA overtime payment policy, including its criteria for temporary and continuity of care approval.** Under the new policy, PCA overtime hours are capped at 10 hours per week (above 40 standard hours). A consumer may request authorization to schedule a PCA to work up to 66 hours per week under certain circumstances. If approved, MassHealth will provide either a temporary authorization for up to 12 weeks (e.g., when the member is traveling and it would not be feasible to bring along multiple PCAs to provide the necessary services) or a continuity of care authorization for the duration of the member's prior authorization period (e.g., when the member has complex medical needs that require specialized skills of an experienced PCA).

PCAs are paid a holiday rate for hours worked between 6 a.m. and midnight on certain holidays, are paid for up to three days of jury duty if such duty occurs during regularly scheduled work hours, and earn paid sick time.

Newly hired PCAs (those hired after 1/1/2014) are required and paid to attend a three hour New-Hire Orientation.

Transitional living providers are paid specific rates for certain social, rehabilitation, and health care services (see 114.5 CMR 4.00). If a member has completed the program of transitional living services but cannot secure an appropriate living arrangement, MassHealth will pay an administrative day rate covering the program's overhead expenses and the member's personal care services. Providers are paid for a medical leave of absence for a maximum of 13 days per member per episode of hospitalization and a nonmedical leave of absence for a cumulative maximum of 10 days during the member's stay in the Transitional Living Program.

Funding trends

Just over \$574 million was spent on PCA services for almost 30,000 members in 2015, up from 530 million spent for just under 29,000 members in 2012.

Relevant sources

- Personal Care Manual:
www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-personalcare.pdf
- 101 CMR 309.00:
www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-309.pdf
- 114.5 CMR 4.00:
www.mass.gov/courts/docs/lawlib/111-115cmr/114-5cmr4.pdf

* The Transitional Living Program is a structured group-living environment for persons with severe disabilities who demonstrate an aptitude for independent living but who can clearly benefit from functional skills training and supervised experience in management of health care, PCA services, and community activity in gaining the ability and confidence necessary for independent living.

** For more information see www.mass.gov/eohhs/consumer/insurance/masshealth-member-info/pca/pca-overtime-overview.html.

**THERAPIES—PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH/LANGUAGE THERAPY
(OUTSIDE THE HOME HEALTH SETTING)**

Description of the service	<p>Therapy services include physical therapy, occupational therapy, and speech/language therapy provided by independent therapists, rehabilitation centers, or speech and hearing centers.</p> <p>Therapy services are designed to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions (physical therapy), functions that affect ADLs (occupational therapy), and speech/language communication and swallowing disorders (speech/language therapy) that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries.</p> <p>MassHealth-covered therapy services include:</p> <ul style="list-style-type: none"> • Individual treatment, including the design, fabrication, and fitting of an adaptive device (for members under age 21) • Comprehensive evaluation • Group therapy
Eligibility for the service, how members access it, and who uses it	<p>MassHealth Standard, CarePlus, CommonHealth, and Family Assistance Direct Coverage members are eligible for therapy services.</p> <p>Eligible members must have a written referral for therapy services from a licensed physician or licensed nurse practitioner. Referrals for physical or occupational therapy must be renewed every 60 days if the member requires continuous treatment.</p> <p>Prior to receiving therapy services, the therapist must conduct a comprehensive evaluation. The evaluation is an in-depth assessment of the member’s medical condition, disability, and level of functioning that determines the need for treatment and, when indicated, is used to develop a treatment plan.</p> <p>The member can receive services in a therapist’s office (whether an individual practice, group practice, or association of practitioners) or outside an office, such as in a nursing facility, the member’s home, or other setting to which the therapist travels from his or her usual place of business.</p> <p>Prior authorization from MassHealth is required for therapy services for:</p> <ul style="list-style-type: none"> • More than 20 physical therapy visits (including group therapy) in a 12-month period • More than 20 occupational therapy visits (including group therapy) in a 12-month period • More than 35 speech/language therapy visits (including group therapy) in a 12-month period
Organizations that provide the service and workforce	<p>MassHealth contracts with 774 therapy providers, including independent therapists (licensed physical, occupational, and speech/language therapists or therapy assistants), rehabilitation centers, and speech and hearing centers. This is down from 895 providers in 2012.</p>
Payment method and rate	<p>MassHealth pays for therapy services at the lower of the provider’s usual and customary fees to patients other than publicly aided patients, or according to the schedule of allowable fees (see 101 CMR 339.04).</p> <p>Examples of therapy rates for specific services include:</p> <ul style="list-style-type: none"> • Physical therapy and rehabilitation services—\$52.66 for a 30-minute physical therapy evaluation for a patient with moderate complexity • Therapeutic procedures—\$13.17 per 15 minutes for aquatic therapy with therapeutic exercises • Evaluation and management—\$75.22 for an office/outpatient visit for a new patient, including detailed history, detailed examination, and medical decision-making of low complexity <p>Some service limits apply to MassHealth’s payment for therapy services, including, but not limited to:</p> <ul style="list-style-type: none"> • MassHealth will not pay for more than one individual treatment and one group therapy session per member per day • MassHealth will not pay for a treatment claimed for the same day of service as a comprehensive evaluation (as the evaluation fee includes payment for both the written report and any treatment provided at the time of the evaluation)

(continued)

**THERAPIES—PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH/LANGUAGE THERAPY
(OUTSIDE THE HOME HEALTH SETTING) *(continued)***

Funding trends MassHealth spent \$4.2 million on therapy services in 2015 for over 11,500 members, up from \$3.2 million for 8,600 members in 2012.

Relevant sources

- Therapist Manual:
www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-therapist.pdf
- 101 CMR 339.00 (formerly 114.3 CMR 39.00):
www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-339.pdf
- 101 CMR 317.00:
www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-317-medicine.pdf



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