SECTION 3: SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, 1920 (a), 1902 (e), 1905 (a), 1905 (p) 1915, 1920, and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902 (a), 1902 (e), 1905 (a), 1905 (p) 1915, 1920, and 1925 of the Act.

(1) Categorically Needy

Services for the categorically needy are described below and in **Attachment 3.1-A**. These services include:

1902 (a) (10) (A) and 1905 (a) of the Act

(i) Each item or service listed in section 1905 (a) (1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905 (a) (17) of the Act are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

☐ Not applicable. Nurse-midwives are not authorized to practice in this state.

State Plan under Title XIX of the Social Security Act
State: Massachusetts

Citation 3.1 (a) (1) Amount, Duration, and Scope of Services: Categorically Needy (cont.)

1902 (e) (5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

☒ (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902 (a) (10), Clause (VII) of the matter following (E) of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902 (a) (10) (A) (i) (IV) and 1902 (a) (10) (A) (ii) (IX) of the Act.

Citation 3.1 (a) (1) Amount, Duration, and Scope of Services: Categorically Needy (cont.)

(vi) Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1 (b) of this plan.

1902 (e) (7) of the Act

(vii) Inpatient services that are being furnished to infants and children described in section 1902 (1) (1) (B) through (D), or section 1905 (n) (2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

1902 (e) (9) of the Act

☐ (viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1 (h) of this plan.

1902 (a) (52) and 1925 of the Act

(ix) Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.

1905 (a) (23) and 1929

☐ (x) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Attachment 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services that may complicate the pregnancy.

PACE State Plan Amendment Pre-Print

Citation	3.1(a)(1)	Amount, Duration, and Scope of Services: Categorically Needy (continued)
1905(a)(26) and 1934 of the Act	☒	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

Attachment 3.1-A identifies the medical and remedial services provided to the categorically needy. Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage – that is in excess of established service limits – for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly populations, this also is not applicable for this program.)

Citation 3.1 Amount, Duration, and Scope of Services (cont.)

3.1 (a) (2) Medically Needy (cont.)

42 CFR Part 440, Subpart B

☒ This State plan covers the medically needy. The services described below and in Attachment 3.1-B are provided

Services for the medically needy include:

1902 (a) (I0) C (iv) of the Act (42 CFR 440.220)

i. If services in an institution for mental disease or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905 (a) (1) through (5) and I (17) of the Act, or seven of the services listed in sectino1905 (a) (1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A, and in sections 1902, 1095, and 1915 of the Act.

☐ Not applicable with respect to nurse-midwife services under section 1902 (a) (17). Nurse-midwives are not authorized to practice in this State.

1902 (e) (5) of the Act (42 CFR 440.160 and 440.140)

ii. Prenatal care and delivery services for pregnant women.

Citation 3.1 (a) (2) Amount, Duration, and Scope of Services: Medically Needy (cont.)

iii. Pregnancy –related including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant , were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

☒ iv. Services for any medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

v. Ambulatory services, as defined in **Attachment 3.1-B** for recipients under age 18 and recipients entitled to institutional services.

☐ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the mentally needy.

vi. Home health services to recipients entitled to nursing facility services as indicated in items 3.1 (b) of this plan.

42 CFR 440.140 ☒
440.150, 440,160
Subpart B,
442.441,
Subpart C ☒
1902 (a) (20)
And (21) of the Act ☒

vii. Services in an institution for mental disease for individuals over age 65.

viii. Services in an intermediate care facility for the mentally retarded.

ix. Inpatient psychiatric services for individuals under age 21.

Citation 3.1 (a) (2) Amount, Duration, and Scope of Services: Medically Needy (cont.)

1902 (e) (9) of Act

☐ (x) Respiratory care services are provided to ventilator-dependent individuals as indicated in item 3.1 (h) of this plan.

1905 (a) (23) and 1929 of the Act

☐ (xi) Home and Community Care for Functionally Disabled and Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Attachment 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

PACE State Plan Amendment Pre-Print

Citation		
3.1(a)(2)		Amount, Duration, and Scope of Services: Medically Needy (continued)
1905(a)(26) and 1934 of the Act	☒	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

Attachment 3.1-B identifies the medical and remedial services provided to the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage – that is in excess of established service limits – for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Citation 3.1 (a) (4) Amount, Duration, and Scope of Services: Other Required Special Groups: Qualified Medicare Beneficiaries (cont.)

1902 (a) (10) (E) (iv) (II) 1905 (p) (3) (A) (iv) (II), 1905 (p) (3) the Act

(iv) Other Required Special Groups: Qualifying Individuals-2

The portion of the amount of increase to the Medicaid Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902 (a) (10) (E) (iv) (II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

1925 of the Act

(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

Citation 3.1 Amount, Duration, and Scope of Services (cont.)

(a) (3) Other Required Special Groups: Qualified Medicare Beneficiaries

1902 (a) (10) (E), (i) and clause (VIII) of the matter following (F), and 1905 (p) (3) of the Act

Medicare cost sharing for qualified Medicare beneficiaries described in section 1905 (p) of the Act is provided only as indicated in item 3.2 of this plan.

1902 (a) (10) (E) (ii) and 1905 (a) of the Act

(4) (i) Other Required Special Groups: Qualified Disabled and Working Individuals

Medicare Part A premiums for qualified disabled and working individuals described in section 1902 (a) (10) (E) (ii) of the Act are provided as indicated in item 3.2 of this plan.

1902 (a) (10) (E) (iii) and 1905 (p) (3) (A) (ii) of the Act

(ii) Other Required Special Groups: Specified Low-Income Medicare Beneficiaries

Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902 (a) (10) (E) (iii) of the Act are provided as indicated in item 3.2 of this plan.

1902 (a) (10) (E) (iv) (I) 1905 (p) (3) (A) (ii), and 1933 of the Act

(iii) Other Required Special Groups: Qualifying Individuals-1

Medicare Part B premiums for qualifying individuals described in 1902 (a) (10) (E) (iv) (I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

State Plan under Title XIX of the Social Security Act
State: Massachusetts

Citation

3.1 (a) Amount, Duration, and Scope of Services (cont.)

Sec. 245A (h) of the Immigration and Nationality Act

(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved state Medicaid plan are provided the services covered under the plan if they:

(A) are aged, blind, or disabled individuals as defined in section 1614 (a) (1) of the Act;

(B) are children under 18 years of age; or

(C) are Cuban or Haitian entrants as defined in section 501 (e) (1) and (2) (A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53 (b), aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1 (a) (6) (i) (A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved state plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Citation 3.1 Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (cont.)

1902 (a) and 1903 (v) of the Act

(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a state supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903 (v) (3) of the Act.

1905 (a) (9) of the Act

(7) Homeless Individuals

Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.

1902 (a) (47) and 1920 of the Act

☒ (8) Presumptively Eligible Pregnant Women

Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State Plan.

42 CFR 441.55
50 FR 43654
1902 (a) (43), 1905 (a) (4) (B), and 1905 (r) of the Act

(9) EPSDT Services

The Medicaid agency meets the requirements of sections 1902 (a) (43), 1905 (a) (4) (B), and 1905 (r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

Citation 3.1 (a) (9) Amount, Duration, and Scope of Services: EPSDT Services (cont.)

42 CFR 441.60

☒ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.

The Department's Managed Care Unit has in place, through its purchasing specifications and utilization reporting, methods to ensure that continuing care providers have complied with their agreements, including EPSDT requirements.

42 CFR 440.240 and 440.250

(a) (10) Comparability of Services

1902 (a) and 1902 (a) (10), 1902 (a) (52) 3 (v), 1915 (g) and 5 (b) (4) of the Act

Except for those items or services for which sections 1902 (a),1902 (a) (10), 1903 (v), 1915 and 1925 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

☒ (iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

Citation

42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

3.1 (b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or older.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

☒ Yes.

☐ Not applicable. The State Plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy.

☒ Yes, to all.

☐ Yes, to individuals age 21 or over; SNF services are provided.

☐ Yes, to individuals under age 21; SNF services are provided.

☐ No, SNF services are not provided.

☐ Not applicable; the medically needy are not included under this plan.

Citation 3.1 Amount, Duration, and Scope of Services (cont.)

42 CFR 431.53 (c) (1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in **Attachment 3.1-D**.

42 CFR 483.10 (2) Payment for Nursing Facility Services

The state includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

Citation

42 CFR 440.260
AT-78-90

3.1 Amount, Duration, and Scope of Services (cont.)

(d) Methods and Standards to Assure Quality of Services

The standards established and the methods used to assure high quality care are described in **Attachment 3.1-C**.

Citation

3.1 Amount, Duration, and Scope of Services (cont.)

42 CFR 441.20
AT-78-90

(e) Family Planning Services

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

Citation 3.1 Amount, Duration, and Scope of Services (cont.)

42 CFR 441.30
AT-78-90

(f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

☐ Yes.

☐ No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

☒ Not applicable. The conditions in the first sentence do not apply.

1903 (i) (1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

☐ No.

☒ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at **Attachment 3.1-E.**

Citation

3.1 Amount, Duration, and Scope of Services (cont.)

42 CFR 431.110 (b)
AT-78-90

(g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110 (b), on the same basis as other qualified providers.

1902 (e) (9) of the Act.
P.L. 99-509 (Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902 (e) (9) (C) of the Act, are provided under the plan to individuals who:

(1) are medically dependent on a ventilator for life support at least six hours per day;

(2) have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs, or ICFs for the lesser of:

☐ 30 consecutive days;

☐ __ days (the maximum number of inpatient days allowed under the State Plan);

(3) except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) have adequate social support services to be cared for at home; and

(5) wish to be cared for at home.

☐ Yes. The requirements of section 1902 (e) (9) of the Act are met.

☒ Not applicable. These services are not included in the plan.

Citation

3.2 Coordination of Medicaid with Medicare with Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902 (a) (10) (E) (i) and 1905 (p) (1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group as defined in Item A.25 of **Attachment 2.2-A**, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-in agreement for:

☒ Part A ☒ Part B

☐ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Citation

1902 (a) (10) (E) (ii) and 1905 (a) of the Act

(ii) Qualified Disabled and Working Individual (QDWI)

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in **Attachment 4.18-E**, for individuals in the QDWI group defined in item A.26 of **Attachment 2.2-A** of this plan.

1902 (a) (10) (E) (iii) and 1905 (p) (3) (A) (ii) of the Act

(iii) Specified Low-Income Medicare Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of **Attachment 2.2-A** of this plan.

1902 (a) (10) (E) (iv) (I) 1905 (p) (3) (A) (ii), and 1933 of the Act

(iv) Qualifying Individual-1 (QI-1)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902 (a) (10) (E) (iv) (I) and subject to 1933 of the Act.

1902 (a) (10) (E) (iv) (II) 1905 (p) (3) (A) (ii), and 1933 of the Act

(v) Qualifying Individual-2 (QI-2)

The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902 (a) (10) (E) (iv) (II) and subject to 1933 of the Act.

Citation

1843 (b) and 1905 (a) of the Act and 42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

☒ All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); (b) receiving State supplements under title XVI, or (c) within a group listed at 42 CFR 431.625 (d) (2).

☒ Individuals receiving title II or Railroad Retirement benefits.

☒ Medically needy individuals (FFP is not available for this group).

1902 (a) (30) and 1905 (a) of the Act

(2) Other Health Insurance

☐ The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

Citation 3.2 (2) Coordination of Medicaid with Medicare with Other Insurance (cont.)

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902 (a) (30), 1902 (n), 1905 (a), and 1916 of the Act

Supplement 1 to **Attachment 4.19-B** describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a) (10) (E) (i) and 1905 (p) (3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902 (a) (10), 1902 (a) (30), and 1905 (a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2 (a) (1) (iv), payment is made as follows:

42 CFR 431.625

☐ For the entire range of services available under Medicare Part B.

☒ Only for the amount, duration, and scope of services otherwise available under this plan.

1902 (a) (10), 1902 (a) (30), 1905 (a), and1905 (p) of the Act

(iii) Dual Eligible — QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

Citation 3.2 (2) Coordination of Medicaid with Medicare with Other Insurance

1906 of the Act

(c) Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations

The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State Plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans and cost-effective student health insurance coverage offered in the individual market.

When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State Plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22 (h).

1902 (a) (10) (F) of the Act

(d) ☒ The Medicaid agency pays premiums for individuals described in item 19 of **Attachment 2.2-A**.

Citation

42 CFR 441.101,
42 CFR 431.620 (c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☒ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620 (c) and (d) are met.

☐ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

Citation	3.4 Special Requirements Applicable to Sterilization Procedures
42 CFR 441.252 AT-78-99	All requirements of 42 CFR Part 441, Subpart F are met.

Citation

3.5 Families Receiving Extended Medicaid Benefits

1902 (a) (52) and 1925 of the Act

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope of services provided to categorically needy AFDC recipients as described in **Attachment 3.1-A** (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are:

☒ Equal in amount, duration, and scope of services provided to categorically needy AFDC recipients as described in **Attachment 3.1-A** (or may be greater if provided through a caretaker relative employer's health insurance plan).

☐ Equal in amount, duration, and scope of services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

- ☐ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
- ☐ Medical or remedial care provided by licensed practitioners.
- ☐ Home health services.

Citation 3.5 Families Receiving Extended Medicaid Benefits (cont.)

- ☐ private duty nursing services
- ☐ physical therapy and related services
- ☐ other diagnostic, screening, preventive, and rehabilitation services
- ☐ Inpatient hospital services and nursing facility services for
- ☐ individuals 65 years of age and over in an institution for mental disease
- ☐ Inpatient psychiatric services for individuals under age 21
- ☐ Hospice services
- ☐ Respiratory care services
- ☐ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary

Citation

3.5 Families Receiving Extended Medicaid Benefits (cont.)

(c) ☐ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance:

☐ First six months ☐ Second six months

☐ The agency requires caretakers to enroll in employer's health plans as a condition of eligibility.

☐ First six months ☐ Second six months

(d) ☒ (1) The Medicaid agency provides assistance to families during the second six-month period of extended Medicaid benefits through the following alternative methods.

☐ Enrollment in the family option of an employer's health plan.

☐ Enrollment in the family option of a state employee health plan.

☐ Enrollment in the state health plan for the uninsured.

☒ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Citation 3.5 Families Receiving Extended Medicaid Benefits (cont.)

Supplement 2 to Attachment 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency:

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

☒ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

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Citation

3.9 Reimbursements for Prescribed Drugs

1902 (a) (54)
1903 (i) (10)
1927
P.L. 101-508
(s. 4401)

The state meets all the requirements applicable to reimbursement for prescribed drugs.

1. Inpatient hospital services other than those provided in an institution for mental diseases.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

2. a. Outpatient hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4). (Effective 4/1/90, see **Attachment 4.19-B**, 2 A I (90-14).)

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

3. Other laboratory and x-ray services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

*Description provided on **Supplement to Attachment 3.1-A**.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
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4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

c. Family planning services and supplies for individuals of child-bearing age.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

d.1 Face-to-face tobacco cessation counseling services for pregnant women provided:

☒ (i) By or under supervision of a physician**;
☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services;** or
☐ (iii) Any other healthcare professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.

** Describe if there are any limits on who can provide these counseling services

All healthcare professionals except physicians, registered nurses, certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, clinical nurse specialists and physician assistants must complete a training course to provide tobacco cessation counseling services. Healthcare professionals must be under the supervision of a physician if required under state law.

d.2 Face-to-face tobacco cessation counseling services benefit package for pregnant women

☒ Provided: ☐ No limitations ☒ With limitations**

** Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.

Please describe any limitations:
Prior authorization is required for more than a total of 16 group and individual counseling sessions per member per 12 month cycle. Prior authorization is required for more than two intake sessions (quit attempts) per member per 12 month cycle.

*Description provided on **Supplement to Attachment 3.1-A**

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5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Medical and surgical services furnished by a dentist (in accordance with section 1905 (a) (5) (B) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

6. Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law.

a. Podiatrists' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on **Supplement to Attachment 3.1-A**.

b. Optometrists' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Chiropractors' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Other practitioners' services.

☒ Provided: Identified on attached sheet with description of limitations, if any.
☐ Not provided.

e. Audiologists' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

f. Midlevel Practitioner Services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

7. Home health services.

a. Intermittent or part time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☒ No limitations ☐ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☒ No limitations ☐ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations*

* Limitations are described in **Supplement to Attachment 3.1-A**.

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

8. Private duty nursing services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Limitations are described in **Supplement to Attachment 3.1-A**.

9. Clinic services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

10. Dental services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

11. Physical therapy and related services.

a. Physical therapy

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Occupational therapy.

☒ Provided: ☐ No limitations ☒ With limitations*

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Description provided on **Supplement to Attachment 3.1-A**.
** See Page 3 of **Supplement to Attachment 3.1-A**.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Dentures.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

* Description provided on **Supplement to Attachment 3.1-A**.

b. Screening services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

c. Preventive services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

d. Rehabilitative services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Skilled nursing facility services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

c. Intermediate care facility services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

* Description provided on **Supplement to Attachment 3.1-A**.

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902 (a) (31) (A) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

16. Inpatient psychiatric facility services for individuals under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided

18. Hospice care (in accordance with section 1905 (o) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

☒ Provided in accordance with section 2302 of the Affordable Care Act

* Description provided on **Supplement to Attachment 3.1-A**.

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, **Supplement 1 to Attachment 3.1-A** (in accordance with Section 1905 (a) (19) or Section 1915 (g) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Special tuberculosis (TB) related services under section 1902 (z) (2) (F) of the Act.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

☐ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

☐ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.
* Description provided on **Supplement to Attachment 3.1-A**.

21. Ambulatory prenatal care for pregnant women furnished during a presumption eligibility period by a qualified provider (in accordance with section 1920 of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

22. Respiratory care services (in accordance with section 1902 (e) (9) (A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

23. Pediatric or family nurse practitioners' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Description provided on **Supplement to Attachment 3.1-A**.

24. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations**
☐ Not provided.

Brokered Transportation

MassHealth provides non-emergency transportation to MassHealth Standard, CommonHealth and CarePlus members through selective broker contracts when no public transportation is available that is suitable to a member's condition within a specified distance from an authorized point of origin and destination. Payment for the non-emergency transportation services arranged through a broker is claimed as medical assistance. Delivery methods consist of ambulatory and non-ambulatory transport, including taxi, livery, ferry, and chair car service, or other methods suitable to the member's condition. MassHealth requires prior authorization to determine the medical necessity of non-emergency transportation provided through the brokerage system. Transportation requests are approved by EOHHS and implemented by the brokers. The state will operate the broker program without regard to freedom of choice of providers (section 1902(a)(23) of the Social Security Act).

The state assures that the six Regional Transit Authorities that serve as transportation brokers were selected by the MassHealth agency pursuant to a competitive procurement conducted consistent with federal requirements, and based on the state's evaluation of the broker's experience, performance, references, resources, qualifications, and cost. Each broker is responsible for arranging with its contracted network of transportation providers to deliver non-emergency transportation to and from medically necessary MassHealth covered services for members in the broker's contractually designated service area.

The state assures that its brokerage contracts are subject to regular auditing and oversight by the state to ensure the quality and timeliness of the transportation services provided, and the adequacy of beneficiary access to medical care and services. In addition, the state requires each broker to undertake extensive oversight activities with respect to its network of transportation providers, and assures that brokers have oversight procedures to monitor beneficiary access and complaints and ensure that transportation is timely and transport personnel are licensed, qualified, competent and courteous.

The state assures that transportation services will be provided under contracts with brokers who comply with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate). The brokerage contract requires the brokers to comply with 42 CFR § 440.170(a)(4) governing the provision of non-emergency medical transportation, including prohibitions on referrals and conflicts of interest, and provides for the broker to be liable for the full cost of services resulting from a prohibited referral or relationship, as specified in the contracts. Specifically, the brokers are prohibited from directly providing non-emergency medical transportation services, and are prohibited from making a referral or subcontracting to a transportation service provider if the broker has a financial relationship with the transportation provider, as defined at 42 CFR § 411.354(a); or if the broker has an immediate family member, as defined at 42 CFR § 411.351, that has a direct or indirect financial relationship with the transportation provider.

The brokerage contract prohibits the broker from withholding necessary transportation from a MassHealth member for the purpose of financial gain or any other purpose; authorizing transportation that is not the most appropriate and a cost effective means of transportation for that member for the purpose of financial gain or any other purpose; soliciting or accepting any payment or other form of remuneration, including any kickback, rebate, cash, gift, or service in kind from a transportation provider or any other party in order to influence referrals or subcontracting for non-emergency medical transportation provided to a MassHealth member.

Payments under the brokerage contracts are structured to ensure cost-effectiveness. Brokers are required to competitively procure and contract with their network of transportation providers and develop competitive methods of awarding trips and routes to transportation providers. Brokers schedule trips with the lowest cost qualified transportation provider, and the brokers receive reimbursement at cost from the state for their payments to transportation providers.

Brokers are paid a broker-specific average monthly trip cost for each eligible trip. For demand-response trips, the average monthly trip cost is calculated by dividing the broker's total expenditures for demand-response trips by the number of demand-response trips in that month. For program based trips, the average monthly trip cost for each broker is calculated by first determining route-specific average monthly trip rates, and then calculating a combined average trip rate for all routes. To further encourage cost savings, brokers also receive a shared ride incentive payment if they can achieve a target rate of shared ambulatory trips.
A fixed monthly broker management fee paid under the brokerage contract is claimed as an administrative expense. The broker management fee is negotiated between EOHHS and the broker based on the broker's reasonable costs of performing the broker management function, exclusive of direct transportation costs.

The source of the non-federal share of payments for brokered transportation services to MassHealth members is general fund appropriations to the state Medicaid agency.

****** Description of non-brokered transportation is provided on **Attachment 3.1-D**

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided.

c. Care and services provided in Christian Science sanitoria.

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided.

f. Critical Access Hospital Services

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided.

* Description provided on **Supplement to Attachment 3.1-A**.

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25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in **Supplement 2 to Attachment 3.1-A**, and Appendices A-G to **Supplement 2 to Attachment 3.1-A**.

☐ Provided ☒ Not provided.

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Item 26: Personal Care Services

Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

☒ Provided:
- ☒ State Approved (Not Physician) Service Plan Allowed
- ☒ Services Outside the Home Also Allowed
- ☒ Limitations Described on Supplement to Attachment 3.1-A

☐ Not provided

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27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in **Supplement 3 to Attachment 3.1-A**.

☒ Election of PACE: by virtue of this submittal, the state elects PACE as an optional State Plan service.

☐ No election of PACE: by virtue of this submittal, the state elects to not add PACE as an optional State Plan service.

28. Freestanding Birth Center Services

i. Licensed or Otherwise State-Approved Freestanding Birth Centers

☒ Provided: ☐ No limitations ☒ With limitations

☐ None licensed or approved

Please describe any limitations:

Freestanding birth center services are covered for women with low risk pregnancies. Freestanding birth center services include care during pregnancy, labor, delivery, and recovery following delivery, including newborn nursery and post-partum care.

ii. Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

☒ Provided: ☐ No limitations ☒ With limitations

☐ Not applicable (There are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

The limitations to the practitioners' services are the same limitations as noted in their respective section of the State Plan.

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan: Physicians, and certified nurse midwives.

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

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Item 1: **Inpatient Hospital Services**

1. Utilization Management: As a condition of payment, MassHealth requires preadmission screening for all elective admissions to acute hospitals and for all admissions to a chronic disease and rehabilitation hospital, except for members with other insurance (including Medicare).
2. Prior Authorization: MassHealth requires prior authorization for certain acute inpatient hospital services based on medical necessity, including certain drugs and biologics administered in the acute inpatient hospital setting.

Item 2.a: **Outpatient Hospital Services**

MassHealth requires prior authorization for certain outpatient hospital services based on medical necessity, including for more than 20 occupational therapy visits, 20 physical therapy visits, or 35 speech/language therapy visits, including group-therapy visits, for a member within a 12-month period; and for certain drugs and biologics administered in the acute outpatient hospital setting.

DEP/ESPs provide crisis assessment, stabilization, special services and other interventions in advance of a hospital admission for psychiatric treatment. Such services are available 24 hours a day, 7 days a week in order to ensure appropriate access to inpatient hospitalization and diversion from inpatient hospitalization when possible. To qualify as a DEP/ESP, a provider of hospital services must be designated as such by the Commonwealth.

Item 4.a: **Nursing Facilities Services**

If a utilization review team recommends that a recipient in a multi-level long-term-care facility be changed to a lower level of care, the facility is responsible for relocating a recipient to the recommended level of care within the facility. The recipient has the right to appeal the recommendation.

Item 4b: Early and Periodic Screening, Diagnostic and Treatment services for individuals under 21 years of age, and treatment of conditions found.

In addition to all other medically necessary services covered for individuals under age 21, the following services are covered as Rehabilitation services as defined in 42 USC 1396d (a) (13). These services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual:

a. Mobile Crisis Intervention (Services described in this section are effective July 1, 2009.)

Mobile Crisis Intervention provides a short term service that is mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health (mental health or substance abuse) crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Services are available 24 hours a day, 7 days a week. Phone contact and consultation may be provided as part of the intervention. Mobile crisis services may be provided by a single crisis worker or by a team of professionals that are qualified providers who are trained in crisis intervention.

Mobile Crisis Intervention includes the following activities when performed to resolve the immediate crisis:

- Assessment;
- Crisis counseling including individual and family counseling;
- Clinical consultation and coordination with other health care providers;
- Psychopharmacological management, including availability of on-site prescriber;
- Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support;
- Development of a risk management/safety plan. In cases where the youth does not already have such a plan, Mobile Crisis Intervention creates a risk management/safety plan in concert with the parent(s)/guardian(s)/caregiver(s) and any existing service providers (e.g., ICC, In-Home Therapy Services, outpatient therapist); and
- Referral to other services as needed.

Settings: Mobile Crisis Intervention is provided where the child is located.

Providers: Components of Mobile Crises Crisis Intervention are provided by practitioners, as described below. Practitioners must be working under an employment or contractual arrangement with one of the following: outpatient hospitals, community health centers, mental health centers and other clinics.

- **Assessment** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns

- **Crisis counseling including individual and family counseling** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, bachelor-level counselors/paraprofessionals, LADC Is
- **Clinical consultation and coordination with other health care providers** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, bachelor-level counselors/paraprofessionals, LADC Is

- **Psychopharmacological management** - Psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, board-certified or board-eligible child psychiatrists, psychiatry residents.

- **Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, associate-level counselors/paraprofessionals, bachelor-level counselors/paraprofessionals, LADC Is, LADC IIs, LADC IIIs, LSWs, and LSWAs.

- **Development of a risk management/safety plan** -LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns

- **Referral to other services as needed:** LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, associate-level counselors/paraprofessionals, bachelor-level counselors/paraprofessionals, CADACs, CADAC IIs, LADC Is, LADC IIs, LADC IIIs, LSWs, and LSWAs.

b. In-Home Behavioral Services: (Services described in this section are effective October 1, 2009.)

This service provides for the development of a highly specific behavior plan; supervision and coordination of interventions; and training other interveners to address specific behavioral objectives or performance goals in order to treat challenging behaviors that interfere with the youth's successful functioning. An In-Home Behavioral service includes two components: behavior management therapy and behavior management monitoring. It is delivered by one or more members of a team of qualified providers consisting of professional and paraprofessional staff.

1. Behavior management therapy: Behavior management therapy includes activities that are required to develop, implement, monitor and update a behavior plan, including overseeing activities of the behavior management monitor. Behavior management therapy is performed by a licensed clinician who meets the qualifications of a Behavior management therapist as described in the provider qualifications section below.

   Behavior management therapy includes the following:

   - Functional behavioral assessment;
   - Development of a focused behavior plan that identifies specific behavioral and measurable objectives or performance goals and interventions that are designed to diminish, extinguish, or improve specific behaviors related to a youth's behavioral health (mental health or substance abuse) condition(s);
   - Development or revision of a youth's risk management/safety plan to address the specific behavioral needs of the youth;
   - Counseling the parent(s)/guardian(s)/caregiver(s) on how to implement strategies identified in the behavior plan;
   - Working closely with the behavior management monitor to ensure the behavior plans and risk management/safety plan are implemented as developed, and to make any necessary adjustments to the plans;
   - Clinical consultation and coordination with other behavioral health (mental health or substance abuse) care providers; and
   - Referral to other services as needed.

2. Behavior management monitoring. This service includes activities related to the implementation of the behavior plan and a risk management/safety plan as needed. Behavioral management monitoring also includes monitoring the youth's behavior, reinforcing implementation of the behavior plan by the parent(s)/guardian(s)/caregiver(s), and reporting to the behavior management therapist on implementation of the behavior plan and progress toward behavioral objectives or performance goals.

   Behavioral management monitoring is performed by a paraprofessional who meets the qualifications of a behavior management monitor as described in the definitions section below.

   Behavior management monitoring includes the following:

   - Monitoring the youth's progress on implementation of the goals of the behavior plan developed by the behavior management therapist;
   - Assisting the youth in implementing the goals of the behavior plan developed by the behavioral management therapist;
   - Providing guidance to the parent(s)/guardian(s)/caregiver(s) in implementing the plan; and
   - Working closely with the behavior management therapist to ensure the behavior plans and risk management/safety plan are implemented as developed.

Settings: In-Home Behavioral Services may be provided in any setting where the child is naturally located including, but not limited to, the home (including foster homes and therapeutic foster homes), schools, child care centers, and other community settings.

Providers The following practitioners may provide any component of behavior management therapy as described above: Developmental-behavioral pediatricians, developmental-behavioral pediatric fellows, LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns and social work interns. Behavior management monitors may provide any component of behavior management monitoring as described above.

Qualified Practitioners of behavior management therapy also must have two years relevant experience providing direct services to youth and families who require behavior management to address behavioral health (mental health or substance abuse) needs; course work and training in conducting functional behavioral assessments, and selecting, implementing and evaluating intervention strategies; supervised experience conducting functional behavioral assessments and designing, implementing, and monitoring behavior analysis programs for clients and other qualifications established by the state. Practitioners must be working under an employment or contractual agreement with one of the following: outpatient hospitals, community health centers, mental health centers, other clinics, and private agencies certified by the Commonwealth. .

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c. In-Home Therapy Services: (Services described in this section are effective November 1, 2009.)

This service provides for the development of an individualized treatment plan; supervision and coordination of interventions for the purpose of treating the youth's mental health and substance abuse needs. The intervention is designed to enhance and improve the family's capacity to improve the youth's functioning in the home and community and may prevent the need for the youth's admission to an inpatient hospital, psychiatric residential treatment facility or other treatment setting. This service is delivered by one or more members of a team of qualified providers consisting of professional and paraprofessional staff, offering a combination of medically necessary in home therapy and therapeutic training and support.

1.

In Home Therapy: In-home therapy is a structured, consistent, strength-based therapeutic relationship between a licensed clinician and the youth and family. The licensed clinician, in collaboration with the family and youth, develops an individualized treatment plan and, using established psychotherapeutic techniques, and intensive family therapy works with the entire family or a subset of the family to implement focused structural or strategic interventions to advance therapeutic goals. In addition, the clinician assists in identifying and utilizing community resources and develops and maintains natural supports for the youth and parent(s)/guardian(s)/caregiver(s) in order to promote sustainability of treatment gains. Phone contact and consultation are provided as part of the intervention. In-Home therapy is performed by a licensed clinician who meets the qualifications of an in-home therapist as described section below.

In-Home Therapy includes the following:

- Assessments;
- Development of an individualized treatment plan by the qualified practitioner in partnership with the youth and parent(s)/guardian(s)/caregiver(s) and, with required consent, in consultation with other providers that is designed to address the youth's mental health or substance abuse condition;
- Ongoing monitoring and modification of the individualized treatment plan as indicated;
- Review/development of a risk management/safety plan;
- Phone and face-to-face consultation with other providers, individuals and entities who may impact the youth's treatment plan;
- Family counseling through which the licensed clinician works with the entire family, or a subset of the family, to advance therapeutic goals; and
- Referral to other services as needed.

2. Therapeutic training and support is a service provided by an associate-level or bachelor-level paraprofessional working under the supervision of a clinician to support implementation of the in-home therapists treatment plan in order to achieve the goals of the that plan. The paraprofessional assists a licensed clinician in implementing the therapeutic objectives of the individualized treatment plan. Phone contact and consultation may be provided as part of the intervention.

   Therapeutic training and support includes the following:

   - Providing guidance to the youth and parent(s)/guardian(s)/caregiver(s) in implementing the treatment plan;
   - Providing skills training for youth and parent(s)/guardian(s)/caregiver(s) in support of the treatment plan goals; and
   - Monitoring the youth's and parent(s)/guardian(s)/caregiver(s) progress on achieving treatment plan goals and communicating regularly with the clinician so that the treatment plan can be modified and necessary.

   Settings: In home therapy services may be provided in any setting where the child is naturally located including, but not limited to, the home (including foster homes and therapeutic foster homes), schools, child care centers, and other community settings.

   Providers: The following practitioners may provide any component of in-home therapy as described above: In-home therapy services are delivered by the following practitioners: LICSW, LCSW, LMFT, LMHC, Licensed psychologist, Master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinic specialists trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns. The following practitioners may provide any component of therapeutic training and support as described above: Associate-level counselors / paraprofessionals, bachelor-level counselors / paraprofessionals. Practitioners must be working under an employment or contractual arrangement with one of the following outpatient hospitals, community health centers, mental health centers, other clinics and private agencies certified by the Commonwealth. .

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d. Therapeutic Mentoring Services: (Services described in this section are effective October 1, 2009.)

Therapeutic mentoring services are structured, one-to-one, strength-based services that are designed to help ameliorate behavioral health (mental health or substance abuse) related conditions which prevent the youth from appropriate social functioning. These services must be delivered according to an individualized treatment plan developed by either an outpatient clinician, an in-home therapy clinician or, for youth enrolled in Intensive Care Coordination, a care planning team. Progress toward meeting the identified goal(s) must be documented and reported regularly to the provider responsible for the youth's treatment plan.

The therapeutic mentor does not provide social, educational, artistic, athletic, recreational or vocational services.

Settings: Therapeutic mentoring services are provided to youth in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), school, child care centers and other community settings. .

Providers: Therapeutic mentoring services are delivered by therapeutic mentors. Practitioners must be working under an employment or contractual arrangement with on of the following: outpatient hospitals, community health centers, mental health centers, other clinics, and private agencies certified by the Commonwealth**.** Providers of therapeutic mentoring utilize therapeutic mentors to provide these services.

e **Family Support and Training:** (Services described in this section are effective July 1, 2009.)

A family support and training partner addresses goals established in an individualized treatment plan in order to resolve or ameliorate the youth's mental health, behavioral and emotional needs through enhancing the capacity of the parent(s)/guardians/caregivers) to implement activities required to meet the goals of the plan. Family support and training is a skill-building support and not a form of therapy or counseling. The individualized treatment plan must be developed by either an outpatient clinician, an In-home therapy clinician or, for youth enrolled in Intensive Care Coordination, a care planning team. These services include the following when they are relevant to the goals in the youth's individualized care plan:

- providing guidance to parent(s)/guardians(s)/caregiver(s) on navigating systems that support youth with mental health, behavioral and emotional needs, such as working effectively with state agency case managers, school system officials, provider agency staff and clinicians;
- fostering empowerment of parent(s)/guardian(s)/caregiver(s) by offering supportive guidance for parents of youth with mental health needs and encouraging participation in peer/parent support and` self-help groups;
- providing guidance to the parent(s)/guardian(s)/caregiver(s) how to find, access and use formal and informal community-based resources (e.g., after-school programs, food assistance, housing resources, youth-serving systems, etc.); and
- modeling these skills for parent(s)/guardians(s)/caregiver(s).

Family support and training services do not include respite care or child care services.

Settings: Family support and training services are provided in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and other community settings.

Providers: Family support and training services are delivered by a family support and training partner. A family support and training partner must be working under an employment or contractual arrangement with one of the following: outpatient hospitals, community health centers, mental health centers, other clinics and private agencies certified by the Commonwealth. .

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Definitions:

Associate-level counselors/paraprofessional
Associate-level counselors/paraprofessionals must have an associate's degree in a human services field from an accredited academic institution and one (1) year of relevant experience working with families or youth. If the associate's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Associate-level counselors/paraprofessionals are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Bachelor-level counselors/paraprofessional
Bachelor-level counselors/paraprofessionals must have a bachelor's degree in a human services field from an accredited academic institution and one year of relevant experience working with families or youth. If the bachelor's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Bachelor-level counselors/paraprofessionals are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Behavior Management Monitor
Behavioral management monitors must have a bachelor's degree in a human services field from an accredited university and one (1) year of relevant experience working with families, children or adolescents who require behavior management, or an associate's degree and a minimum of two (2) years of relevant experience working with families, children or adolescents who require behavior management. Behavior management monitors are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist..

Certified Alcoholism/Drug Abuse Counselor (CADAC)
Certified by the private Massachusetts Board of Substance Abuse Counselor Certification (MBSACC). CADAC certification requires a combination of either a Master's degree in a "behavioral science area" and 2,000 hours of supervised experience or a Bachelor's degree in a behavioral science area and 4,000 hours of supervised experience or an Associates' degree in a behavioral science area and 6,000 hours of supervised experience. Certification also requires documentation of having received a minimum of 270 clock hours of continuing education related to the five domains for alcohol and other drug abuse. Consistent with applicable state licensure requirements, certified alcoholism/drug abuse counselors are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Certified Alcoholism/Drug Abuse Counselor II (CADAC II)
Certified by the private Massachusetts Board of Substance Abuse Counselor Certification (MBSACC). CADAC II certification requires a master's degree (or higher) from a regionally accredited academic institution in a human services behavioral sciences field with a clinical application (i.e., practicum); 2,000 hours of supervised experience and documentation of completion of 300-hour practicum. Consistent with applicable State licensure requirements, certified alcoholism/drug abuse counselor IIs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist..

Developmental-Behavioral Pediatrician
A person with a current, valid, unrestricted license to practice medicine issued by the Massachusetts Board of Registration in Medicine, who is board-certified in Pediatrics and either board-eligible or board-certified in Developmental-Behavioral Pediatrics

Developmental-Behavioral Pediatric Fellow
A person with a current, valid, unrestricted license to practice medicine issued by the Massachusetts Board of Registration in Medicine, who is board-certified in Pediatrics and enrolled in a training program in Developmental-Behavioral Pediatrics accredited by the Accreditation Council for Graduate Medical Education (ACGME). Services provided by the Developmental-Behavioral Pediatric Fellow must be provided in a setting approved for training by the sponsoring training institution, under supervision of a board certified or eligible Developmental-Behavioral Pediatrician, consistent with applicable state licensure requirements.

Family Support and Training Partner
A family support and training worker must have experience as a caregiver of a youth with special needs, preferably youth with behavioral health needs, experience in navigating any of the youth and family-serving systems and teaching family members who are involved with the youth and family serving systems, and either: a bachelor's degree in a human services field from an accredited academic institution, or an associate's degree in a human services field from an accredited academic institution and one (1) year of experience working with children/adolescents/transition-age youth and families, or a high school diploma or General Education Development (GED) and a minimum of two (2) years of experience working with children/adolescents/transition age youth and families. If the bachelor's or associate's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Family partners are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Alcohol and Drug Counselor I – LADC I
A person licensed by the Department of Public Health to conduct an independent practice of alcohol and drug counseling, and to provide supervision to other alcohol and drug counselors, as defined in 105 CMR 168.000. These requirements include: a master's or doctoral degree in behavioral sciences, a minimum of 270 hours of training in substance abuse counseling, 300 hours of supervised practical training and 6,000 hours of supervised alcohol and drug counseling work experience.

Licensed Alcohol and Drug Counselor II – LADC II
A person licensed by the Department of Public Health to practice alcohol and drug counseling under clinical supervision, as defined in 105 CMR 168.000. These requirements include: a high school diploma or equivalent, a minimum of 270 hours of training in substance abuse counseling, 300 hours of supervised practical training and 6,000 hours of supervised alcohol and drug counseling work experience (4,000 if applicant holds a bachelor's degree). Consistent with applicable state licensure requirements, LADC IIs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Alcohol and Drug Counselor Assistant – LADC III
A person licensed by the Department of Public Health to provide recovery based services under direct clinical and administrative supervision, as defined in 105 CMR 168.000. These requirements include a high school diploma or equivalent, 2,000 hours of work experience in the alcohol or drug abuse field and a minimum of 50 hours of training in substance abuse counseling. Consistent with applicable state licensure requirements LACD IIIs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Independent Clinical Social Worker (LICSW)
A person with a current, valid, unrestricted license to practice as an LICSW, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: master's or doctoral degree in Social Work from a program accredited by the Council on Social Work Education and two years supervised experience.

Licensed Clinical Social Worker (LCSW)
A person with a current, valid, unrestricted license to practice as an LCSW, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: master's or doctoral degree in Social Work from a program accredited by the Council on Social Work Education. Consistent with applicable state licensure requirements, LCSWs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Social Worker (LSW)
A person with a current, valid, unrestricted license to practice as an LSW, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: a bachelor's degree in Social Work from a program accredited by the Council on Social Work Education or a bachelor's degree in any subject and 3500 hours of supervised experience providing social work services. Consistent with applicable state licensure requirements, LSWs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Social Work Associate (LSWA)
A person with a current, valid, unrestricted license to practice as an LSWA, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: an associate degree, or at least sixty credit hours of college education, in the fields of social work, psychology, counseling or other similar human services field, from an accredited college or university; or a baccalaureate degree in any field from an accredited college or university; or a minimum of one thousand (1000) hours of education in social work theory and methods in courses or programs approved by the Board of Registration of Social Workers. Consistent with applicable state licensure requirements, LSWAs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Marriage and Family Therapist (LMFT)
A person with a current, valid, unrestricted license to practice as a LMFT, issued by the Massachusetts Board of Registration of Allied Mental Health Professionals. These requirements include: a master's degree in the mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university and two years supervised experience.

Licensed Mental Health Counselor (LMHC)
A person with a current, valid, unrestricted license to practice as a LMHC, issued by the Massachusetts Board of Registration of Allied Mental Health Professionals. These requirements include: a master's degree in the mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university and two years supervised experience.

Licensed Psychologist
A person with current, valid, unrestricted license to practice psychology issued by the Massachusetts Board of Registration in Psychology. These requirements include a doctoral degree from a program accredited by the American Psychological Association and two years supervised experience .

Marriage and Family Therapy Intern
The marriage and family therapy intern must be a second-year, clinical-track student in a structured field placement that is a component of a master's in marriage and family therapy or a master's in a counseling program that is fully accepted by the Board of Allied Mental Health and Human Services Profession. The marriage and family therapy intern must provide services under the direct supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse, or Nurse Clinical Specialist consistent with applicable state licensure requirements.

Master's Level Counselor
A person with a master's or doctoral degree in a mental health field (including, but not restricted to, counseling, family therapy, social work, psychology, etc.) from an accredited college or university who is supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse, or Nurse Clinical Specialist.

Mental Health Counselor Intern
The Mental Health Counselor Intern must be a second-year, clinical-track student in a structured field placement that is a component of a master's in mental health counseling or a master's in a counseling psychology program that is fully accepted by the Board of Allied Mental Health and Human Services Profession Consistent with applicable state licensure requirements, the Mental Heath Counselor Intern provides services under the supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Psychiatric Nurse
A person with a current, valid, unrestricted license to practice as a registered nurse issued by the Board of Registration in Nursing, a master's degree in the mental health fields and one (1) year of experience delivering mental health services to families and youth. Consistent with applicable state licensure requirements, the Psychiatric Nurse provides services under the supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Psychiatric Nurse Mental Health Clinical Specialist
A person with a current, valid, unrestricted license to practice as a registered nurse issued by the Massachusetts Board of Registration in Nursing and current, valid, unrestricted authorization by the Massachusetts Board of Registration in Nursing to practice as a Psychiatric Nurse Mental Health Clinical Specialist.

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Psychiatric Nurse Mental Health Clinical Specialist Trainee
A person with a current, valid, unrestricted license to practice as a registered nurse issued by the Massachusetts Board of Registration in Nursing who is enrolled in a Psychiatric Nurse Mental Health Clinical Specialist training program recognized by the Massachusetts Board of Registration in Nursing. Consistent with applicable state licensure requirements, services provided by the Psychiatric Nurse Mental Health Clinical Specialist trainee are provided under supervision of a Psychiatric Nurse Mental Health Clinical Specialist.

Psychiatric Resident
A person with a current, valid, full or limited license to practice medicine issued by the Massachusetts Board of Registration in Medicine, who is enrolled in an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency training program in either adult psychiatry or child and adolescent psychiatry. Services provided by the Psychiatric intern are provided in a setting approved for residency training by the sponsoring training institution, under supervision of a board certified or eligible child psychiatrist, consistent with applicable state licensure requirements.

Psychiatrist
A person with a current, valid, unrestricted license to practice medicine issued by the Massachusetts Board of Registration in Medicine. Psychiatrists treating youth ages 0 to 19 shall be board-certified or board-eligible in child and adolescent psychiatry. Psychiatrists treating youth ages 19 to 21 shall be trained in adult psychiatry.

Psychology Intern
The psychology intern must be admitted to doctoral candidacy in a structured clinical, or counseling, American Psychological Association (APA)-approved doctoral program. Consistent with state licensure requirements, services provided by a psychology intern are provided under the direct supervision of a licensed psychologist.

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Pursuant to MGL Chapter 112 §165, applied behavior analysts must be licensed by the Commonwealth of Massachusetts Board of Registration of Allied Mental Health and Human Services Professions. Licensed applied behavior analysts or licensed physicians, psychologists or psychiatrists working under the scope of their practices may bill for applied behavior analyst services provided directly by a licensed assistant applied behavior analysts or a non-licensed para-professional, when the services are performed under the supervision of the licensed applied behavior analyst or licensed physician, psychologist or psychiatrist working under the scope of his or her practice and the provided services are within the scope of practice for a licensed applied behavior analyst.

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Limitations to Services Provided to the Categorically Needy

Item 5: **Physician's Services**

Physician services are provided in accordance with 42 CFR 440.50.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Services that are subject to prior authorization include certain surgery services, including reconstructive surgery and gender reassignment surgery; and certain practitioner-administered drugs. MassHealth covers one application of fluoride varnish every three months for members under 21 years of age without prior authorization; additional applications are covered with medical justification.

See also Supplement to Attachment 3.1-A, p.1, Item 1.

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G. School-Based Services:

School-Based Services (SBS) are services that are listed in a recipient student's Individualized Education Plan (IEP), a section 504 accommodation plan pursuant to 34 C.F.R. § 104.36, an Individualized Health Care Plan, an Individualized Family Service Plan, or are otherwise medically necessary, that are coverable under one or more of the service categories described in Section 1905(a) of the Social Security Act, and that are necessary to correct or ameliorate defects or physical or mental illnesses or conditions discovered by an EPSDT screen.

Service providers shall be licensed or otherwise qualified under the applicable State practice act or comparable licensing criteria by the State Department of Public Health, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them is done by practitioners qualified to make those determinations within their licensed scope of practice.

Covered services include: physical therapy, occupational therapy and other services, including services provided by audiologists and services for individuals with speech, hearing and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR § 440.110; physician services under 42 CFR § 440.50(a); optometry services provided by a qualified professional under 42 CFR § 440.60; respiratory therapy provided by a qualified professional under 42 CFR § 440.60; nursing services coverable under 42 CFR § 440.80 and 42 CFR § 440.60 ordered by a licensed physician and performed by a registered nurse or licensed practical nurse; nursing services provided on a restorative basis under 42 CFR § 440.130(d), including services delegated to individuals who receive appropriate teaching, direction, and supervision from a Registered Nurse or Practical Nurse; fluoride varnish performed by a dental hygienist under 130 CMR § 420.424(b) in accordance with 42 CFR § 440.100; personal care services coverable and performed by individuals qualified under 42 CFR § 440.167; services performed by licensed practitioners within the scope of their practice for individuals with behavioral health (mental health and substance abuse) disorders, as defined under state law, and coverable as medical or other remedial care under 42 CFR § 440.60; diagnostic, screening, preventive, and rehabilitative services covered under 42 CFR § 440.130; medical nutritional services provided by a qualified professional under 42 CFR § 440.60; and sports related or other injury assessment and therapy provided by a qualified professional under 42 CFR § 440.60. Assessments and independent evaluations are covered as necessary to assess or reassess the need for medical services in a child's treatment plan and must be performed by any of the above licensed practitioners within the scope of practice.

Item 6: **Licensed Practitioners Services**

Licensed Practitioner Services are provided in accordance with 42 CFR 440.60.

a. **Podiatrists' Services** – Coverage is for podiatry services that are considered medically necessary. Office visits are limited to one initial visit, one limited visit per 30 day period, one extended visit per 30 day period, and one follow up visit per week. Out of office visits are limited to one visit in a 30 day period in a long-term-care facility or the member's home and two visits in a 30 day period in a hospital setting.

b. **Optometrists' Services** –

Members under age 21 are limited to one comprehensive examination within a 12 month period; additional services are provided when medically necessary. . Members aged 21 or older are limited to one comprehensive eye examination within a 24 month period; additional services are provided when medically necessary.

Services that are subject to prior authorization include: fundus photography; non-plastic prosthetic eyes; unlisted services; and vision training.

Exclusions consist of treatment for congenital dyslexia.

c. **Chiropractic Services** – include chiropractic manipulative treatment and radiology services. Services are limited to medically necessary treatment related to a neuromusculoskeletal condition. The MassHealth agency limits payment for chiropractor services for any combination of office visits and chiropractic manipulative treatments. Any office visits or chiropractic manipulative treatments in excess of 20 per member per calendar year are subject to prior authorization.

d. **Other Practitioners' Services** – Other practitioners' services also include psychologists' services, which are limited to psychological testing only; hearing instrument specialist services and public health dental hygienist services. Hearing instrument specialist services are limited to the practice of fitting and dispensing of hearing aids which means the measurement of human hearing solely for the purpose of making selections, adaptations or sales of hearing aids intended to compensate for impaired hearing. The MassHealth agency does not pay for more than one hearing aid per ear per member in a 60 month period without prior authorization.

Public health dental hygienist services are limited to services provided in public health settings within the scope of practice governed by the Massachusetts Board of Registration in Dentistry and covered by the MassHealth agency.

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State: Massachusetts
Limitations to Services Provided to the Categorically Needy

Item 6: **Licensed Practitioners Services (continued)**

f. Midlevel Practitioner Services – Midlevel practitioner services include the services of certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and psychiatric clinical nurse specialists licensed under state law. The services of all midlevel practitioners are limited to their scope of practice authorized by state law and must be provided in accordance with applicable state licensure and other applicable federal and state requirements.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Limits on covered services can be exceeded when medically necessary, with prior authorization.

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Item 7: **Home Health Services**

c. Medical supplies, equipment, and appliances must be prescribed or ordered by the recipient's physician and must be furnished and claimed directly by appropriate vendors in accordance with the Division's regulations relative to drugs, restorative services, and rehabilitative services. Home health agencies must transmit such prescriptions and orders to vendors who are providers in the Medical Assistance Program.

Item 8: Private Duty Nursing Services

a. Private duty nursing services are provided in accordance with 42 CFR 440.80
b. Private duty nursing services are not provided in a hospital or skilled nursing facility.
c. Private duty nursing services are subject to prior authorization

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State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

Item 9: **Clinic Services**

Clinic Services are covered with limitations, including those specified in Item 9. MassHealth does not cover experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments, or nonmedical services (e.g., vocational and educational services, research).

Specific clinic services covered by MassHealth include the following:

a. Designated Emergency Mental Health Provider

Designated Emergency Mental Health Providers/Emergency Services Programs (DEP/ESPs) provide crisis assessment, interventions, and stabilization services in advance of a hospital admission for psychiatric treatment. Such services are available 24 hours a day, 7 days a week in order to ensure appropriate access to inpatient hospitalization and diversion from inpatient hospitalization when possible. DEP/ESP services are provided in freestanding facilities. DEP/ESPs operate under the direction of a psychiatrist. To qualify as a DEP/ESP, a provider must be designated as such by the Commonwealth.

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State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

(Item 9 Clinic Services, continued)

b. Freestanding Ambulatory Surgery Centers

MassHealth covers the following services in freestanding ambulatory surgery centers (FASCs) - outpatient same-day surgical, diagnostic, and medical services requiring general, local or regional anesthesia, a dedicated operating room, and a postoperative recovery room to patients who require constant medical supervision for a limited amount of time upon completion of the surgery or procedure, and are not expected to require hospitalization or overnight services. FASC services also include anesthesia, laboratory, radiology, drugs, biologicals, equipment, and supplies, related to the provision of the surgery or procedure.

MassHealth covers sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing – and sterilization-related services (including anesthesia, laboratory, radiology, drugs, equipment, and supplies) in FASCs when the member has voluntarily given informed consent in the manner and at the time required by federal law.

MassHealth does not cover the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does cover diagnosis of male or female infertility.

FASCs must obtain prior authorization for FASC services provided out of state when the FASC is located more than 50 miles from the Massachusetts border.

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State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

(Item 9 Clinic Services, continued)

c. Family Planning Clinics

MassHealth covers family planning-related services, including medical examinations, counseling, follow-up health care, laboratory tests, procedures, supplies and drugs, including contraceptive supplies and drugs, provided in a family planning clinic.

MassHealth covers sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing – and sterilization-related services (including anesthesia, laboratory, radiology, drugs, equipment, and supplies) in family planning clinics when the member has voluntarily given informed consent in the manner and at the time required by federal law.

MassHealth does not cover the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does cover diagnosis of male or female infertility.

The family planning agency may be paid for a maximum of one HIV pre-test counseling visit and one HIV post-test counseling visit per member per test per day. The MassHealth agency pays for a maximum of four HIV pre-test counseling visits and four HIV post-test counseling visits per calendar year.

(Item 9 Clinic Services, continued)

d. Sterilization Clinics

MassHealth covers sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing – and sterilization-related services (including anesthesia, laboratory, radiology, drugs, equipment, and supplies) provided in sterilization clinics.

Sterilization is covered in sterilization clinics when the member has voluntarily given informed consent in the manner and at the time required by federal law.

MassHealth does not cover the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does cover diagnosis of male or female infertility.

(Item 9 Clinic Services, continued)

e. Radiation Oncology Centers

MassHealth covers radiation oncology and related services provided in radiation oncology centers, including radiologic procedures, drugs, equipment and supplies, and routine laboratory tests necessary for the diagnosis, detection, and treatment of disease, and for the maintenance of the health of MassHealth members.

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State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

(Item 9, Clinic Services continued)

f. Renal Dialysis Clinics

MassHealth covers renal dialysis and related services, including supplies, drugs and routine laboratory tests, provided in renal dialysis clinics. MassHealth covers home dialysis training, including self-dialysis (hemodialysis, intermittent peritoneal dialysis, and continuous cycling peritoneal dialysis) and continuous ambulatory peritoneal dialysis training only when the MassHealth member attends such training at the clinic site.

(Item 9 Clinic Services, continued)

g. Rehabilitation Centers

MassHealth covers the following services in freestanding rehabilitation centers for individuals requiring physical rehabilitation: rehabilitation evaluations conducted by physicians; and physical, occupational and speech/language therapy visits and evaluations performed by licensed therapists to improve or prevent the worsening of a congenital or acquired condition.

MassHealth covers maintenance therapy performed by a licensed therapist when the therapist's specialized knowledge and judgment are required to perform services that are part of a maintenance program.

MassHealth requires the rehabilitation center to obtain prior authorization for more than 20 occupational therapy visits, 20 physical therapy visits, or 35 speech/language therapy visits, including group therapy visits, for a member within a 12-month period. Diversional and recreational therapy are not covered.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

(Item 9 Clinic Services, continued)

h. Speech and Hearing Centers

MassHealth covers the following services in a freestanding speech and hearing center: audiological services, and speech, hearing or language services performed by a licensed, certified audiologist or licensed, certified speech therapist.

MassHealth covers maintenance therapy performed by a licensed therapist when the therapist's specialized knowledge and judgment are required to perform services that are part of a maintenance program.

MassHealth requires the speech and hearing center to obtain prior authorization for more than 35 speech and language pathology visits, including group therapy visits, for a member in a 12-month period. Diversional and recreational therapy are not covered.

MassHealth covers up to one individual treatment and one group therapy session per member per day at the speech and hearing center.

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State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

(Item 9 Clinic Services, continued)

i. Mental Health Centers

MassHealth covers diagnosis and treatment of mental and emotional disorders at mental health centers. Such services include diagnostic services, psychological testing, individual therapy, couple therapy, family therapy, group therapy, medication visit, case consultation, family consultation and psychotherapy for crisis/emergency services.

MassHealth does not cover nonmedical services provided by mental health centers (e.g., vocational, educational, recreational, community, and life-enrichment services) or diagnostic or treatment services provided at a mental health center as an integral part of a planned and comprehensive program (e.g., a residential, day activity, or drop-in program) that is organized to provide primarily non-medical or other nonreimbursable services. Play therapy, as an alternative to strictly verbal expression, is not considered a recreational service and is covered.

MassHealth covers multiple treatment modalities for a member on the same day, except for diagnostics. MassHealth does not cover more than one session of a single type of service provided to an individual member on the same day, except for the provision of psychotherapy for crisis.

Group Therapy is limited to a maximum of 12 members per group.

Psychotherapy for crisis is limited to one initial unit of service and up to three add-on units of service per date of service.

(Item 9 Clinic Services, continued)

j. Substance Use Disorder Treatment Clinics

MassHealth covers individual, group, and family/couple substance abuse rehabilitative counseling, case consultation, and acupuncture detoxification at substance abuse outpatient counseling programs.

MassHealth covers medication assisted treatment for opioid dependency at opioid treatment service centers, in accordance with applicable clinical standards. Prior authorization is required for buprenorphine.

Item 10: **Dental Services**

A. For members under age 21, all medically necessary dental services, including comprehensive and periodic oral evaluations and all dental services needed for maintenance of dental health, restoration of teeth, and relief of pain and infections are covered.

B. For members age 21or over the following dental services are covered:

- diagnostic services including oral evaluation (comprehensive and periodic) and radiographs;
- preventive services including prophylaxis;
- emergency care visits;
- certain restorative services (fillings);
- certain prosthodontic services (full and partial dentures including repairs);
- extractions;
- anesthesia;
- treatment of complications related to surgery;
- certain oral surgery such as biopsies and soft-tissue surgery; and
- certain periodontal services, including gingivectomies, gingivoplasties, and periodontal scaling and root planing.

In addition, for members age 21 or over, there are limited exceptions that allow for topical fluoride when documented as medically necessary.

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Limitations to Services Provided to the Categorically Needy

Item 17: **Nurse-Midwife Services**

Nurse-midwife services are provided by certified nurse-midwives in accordance with 42 CFR 440.165.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Limits on covered services can be exceeded when medically necessary, with prior authorization.

See also Supplement to Attachment 3.1-A, p.1, Item 1.

Item 23: Pediatric or Family Nurse Practitioners' Services

Pediatric and family nurse practitioner services are provided by certified nurse practitioners in accordance with 42 CFR 440.166.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Limits on covered services can be exceeded when medically necessary, with prior authorization.

See also Supplement to Attachment 3.1-A, p.1, Item 1.

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Limitations to Services Provided to the Categorically Needy

Item 11: **Therapies and Related Services**

Speech, occupational and physical therapies to improve or prevent the worsening of a congenital or acquired condition are provided in accordance with 42 CFR 440.110. MassHealth pays for maintenance therapy performed by a licensed therapist when the therapist's specialized knowledge and judgment are required to perform services that are part of a maintenance program. Diversional and recreational therapy are not reimbursable services.

Services that are subject to prior authorization include more than 20 occupational therapy visits, 20 physical therapy visits, or 35 speech/language therapy visits, including group therapy visits, for a member within a 12 month period.

Audiologist Services are provided in accordance with 42 CFR 440.110. The MassHealth agency does not pay for more than one hearing aid per ear per member in a 60-month period without prior authorization.

Item 12: **Prescribed Drugs, Dentures, Prosthetic Services, and Eyeglasses**

a. **Prescribed Drugs** - Legend FDA-approved drugs and certain non-legend over-the-counter drugs are reimbursable subject to the conditions specified in 130 CMR 406.000. Prescribers must obtain prior authorization for non-generic multiple source drugs, and for any drug identified by the Division in accordance with 130 CMR 450.303. Insulins are reimbursable for recipients without restrictions.

Active pharmaceutical ingredients (APIs) and excipients that are included in an extemporaneously compounded prescription written by an authorized prescriber and dispensed by MassHealth pharmacy providers are covered if medically necessary.

The state is in compliance with Section 1927 of the Social Security Act. Based on the requirements of Section 1927 of the Social Security Act, the state has the following policies for the supplemental rebate program for the Medicaid population:

1. The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates.

2. A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on March 31, 2016, and entitled, "State of Massachusetts Supplemental Rebate Agreement" has been authorized by CMS, and a value-based rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on March 12, 2019, and entitled, "State of Massachusetts Value-Based Supplemental Rebate Agreement" has been authorized by CMS.
3. Manufacturers with supplemental rebate agreements are allowed to audit utilization data. Supplemental rebates received by the state in excess of those required under the National Drug Rebate Agreement (NDRA) will be shared with the federal government on the same percentage basis as applied under the NDRA.
4. The unit rebate amount under the NDRA is confidential and cannot be disclosed in accordance with Section 1927(b)(3)(D) of the Social Security Act. No substantial changes will be made to the supplemental rebate agreement without CMS authorization. Supplemental rebates received pursuant to these agreements are only for the MassHealth program.
5. All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provisions of the NDRA.
6. The prior authorization process for covered outpatient drugs conforms to Section 1927(d)(5) of the Social Security Act. The prior authorization process provides for a turnaround response by either telephone or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a seventy-two hour supply of medication.
7. The state may agree within the terms of a supplemental rebate agreement that the covered drug(s) may or may not be subject to prior authorization, for as long as the agreement is in effect, and that the state may obtain supplemental drug rebates in either case. This may include instances in which the state imposes prior authorization on a drug or drugs for clinical purposes, instances in which the state imposes prior authorization on a drug or drugs as part of a "step-edit" approach, and instances in which the state imposes prior authorization on a drug or drugs (which may include a generic drug) when the application of the supplemental rebate on the preferred drug or drugs results in a lower net cost to the state. The state may also enter value- or outcome-based agreements.
8. Only drugs supplied to MassHealth members will be covered under these agreements. In addition to collecting supplemental rebates for fee-for-service claims, the state may, at its option, also collect supplemental rebates for MassHealth member utilization through MCE(s) under an agreement.
9. The state may continue to collect supplemental rebates under agreements that are currently in process or effect based on the form of agreement approved by CMS as part of MA-TN-012-005 until those agreements are otherwise terminated or amended to align with the CMS-approved forms referred to in paragraph 2, above.

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

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The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

☑ **The following excluded drugs are covered:**

☑ (a) agents when used for anorexia, weight loss, weight gain (for medically necessary appetite stimulants only)

☐ (b) agents when used to promote fertility

☑ (c) agents when used for the symptomatic relief cough and colds (covered only when dispensed to members residing in a nursing facility).

☑ (d) prescription vitamins and mineral products, except prenatal vitamins and fluoride-containing products

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☑ (f) nonprescription drugs, as follows:

Allergy Agents, Ophthalmic
Analgesics
Anthelmintic Agents
Antihistamines/Decongestants
Antimicrobials, Topical
Contraceptives, Oral
Dermatologic Agents, Topical
Gastrointestinal Products
Nonoxynol-9
Otic Agents
Pediculicides/Scabicides

☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

b. **Dentures** - Dentures are provided in accordance with 42 CFR 440.120. See **Supplement to Attachment 3.1-A**, page 3, Item 10, above.

c. **Prosthetic Devices** Prosthetic devices (including orthotics) are provided in accordance with 42 CFR 440.120.

MassHealth covers medically necessary prosthetics and orthotic services, including repairs after exhaustion of manufacturer warranties.

Prosthetic services that are subject to prior authorization include: addition to lower extremity prosthesis, endoskeletal ankle foot system, microprocessor controlled, lower extremity prosthesis not otherwise specified, external power device, electronic elbow and accessories, upper extremity prosthesis not otherwise specified, breast prosthesis, unlisted procedures for miscellaneous prosthetic services.

Orthotic services that are subject to prior authorization include: compression garments, protective helmet, foot pressure off loading device, spinal orthosis not otherwise specified, lower extremity orthosis not otherwise classified, orthopedic foot wear and upper limb orthosis not otherwise specified.

Members of any age may obtain prior authorization for units in excess of the limits for service codes for all other prosthetic and orthotic services.

d. **Eyeglasses** Eyeglasses are provided in accordance with 42 CFR 440.120. The following are covered services: eyeglasses, eyeglass parts, eyeglass dispensing, contact lenses and other visual aids

Services that are limited to members who meet certain clinical criteria include: tinted lenses, coated lenses, and two pairs of eyeglasses instead of bifocals, cataract lenses and contact lenses..

Services that are subject to prior authorization include: extra or spare eyeglasses; the following types of contact lenses--PMMA color vision, deficiency, gas permeable or hydrophilic toric prism ballast, gas permeable or hydrophilic bifocal; low vision aids; glass lenses; special-needs lenses; tints other than “pink 1” and “pink 2” that are available for plastic lenses only, and, polycarbonate lenses for members aged 21 or older or for any member who is amblyopic or monocular.

Exclusions consist of absorptive lenses of greater than 25% absorption, prisms obtained by decentration; contact lenses for extended wear use; invisible bifocals; and Welsh 4-drop Lens.

The volume purchase of eyeglasses limits the selection of frames and lenses to a basic assortment from the optical supplier.

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and Remedial Care and Services Provided to the Categorically Needy

Item 16: Inpatient Psychiatric Facility Services for Individuals under 22 Years of Age

Preadmission screening will be required for all non-court-ordered admissions of Medicaid recipients (as per 42 CFR 441.152). Such certification of the need for services for conversion cases (people applying for Medicaid eligibility while hospitalized in an inpatient psychiatric facility) will be made by the team responsible for the plan of care (42 CFR 441.153(b)). Periodic reviews of use will be performed by the Medicaid agency or its designee.

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and Remedial Care and Services Provided to the Categorically Needy

Item 15: **Intermediate Care Facilities**

Effective November 1, 1993, coverage is limited to state school ICF/MR (these schools have more than 15 beds). The reimbursement methodology for these services is described in Attachment 4.19-D (3).

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(Item 9 Clinic Services, continued)

k. **Limited Services Clinic**

MassHealth covers vaccines and immunizations, as well as medical evaluation, testing, screening, treatment, and clinical laboratory services for episodic, urgent care relating to an illness provided in state-licensed limited services clinics.

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Item 20: **Extended Services for Pregnant Women**

The major categories of services available to pregnant women as pregnancy-related services include inpatient hospital, outpatient hospital, laboratory and X-ray, family planning, physician, clinic, dental, prescription drug, and nurse-midwife services.

Extended services to pregnant women may be provided by physicians and community health centers. Such extended services include coordinated medical management, health-care counseling, obstetrical-risk assessment and monitoring and rehabilitation services including treatment for alcoholism and drug dependency.

Item 24.d: **Nursing Facility Services for Patients under 21 Years of Age**

Skilled nursing facility services for patients under 21 years of age are covered if a Department of Public Health review team approves the facility.

Item 26. Personal Care Services

Personal care services provided through the state plan are provided either through Personal Care Attendant Services or Transitional Living Services.

A. Personal Care Attendant (PCA) Services

All personal care services provided by a Personal Care Attendant (PCA) through the state plan are consumer directed, and the consumer (the MassHealth member) is the employer of his/her PCAs.

PCA services furnished under the state plan are limited to "employer authority" only. That is, all PCA funds under the PCA state plan must be used solely to pay for employer required tasks, and cannot be used for any other purpose, such as the purchase of products and services other than those provided by a PCA to meet the consumer's personal care needs. Personal care services provided by PCAs are performed by Medicaid enrolled providers. The state will ensure the requirements for provider agreements found at 42 CFR 431.107 are met prior to initial payment of Personal Care Attendants (PCAs) being hired as PCAs.

All consumers are responsible for recruiting, screening, hiring, firing, training and scheduling PCAs, as well as submitting activity forms (PCA timesheets) to the fiscal intermediary (FI) for processing and payment. If the consumer is not able to perform these activities on his/her own, the consumer must appoint a surrogate to assist him/her to manage PCA services.

The state contracts with fiscal intermediaries (FIs) in accordance with the requirements of 42 CFR 434.10 to perform employer required tasks and administrative tasks on behalf of consumers. The FI receives and processes the PCA timesheet, and submits a claim for PCA services through the state's MMIS system. The state processes the claim and pays the FI to perform all employer required tasks on behalf of the consumer, including filing and paying employer required taxes, withholding PCA taxes, purchasing workers' compensation insurance on behalf of each consumer, and sending a check in the PCA's name to the consumer to pay the PCA, unless the PCA has elected direct deposit.

1. For the state to pay for personal care services provided by a PCA to a consumer (the MassHealth member), the consumer must be able to be appropriately cared for in the home and the following conditions must be met:

   a. The personal care services must meet the state's medical necessity criteria and must be authorized by the state prior to being provided in accordance with a state approved service plan.

   b. The personal care services must, in accordance with 42 CFR 440.167, be authorized for an individual in accordance with a service plan approved by the state.

   c. The consumer, as authorized by the state under a state approved service plan,, must require physical assistance in two or more of the following ADLs:

      1). mobility – physically assisting a consumer who has a mobility impairment that prevents unassisted transferring, walking, or use of prescribed durable medical equipment;
      2). assistance with medication – physically assisting a consumer to take medications prescribed by a physician that otherwise would be self-administered;
      3). bathing or grooming – physically assisting a consumer with basic care such as bathing, personal hygiene, and grooming skills;
      4). dressing – physically assisting a consumer to dress or undress;
      5). passive range-of-motion exercises – physically assisting a consumer to perform range-of-motion exercises;
      6). eating – physically assisting a consumer to eat; and
      7). toileting – physically assisting a consumer with bowel and bladder needs.

2. If the conditions in 1 above are met, the state will pay for a consumer to receive physical assistance with the ADLs identified in 1.c above and the IADLs listed below.

   a. household services – physically assisting with household management tasks that are incidental to the care of the member, including laundry, shopping, and housekeeping;

   b. meal preparation and clean-up – physically assisting a member to prepare meals;

   c. transportation – accompanying the member to medical providers; and

   d. special needs – assisting the member with:

      1). the care and maintenance of wheelchairs and adaptive devices. This includes, but is not limited to, charging the batteries on a powered wheelchair and cleaning and sanitizing medical equipment (wheelchairs and wheelchair accessories, walkers, hoya lifts, and standers). The state assures that routine maintenance performed by PCAs does not duplicate repair services covered under the DME benefit and provided by DME providers.

      2). completing the paperwork required for receiving personal care services. This includes the paperwork required by the PCA program, such as employer forms required by the fiscal intermediary. If the consumer has a surrogate, the state expects the surrogate to complete the paperwork required by the PCA program.

      3). other special needs approved by the state as being instrumental to the health care of the member.

B. Transitional Living Services

Personal care services provided by a Transitional Living provider are provided in a community-based setting operated by the Transitional Living provider and delivered by direct care staff of the Transitional Living provider. Transitional Living services are not provided in an Institute for Mental Disease servicing individuals 22-64.

A member who is eligible to receive personal care services provided by a Transitional Living provider may obtain those services from a qualified Transitional Living provider participating in MassHealth. Personal care services are provided by Transitional Living provider's direct care staff and in accordance with a written individual service plan that is developed with the participation of the member (and the member's surrogate, if applicable), describing in detail the responsibilities of the member, the member's surrogate, if applicable, and the Transitional Living provider.

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1. For the state to pay for personal care services provided by a Transitional Living provider to a member, the member must be able to be appropriately cared for in the provider's Transitional Living provider setting and the following conditions must be met:

   a. The personal care services provided to the member by the Transitional Living provider's direct care staff must meet the state's medical necessity criteria and must be authorized by the state prior to being provided in accordance with a state approved service plan.

   b. The personal care services provided by the Transitional Living provider's direct care staff must, in accordance with 42 CFR 440.167, be authorized for an individual in accordance with a service plan approved by the state.

   c. The member, as authorized by the state under a state approved service plan, must require physical assistance in two or more of the following ADLs:

      1). mobility – physically assisting a consumer who has a mobility impairment that prevents unassisted transferring, walking, or use of prescribed durable medical equipment;
      2). assistance with medication – physically assisting a consumer to take medications prescribed by a physician that otherwise would be self-administered;
      3). bathing or grooming – physically assisting a consumer with basic care such as bathing, personal hygiene, and grooming skills;
      4). dressing – physically assisting a consumer to dress or undress;
      5). passive range-of-motion exercises – physically assisting a consumer to perform range-of-motion exercises;
      6). eating – physically assisting a consumer to eat; and
      7). toileting – physically assisting a consumer with bowel and bladder needs.

2. If the conditions in 1 above are met, the state will pay for a member to receive physical assistance with the ADLs identified in 1.c above and the IADLs listed below.

   a. household services – physically assisting with household management tasks that are incidental to the care of the member, including laundry, shopping, and housekeeping;

   b. meal preparation and clean-up – physically assisting a member to prepare meals;

   c. transportation – accompanying the member to medical providers; and

   d. special needs – assisting the member with:

      1). the care and maintenance of wheelchairs and adaptive devices. This includes, but is not limited to, charging the batteries on a powered wheelchair and cleaning and sanitizing medical equipment (wheelchairs and wheelchair accessories, walkers, hoya lifts, and standers). The state assures that routine maintenance performed by a Transitional Living Services provider does not duplicate repair services covered under the DME benefit and provided by DME providers

      2). other special needs approved by the state as being instrumental to the health care of the member and ability to manage PCA services once transitioned to independent living.

(C) Provider qualifications:

1. Personal Care Attendant Services. The state has established the following minimum qualifications for PCAs:
   a. PCAs cannot be the consumer's family member, surrogate or foster parent;
   b. PCAs must be legally authorized to work in the United States;
   c. PCAs must be able to understand and carry out directions given by the consumer or the consumer's surrogate;
   d. PCAs must be willing to receive training and supervision in all PCA tasks from the consumer or the consumer's surrogate; and
   e. A PCA cannot be listed on the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE)

2. Transitional Living Services. The state has established the following minimum qualifications for Transitional Living Services providers:

   a. To provide Transitional Living Services a provider must:
      1) Submit a proposal for review by the state in accordance with the state's proposal

requirements for transitional living.

2) Obtain written approval from the state to become a MassHealth provider of transitional living services
3) Demonstrate the appropriate licensure or program accreditation by a recognized body for the provider's type of program (if applicable); and
4) Obtain a MassHealth provider identification number.

b. Direct care staff employed by a Transitional Living Services Provider and providing personal care services to a member:

1) Cannot be the member's family member, surrogate or foster parent;
2) Must be legally authorized to work in the United States;
3) Must be able to understand and carry out directions given by the Transitional Living Services provider or the member, or the member's surrogate;
4) Must be willing to receive training and supervision in all personal care services tasks from the Transitional Living Provider or the member, or the member's surrogate; and
5) Cannot be listed on the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE)

State Plan under Title XIX of the Social Security Act
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Case Management Services

A. Target Group:

See pages 1a through 1q

B. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of Section 1919 (g) (1) of the Act is invoked to provide services less than statewide:

C. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (100 (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

D. Definition of services:

See pages 1a through 1q

E. Qualifications of provider:

See pages 1a through 1q

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Reserved

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Reserved

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Reserved

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RESERVED

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Reserved

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Case Management Services (cont.)

H. **Children Served by the Department of Social Services**

1. Target Group

The target group consists of Medicaid eligible children who have been reported to the Department of Social Services as potentially abused or neglected, or are receiving services from the Department of Social Services after being determined to either be at risk of abuse or neglect or substantiated as being abused or neglected children.

2. Definition of Services

Targeted case management is a set of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the case management provider agency. The purpose of case management is to assist individuals in gaining access to needed medical, social, and other services.

Case management will include:

1. collection of assessment data;
2. development of an individualized plan of care;
3. coordination of needed services and providers;
4. home visits and collateral contracts as needed;
5. maintenance of case records; and
6. monitoring and evaluation of client progress and service effectiveness.

3. Qualifications of Providers

The case manager must be a qualified social worker according to the requirements of the Massachusetts Department of Social Services.

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RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
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RESERVED

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Reserved

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Reserved

State Plan under Title XIX of the Social Security Act
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Reserved

K. Children Provided Case Management Services by the Department of Youth Services

1. Target Group:

The target group consists of Medicaid recipients who (1) are between the ages of 7 through 22, (2) are committed to the Department of Youth Services (DYS) by a court of competent jurisdiction in the Commonwealth until the age specified in their commitment (up to their 21st birthday), or voluntarily agree to the continuation of DYS case management services beyond their eighteenth birthday up to their 22nd birthday, and (3) as a result either of their original placement or conditional release forma public institution, reside in placements that include, but are not limited to, their own homes, the homes of relatives, community based residences, or residential treatment facilities.

2. Definition of Services

Targeted case management is a set of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the case management provider agency. The purpose of case management is to assist individuals in gaining access to needed medial, social, educational and other services.

3. Case Management will include:

1. Collection of assessment data;
2. Development of an individualized plan of care;
3. Coordination of needed services and providers;
4. Home visits and collateral contacts as needed;
5. Maintenance of case records; and
6. Monitoring and evaluating client progress and service effectiveness.

4. Qualifications of Providers:

The case manager must have, or work directly under, the supervision of an individual with at least three years of full or equivalent part-time, professional or paraprofessional experience in social work, social casework, guidance, vocational counseling, employment counseling, or educational counseling, the major duties of which include providing such services to juveniles, or in a corrections institutions work, the major duties of which include the custodial care, treatment, counseling and/or rehabilitation of juveniles.

Case Management Services (cont.)

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

1. Target Group

Target group includes Medicaid beneficiaries who are either:

A. 18 years of age or older with intellectual disability, meaning significantly sub-average intellectual functioning existing concurrently and related to significant limitation in adaptive functioning that manifests before 18.

B. under 18 years of age,
   a. with a verified diagnosis of intellectual disability or a closely related developmental condition or, with respect to persons from birth to age five, a developmental delay. Developmental delay means a substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in a developmental disability if services are not provided; and
   b. who demonstrate severe functional impairments, with severe functional impairments meaning functional impairments in at least three specified areas of adaptive functioning, based upon normative expectations of the types of skills normally acquired as the child develops, as measured by standardized assessment or comparable data. The areas of adaptive functioning are: self-care, communication, learning, mobility, and self-direction and, for individuals age 14 years or older, capacity for independent living and economic self-sufficiency.

☒ Target group includes individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are in Institutions for Mental Disease or individuals who are inmates of public institutions.

2. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

3. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

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Case Management Services Provided to the Categorically Needy Groups

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

4. Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Comprehensive assessment and at least annual periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. Reassessments are conducted at least annually, or more frequently if necessary, to address changes in an individual's condition. These assessment activities include:

- Taking client history;
- Identifying the individual's needs and completing related documentation; and
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link an individual with
  - Medical, social, educational providers or
  - Other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities typically occur monthly and include at least one annual monitoring meeting to adequately address the needs of the eligible individuals, and care plan services may be reevaluated at any time. The Monitoring and follow up activities include:

- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring meeting, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - There are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

Case management services are coordinated with and do not duplicate activities provided as a part of institutional services and discharge planning activities.

5. Qualifications of provider:

The Department of Developmental Services (DDS) has been designated to serve as the exclusive source of case management services with respect to the target group. Case management services will be provided by qualified personnel hired into state positions at the Department of Developmental Services in the Human Services Coordinator series. Minimal entrance requirements for the Human Services Coordinator position include at least three years of full-time, or equivalent part-time professional experience in human services work or social work. One year of professional work experience must have involved working with individuals with intellectual or other developmental disabilities. A Bachelor's or higher degree in social work, psychology, sociology, counseling, counseling education, education of the physically or emotionally handicapped, education of the multiple handicapped, education of the learning disabled, human services, rehabilitation, rehabilitation counseling, nursing, recreation therapy, art therapy, dance therapy, music therapy, or physical education may be substituted for two years of the required experience on the basis of two years of education for one year of experience.

6. Freedom of choice:

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

A. Eligible recipients will have free choice of any qualified Medicaid provider of case management services within the specified geographic area identified in this plan.
B. Eligible recipients will have free choice of the providers of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception:

☒ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. Consistent with 42 CFR 441.18(b), Massachusetts designates the Department of Developmental Services as the provider of services covered under this section of the State Plan.

7. Access to Services:

The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
And Remedial Care and Services Provided to the Categorically Needy

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

1. Target Group

To be eligible for this target group, an individual must meet the following criteria:

Clinical Criteria

An individual who is 19 year of age or older must: have a mental illness, as determined by the Department of Mental Health (DMH) in accordance with DMH regulations and meet the following criteria:

1. Includes a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life;
2. Has lasted or is expected to last at least one year;
3. Has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and
4. Meets diagnostic criteria specified within the current edition of Diagnostic and Statistical Manual of Mental Disorders, which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by substance related disorders, mental retardation or organic disorders due to a general medical condition not elsewhere classified.

An individual who is under 19 years of age must have a mental illness as determined by DMH which meet the following criteria:

1. Has lasted, or is expected to last, at least one year;
2. Has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities; and
3. Meets diagnostic criteria specified within the current edition of the Diagnostic and Statistical Manual of Mental Disorders, but is not solely within one or more of the following categories:
    a. Developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation;
    b. Cognitive disorders, including delirium, dementia or amnesia;
    c. Organic disorders due to a general medical condition not elsewhere classified; or
    d. Substance-related disorders.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

☒ Target group includes individuals transitioning to a community setting and case-management services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between ages 22 and 64 who are in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

2. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

3. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

4. Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Assessment and reassessment of individual needs to determine the need for any medical, educational, social or other services. Reassessments are conducted at least annually, or more frequently if necessary, to address changes in an individual's condition. These assessment activities include:

- Taking client history; and
- Identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link an individual with:
  - Medical, social, educational providers; or
  - Other programs and services that are capable of providing needed services, to address identified needs and achieve goals specified in the care plan, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities are conducted at least annually, or more frequently as necessary, to adequately address the needs of the eligible individual, and care plan services may be reevaluated at any time. These Monitoring and follow-up activities include:

- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - There are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

5. Qualifications of providers:

The Department of Mental Health (DMH) has been designated to serve as the exclusive source of case management services with respect to the target group. Case management services will be provided by qualified personnel hired into state positions in the Human Services Coordinator series. Qualified personnel must have demonstrated applicable education and/or professional work experience with the target population.

6. Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

A. Eligible recipients will have free choice of any qualified Medicaid provider of case management services within the specified geographic area identified in this plan.
B. Eligible recipients will have free choice of the providers of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception:

☒ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. Consistent with 42 CFR 441.18(b), Massachusetts designates the Department of Mental Health as the provider of services covered under this section of the State Plan.

7. Access to Services:

The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

8. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, and whether goals specified in the care plan have been achieved; whether the individual has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

9. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted care management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

10. Limitations:

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred; and
- Activities for which third parties are liable to pay as described in 42 USC 1396n(4)(A)

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
And Remedial Care and Services Provided to the Categorically Needy

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

1. Target Group

A Medicaid member is eligible for targeted case management services described below if the member:

A. is eighteen years of age or older;

B. receives a statement from a physician verifying the AIDS diagnosis. Such a diagnosis shall be based on the most recent AIDS definition published by the Federal Center for Disease Control (CDC) as it may from time to time be amended.

C. lives in a staffed, congregate residential program which meets the Department of Public Health (DPH) funding requirements for the AIDS/HIV Bureau, Supportive Residential Services program which require that a person be HIV positive, and in which no more than three mentally and/or physically impaired individuals share a single bedroom and bathroom; and

D. requires and receives from the congregate residential program staff assistance with either activities of daily living (ADL) such as bathing, dressing/grooming, mobility/transfer, eating or toileting and/or instrumental activities of daily living (IADL) such as laundry, shopping, transportation and housekeeping.

☐ Target group includes individuals transitioning to a community setting during a covered stay in an institutional setting.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

2. Areas of state in which services will be provided:

☒ Entire state .

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

3. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (100 (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

4. Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include

- taking client history and
- identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- to help an eligible individual obtain needed services including activities that help link an individual with
  - medical, social, educational providers or
  - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

5. Qualifications of provider:

To be qualified to provide case management services, a provider must possess the following minimal qualifications: a Masters degree in social work or related field, a registered nurse, or three or more years of documented case management experience working with the disabled in a community setting.

6. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

A. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
B. Eligible recipients will have free choice of the providers of other medical care under the plan.

7. Access to Services:

The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or conditional receipt of other Medicaid services on receipt of case management services;
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

8. Case Records:

Providers maintain case records that document for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, and whether goals specified in the care plan have been achieved; whether the individual has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

8. Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

9. Limitations:

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred.
- Activities for which third parties are liable to pay as described in 42 USC 1396n(4)(A).

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
And Remedial Care and Services Provided to the Categorically Needy

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy

M. Targeted Case Management – Individuals under 21 with Serious Emotional Disturbance (SED)

1. **Target Group:** The target group includes individuals under 21 with a Serious Emotional Disturbance (SED) including individuals with co-occurring conditions.

2. **Areas of State in Which Services Will be Provided**

   Services are available state-wide

3. **Comparability of Services**

   Services are not comparable in amount, duration and scope. (Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B)

4. **Definition of Services**

Targeted Case Management Services (Intensive Care Coordination) is defined as follows:

1. Assessment: The Care Manager, working with the Care Planning Team, may use multiple tools, including a strengths-based standardized assessment instrument, in conjunction with a comprehensive psychosocial assessment and other clinical information to organize and guide the development of an individualized care plan. The Care Planning Team is a source for information needed to form a complete assessment of the child. The Care Planning Team includes, as appropriate, the Care Manager, providers, case managers from state agencies that provide services to the child, family members, and natural supports such as neighbors, friends and clergy. Assessment activities include, without limitation: the Care Manager 1) assisting the family to identify appropriate members of the Care Planning Team; 2) facilitating the Care Planning Team to identify strengths and needs of the child and strengths and needs of family in meeting the child's needs and 3) collecting background information and plans from other agencies. The assessment process will determine the needs of the child for any medical, educational, social or other services. Further assessments will be provided as medically necessary.

2. Development of an individualized care plan: Using the information collected through an assessment, the Care Manager, convenes and facilitates the Care Planning Team, together with the Team develops a person and family-centered, Individual Care Plan that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The Care Manager works directly with the child, the family (or the child's authorized health care decision maker) and others to identify the strengths, needs and goals of the child and the strengths, needs and goals of the family in meeting the child's needs. .

3. Referral and Related Activities: Using the individual Care Plan, the Care Manager (1) convenes, coordinates and communicates with the Care Planning Team to implement the Individual Care Plan; (2) works directly with the child and family to implement elements of the Individual Care Plan; (3) prepares, monitors and modifies the Individual Care Plan in concert with the Care Planning Team; (4) coordinates the delivery of available services, including services reimbursable under 42 USC 1396d(a) and educational, social or other services; (5) develops, in concert with the Care Planning Team, a transition plan when the child has achieved the goals of the Individual Care Plan; and (6) collaborates with other service providers on the child and family's behalf.

4. Monitoring and follow-up activities include reviewing the Individual Care Plan every quarter and convening the Care Planning Team at least annually to update the Plan of Care to reflect the changing needs of the child. The Care Manager and the Care Planning Team perform such reviews and include (1) whether services are being provided in accordance with the Individual Care Plan (2) whether the services in the Individual Care Plan are adequate and (3) whether there are changes in the needs or status of the individual and if so, adjusting the Care Plan as necessary.

Services may include contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individuals to access services.

5. Qualifications of Providers:

Providers are agencies known as Community Service Agencies (CSAs) that meet requirements established by the single state Medicaid Agency. To meet such requirements, CSAs must have at least three years' experience providing behavioral health services to youth, from birth to 21 years old, and their families. CSAs are community based child and family service organizations such as community mental health centers, not-for-profit social service agencies and other service providing agencies. CSAs must employ or contract with licensed behavioral health clinicians or non-licensed staff or paraprofessionals supervised by licensed behavioral health clinicians to provide case management services known as Intensive Care Coordination (ICC). Non-licensed staff or paraprofessionals include staff members with a master's degree or a bachelor's degree or with an associates degree and at least five years of experience working with the target population. The case manager, known as the Care Manager, develops and coordinates a child specific care planning team that develops an individualized, child centered, family and strengths-based Plan of Care.

6. Free Choice of Providers

a. Free choice of providers of case management services may be restricted in accordance with the provision of 1915(g)(1) of the Medicaid Act as amended by Section 4118(i) of the Omnibus Budget Reconciliation Act of 1987 and 42CFR 431.51.

b. Eligible members will have free choice of providers of other medical care under the plan

7. Non-Duplication of Payment

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

8. Intensive Care Coordination Services To Individuals in Institutions

Nothing in the definition excludes the provision of Intensive Care coordination to individuals who are in hospitals, ICF-MRs, Institutions for Mental Disease (IMDs), Psychiatric Residential Treatment Facilities (PRTFs), and Skilled Nursing Facilities who meet the definition of the target population described above.

a. Such Intensive Care Coordination Services may by provided to individuals transitioning to a community setting. Intensive Care Coordination Services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

b. These activities shall be coordinated with, and not duplicate, institutional discharge planning.

c. The amount, duration, and scope of Intensive Care Management activities will be documented in the Member's Individual Care Plan

d. Transitional Intensive Care Coordination is provided by and reimbursed only to CSAs

e. The Commonwealth will monitor compliance with these provisions through a system that includes periodic audits and claims reviews.

9. Limitations on Qualified Providers

Providers are limited to regionally based, Community Service Agencies that MassHealth determines are most qualified to provide Intensive Care Coordination to members with SED including co-occurring disorders. These limitations will ensure that individuals within the target group receive needed services by establishing a defined group of providers who have and maintain expertise in the special service needs of this population.

10. Additional Assurances

The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or conditional receipt of other Medicaid services on receipt of case management services;
- Providers of case management services do not exercise the agency's authority to authorize or

deny the provision of other services under the plan.

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred.
- Activities for which third parties are liable to pay as described in 42 USC 1396n (4) (A).

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
PACE State Plan Amendment Pre-Print

Program of All-Inclusive Care for the Elderly (PACE)

1. Target Group

All medically needy and categorically needy individuals who are at least 55 years old, live in the PACE service area, and are certified as eligible for nursing home care by the appropriate State agency. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.

2. Definition of Services

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participant's needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services), which are integrated for a seamless provision of total care. PACE organizations provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare and Medicaid covered services.

3. Qualification of Providers

PACE providers must meet with all the requirements found at 42 CFR Part 460.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.

I. **Eligibility**

The state determines eligibility for PACE enrollees under rules applying to community groups.

☒ A. The state determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The state has elected to cover under its State Plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the state determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

Eligibility Groups	**Regulatory Reference**
Special level income equal to 300% of the SSI Federal benefit	42 CFR 435.236 42 CFR 435.217

☐ B. The state determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.)

☒ C. The state determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the state's approved HCBS waiver(s).

State Plan under Title XIX of the Social Security Act
State: Massachusetts
PACE State Plan Amendment Pre-Print

Regular Post Eligibility

☒ 1. SSI State. The state is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) Sec. 435.726 — states which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A) Individual (check one)

☒ 1. The following standard included under the State plan (check one):

- ☐ (a) SSI
- ☐ (b) Medically Needy
- ☐ (c) The special income level for the institutionalized
- ☐ (d) Percent of the Federal Poverty Level: ___%
- ☒ (e) Other (specify):300% SSI Federal benefit rate

☐ 2. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ 3. The following formula is used to determine the needs allowance:
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):

- ☐ 1. SSI Standard
- ☐ 2. Optional State Supplement Standard
- ☐ 3. Medically Needy Income Standard
- ☐ 4. The following dollar amount: $_____
  Note: If this amount changes, this item will be revised.
- ☐ 5. The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.
- ☐ 6. The amount is determined using the following formula:
  _____
  _____
- ☒ 7. Not applicable (N/A)

(C) Family (check one):

- ☐ 1. AFDC need standard

☐ 2. Medically needy income standard
The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

☐ 3. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ 4. The following percentage of the following standard that is not greater than the standards above:_____%
of_____ standard.

☐ 5. The amount is determined using the following formula:
_____
_____

☐ 6. Other

☒ 7. Not applicable (N/A)

(b) Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

☐ 2. 209(b) state, a state that is using more restrictive eligibility requirements than SSI. The state is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735** — States using more restrictive requirements than SSI.

1. Allowances for the needs of the:

(A) Individual (check one)

☐ 1. The following standard included under the State plan (check one):

☐ (a) SSI
☐ (b) Medically Needy
☐ (c) The special income level for the institutionalized
☐ (d) (Percent of the Federal Poverty Level: _____%
☐ (e) ___Other (specify): _____

☐ 2. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ 3. The following formula is used to determine the needs allowance:
Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

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(B) Spouse only (check one):

- ☐ 1. The following standard under 42 CFR 435.121:
  _____
- ☐ 2. The medically needy income standard
  _____
- ☐ 3. The following dollar amount: $_____
  Note: If this amount changes, this item will be revised.
- ☐ 4. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
- ☐ 5. The amount is determined using the following formula:
  _____
  _____
- ☐ 6. Not applicable (N/A)

(C) Family (check one):

- ☐ 1. AFDC need standard
- ☐ 2. Medically needy income standard
  The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.
- ☐ 3. The following dollar amount: $_____
  Note: If this amount changes, this item will be revised.
- ☐ 4. The following percentage of the following standard that is not greater than the standards above: _____% of_____ standard.
- ☐ 5. The amount is determined using the following formula:
  _____
  _____
- ☐ 6. Other
- ☐ 7. Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

☐ 3. State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:

1. Individual (check one)

☐ (A) The following standard included under the State plan (check one):

- ☐ 1. SSI
- ☐ 2. Medically Needy
- ☐ 3. The special income level for the institutionalized
- ☐ 4. Percent of the Federal Poverty Level: _____%
- ☐ 5. Other (specify): _____

☐ (B) The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ (C) The following formula is used to determine the needs allowance:

_____

_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the Individual's maintenance needs in the community:

_____

_____

_____

_____

_____

_____

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State: Massachusetts
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II. **Rates and Payments**

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in free-for service.

☐ 1. Rates are set at a percentage of fee-for-service costs
☐ 2. Experience-based (Contractors/State's costs experience or encounter data) (please describe)
☐ 3. Adjusted Community Rate (please describe)
☒ 4. Other (please describe)

EOHHS contracts with an actuary to develop the capitation rates for PACE providers in accordance with 42 USC 1396u-4 and 42 CFR 460.182, which rates do not exceed the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program and take into account the comparative frailty of PACE participants. Each year, Capitation Rates are established for the PACE contract period, which is the same as a calendar year, January 1 through December 31.

The contracted actuary uses the following data sources in developing the rates:

1. Calculate Base Data
   - Collect and analyze Medicaid claims and eligibility data from the most recent Base Year available
   - Adjust base data for any payments made outside MMIS
   - Apply separate claims completion factors by calendar year (CY) and consolidated Category of Service (COS) to account for any unpaid claims liability
   - Develop per member per month (PMPM) costs by SFY, region, rating category, and COS
   - Utilize actual member months and the Base Year PMPMs to calculate total Base Year costs
2. Adjustments
   - Apply trend factors to bring claims forward from the Base Year to the rate year
   - Adjust for program changes
   - Certify actuarial equivalence of the populations
3. The State establishes the capitation rates, which are equal to or less than the State's adjusted costs experience, as computed above, by its contracted actuary. The same methodology is applied to all PACE providers.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

William M. Mercer

C. The State will submit all capitated rates to the HCFA Regional Office for prior approval.

III. **Enrollment and Disenrollment**

The state assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the state and the state Administering Agency. The state assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the state's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

Aged, Disabled, AFDC and Under 21

The following ambulatory services are provided.

Ambulatory services are those services, reimbursable by Medicaid, that are provided under circumstances that do no involve an overnight stay by the recipient in a hospital or long-term care facility. Such services may be provided in a hospital outpatient department, clinic, private practitioner's office, or other medical setting, or in the recipient's place of residence; provided that, if the recipient's place of residence is a hospital or ling-term care facility, any services that are included in the per diem rate of such hospital or facility shall not constitute ambulatory services.

Physician services (including radiologists, psychiatrists, ophthalmologists)
Dental services *
Services provided by a licensed practitioner:
- Optometrists' services
- Physical, occupational and speech therapy
- Services provided by registered nurses
- Services provided by licensed practical nurses

Pharmacy services
Psychologists' services
Home health agency services
Laboratory services
Hospital outpatient department services
Freestanding clinic services (including community health centers, mental health centers, rehabilitation clinics)
Medical supplies and durable goods
Family planning services
Transportation services
Health maintenance organization services
Adult foster care
Adult day care
Rehabilitation services in a day facility
Services for centers for independent living
Personal care attendant services
EPSDT
Psychiatric day treatment
Nurse-midwife services
Case management services

See Attachment 3.1-A , p.1 (91-21) for FQHC Coverage

* Description provided on attachment.

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4.d. 1) Face-to-face tobacco cessation counseling services for pregnant women provided:

☒ (i) By or under supervision of a physician;*

☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services;* or

☐ (iii) Any other healthcare professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.

* Describe if there are any limits on who can provide these counseling services

All healthcare professionals except physicians, registered nurses, certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, clinical nurse specialists and physician assistants must complete a training course to provide tobacco cessation counseling services. Healthcare professionals must be under the supervision of a physician if required under state law.

2) Face-to-face tobacco cessation counseling services benefit package for pregnant women

☒ Provided: ☐ No limitations ☒ With limitations*

* Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.

Please describe any limitations:

Prior authorization is required for more than a total of 16 group and individual counseling sessions per member per 12 month cycle. Prior authorization is required for more than two intake sessions (quit attempts) per member per 12 month cycle.

Aged, Disabled, AFDC and Under 21 (cont.)

1. Inpatient hospital services other than those provided in an institute for mental disease.
*Effective 12/1/91, under 18

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

2. a. Outpatient hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

See **Attachment 3.1-A, p.1 (91-21) for FQHC Coverage.**

3. Other laboratory and X-ray services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

c. Family planning services and supplies for individuals of childbearing age.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

* Description provided on attachment.

Aged, Disabled, AFDC and Under 21 (cont.)

5. a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with § 1905 (a) (5) (B) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*

* Description provided on attachment.

6. Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law.

a. **Podiatrists' Services**

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. **Optometrists' Services**

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. **Chiropractors' Services**

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. **Other Practitioners' Services**

☒ Provided: Identified on attached sheet with description of limitations, if any.
☐ Not provided.

e. **Audiologists' Services**

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

f. **Midlevel Practitioner Services**

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

7. **Home Health Services**

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☒ No limitations ☐ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Limitations are described in **Supplement to Attachment 3.1-B**.

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

8. Private duty nursing services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided:

* Limitations are described in **Supplement to Attachment 3.1-B**.

Aged, Disabled, AFDC and Under 21 (cont.)

9. Clinic services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

10. Dental services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

11. Physical therapy and related services.

a. Physical therapy

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Occupational therapy.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Dentures.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Description provided on attachment.
** See Page 3 of **Supplement to Attachment 3.1-A**.

Aged, Disabled, AFDC and Under 21 (cont.)

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Screening services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

c. Preventive services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

d. Rehabilitative services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

14. Services for individuals age 65 or older in institution for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Skilled nursing facility services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

* Description provided on attachment.

Aged, Disabled, AFDC and Under 21 (cont.)

c. Intermediate care facility services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with Section 1902 (a) (31) (a) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

16. Inpatient psychiatric facility services for individuals under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

17. Nurse-midwife services
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

18. Hospice care (in accordance with Section 1905 (o) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*

☒ Provided in accordance with section 2302 of the Affordable Care Act

☐ Not provided

* Description provided on attachment.

Aged, Disabled, AFDC and Under 21 (cont.)

19. Case management services and Tuberculosis related services.

a. Case management services as defined in, and to the group specified in, **Supplement 1 to Attachment 3.1-A** (in accordance with Section 1905 (a) (19) or Section 1915 (g) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided.

b. Special tuberculosis (TB) related services under Section 1902 (z) (2) (F) of the Act.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

☒ Provided:[+] ☐ Additional coverage[++]
☐ Not provided.

b. Services for any other medical conditions that may complicate pregnancy.

☒ Provided:[+] ☐ Additional coverage[++] ☐ Not provided.
☐ Not provided.

21. Certified pediatric or family nurse practitioners' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Description provided on attachment.

[+] Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

[++] Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

Aged, Disabled, AFDC and Under 21

22. Respiratory care services (in accordance with Section 1902 (e) (9) (A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided

23. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary.

a. Transportation

☒ Provided: ☐ No limitations ☒ With limitations**
☐ Not provided.

Brokered Transportation

MassHealth provides non-emergency transportation to MassHealth Standard, CommonHealth and CarePlus members through selective broker contracts when no public transportation is available that is suitable to a member's condition within a specified distance from an authorized point of origin and destination. Payment for the non-emergency transportation services arranged through a broker is claimed as medical assistance. Delivery methods consist of ambulatory and non-ambulatory transport, including taxi, livery, ferry, and chair car service, or other methods suitable to the member's condition. MassHealth requires prior authorization to determine the medical necessity of non-emergency transportation provided through the brokerage system. Transportation requests are approved by EOHHS and implemented by the brokers. The state will operate the broker program without regard to freedom of choice of providers (section 1902(a)(23) of the Social Security Act).

The state assures that the six Regional Transit Authorities that serve as transportation brokers were selected by the MassHealth agency pursuant to a competitive procurement conducted consistent with federal requirements, and based on the state's evaluation of the broker's experience, performance, references, resources, qualifications, and cost. Each broker is responsible for arranging with its contracted network of transportation providers to deliver non-emergency transportation to and from medically necessary MassHealth covered services for members in the broker's contractually designated service area.

The state assures that its brokerage contracts are subject to regular auditing and oversight by the state to ensure the quality and timeliness of the transportation services provided, and the adequacy of beneficiary access to medical care and services. In addition, the state requires each broker to undertake extensive oversight activities with respect to its network of transportation providers, and assures that brokers have oversight procedures to monitor beneficiary access and complaints and ensure that transportation is timely and transport personnel are licensed, qualified, competent and courteous.

The state assures that transportation services will be provided under contracts with brokers who comply with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and

requirements as the Secretary determines to be appropriate). The brokerage contract requires the brokers to comply with 42 CFR § 440.170(a)(4) governing the provision of non-emergency medical transportation, including prohibitions on referrals and conflicts of interest, and provides for the broker to be liable for the full cost of services resulting from a prohibited referral or relationship, as specified in the contracts. Specifically, the brokers are prohibited from directly providing non-emergency medical transportation services, and are prohibited from making a referral or subcontracting to a transportation service provider if the broker has a financial relationship with the transportation provider as defined at 42 CFR § 411.354(a); or if the broker has an immediate family member, as defined at 42 CFR § 411.351, that has a direct or indirect financial relationship with the transportation provider.

The brokerage contract prohibits the broker from withholding necessary transportation from a MassHealth member for the purpose of financial gain or any other purpose; authorizing transportation that is not the most appropriate and a cost effective means of transportation for that member for the purpose of financial gain or any other purpose; soliciting or accepting any payment or other form of remuneration, including any kickback, rebate, cash, gift, or service in kind from a transportation provider or any other party in order to influence referrals or subcontracting for non-emergency medical transportation provided to a MassHealth member.

Payments under the brokerage contracts are structured to ensure cost-effectiveness. Brokers are required to competitively procure and contract with their network of transportation providers and develop competitive methods of awarding trips and routes to transportation providers. Brokers schedule trips with the lowest cost qualified transportation provider, and the brokers receive reimbursement at cost from the state for their payments to transportation providers.

Brokers are paid a broker-specific average monthly trip cost for each eligible trip. For demand-response trips, the average monthly trip cost is calculated by dividing the broker's total expenditures for demand-response trips by the number of demand-response trips in that month. For program based trips, the average monthly trip cost for each broker is calculated by first determining route-specific average monthly trip rates, and then calculating a combined average trip rate for all routes. To further encourage cost savings, brokers also receive a shared ride incentive payment if they can achieve a target rate of shared ambulatory trips.
A fixed monthly broker management fee paid under the brokerage contract is claimed as an administrative expense. The broker management fee is negotiated between EOHHS and the broker based on the broker's reasonable costs of performing the broker management function, exclusive of direct transportation costs.

The source of the non-federal share of payments for brokered transportation services to MassHealth members is general fund appropriations to the state Medicaid agency.

****** Description of non-brokered transportation is provided on **Attachment 3.1-D**

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided

c. Care and services provided in Christian Science sanitaria.

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided

d. Skilled nursing facility services provided for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided.

* Description provided on **Supplement to Attachment 3.1-B.**

Aged, Disabled, AFDC and Under 21 (cont.)

f. Critical Access Hospital Services

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided.

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described, and limited in **Supplement 2 to Attachment 3.1-A**, and **Appendices A-G to Supplement 2 to Attachment 3.1-A**.

☐ Provided ☒ Not Provided

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Provided to the Medically Needy

Item 26: Personal Care Services

Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

☒ Provided:
- ☒ State Approved (Not Physician) Service Plan Allowed
- ☒ Services Outside the Home Also Allowed
- ☒ Limitations Described on Supplement to Attachment 3.1-A

☐ Not provided

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical and Remedial Care
and Services Provided to the Categorically Needy

Aged, Disabled, AFDC and Under 21 (cont.)

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in **Supplement 3 to Attachment 3.1-B**.

☒ Election of PACE: by virtue of this submittal, the state elects PACE as an optional State Plan service.

☐ No election of PACE: by virtue of this submittal, the state elects to not add PACE as an optional State Plan service.

28. Freestanding Birth Center Services

i. Licensed or Otherwise State-Approved Freestanding Birth Centers

☒ Provided: ☐ No limitations ☒ With limitations

☐ None licensed or approved

Please describe any limitations:

Freestanding birth center services are covered for women with low risk pregnancies. Freestanding birth center services include care during pregnancy, labor, delivery, and recovery following delivery, including newborn nursery and post-partum care.

ii. Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

☒ Provided: ☐ No limitations ☒ With limitations

☐ Not applicable (There are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

The limitations to the practitioners' services are the same limitations as noted in their respective section of the State Plan.

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan: Physicians and certified nurse midwives.

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

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Item 1: **Inpatient Hospital Services**

1. Utilization Management. As a condition of payment, MassHealth requires preadmission screening for all elective admissions to acute hospitals and for all admissions to a chronic disease and rehabilitation hospital, except for members with other insurance (including Medicare).
2. Prior Authorization: MassHealth requires prior authorization for certain acute inpatient hospital services based on medical necessity, including certain drugs and biologics administered in the acute inpatient hospital setting.

Item 2.a: **Outpatient Hospital Services**

MassHealth requires prior authorization for certain outpatient hospital services based on medical necessity, including for more than 20 occupational therapy visits, 20 physical therapy visits, or 35 speech/language therapy visits, including group-therapy visits, for a member within a 12-month period; and for certain drugs and biologics administered in the acute outpatient hospital setting.

DEP/ESPs provide crisis assessment, stabilization, special services and other interventions in advance of a hospital admission for psychiatric treatment. Such services are available 24 hours a day, 7 days a week in order to ensure appropriate access to inpatient hospitalization and diversion from inpatient hospitalization when possible. To qualify as a DEP/ESP, a provider of hospital services must be designated as such by the Commonwealth.

Item 4.a: **Nursing Facilities Services**

If a utilization review team recommends that a recipient in a multi-level long-term-care facility be changed to a lower level of care, the facility is responsible for relocating a recipient to the recommended level of care within the facility. The recipient has the right to appeal the recommendation.

Item 4b: Early and Periodic Screening, Diagnostic and Treatment services for individuals under 21 years of age, and treatment of conditions found.

In addition to all other medically necessary services covered for individuals under age 21, the following services are covered as Rehabilitation services as defined in 42 USC 1396d (a) (13). These services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual:

a. Mobile Crisis Intervention (Services described in this section are effective July 1, 2009.)

Mobile Crisis Intervention provides a short term service that is mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health (mental health or substance abuse) crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Services are available 24 hours a day, 7 days a week. Phone contact and consultation may be provided as part of the intervention. Mobile crisis services may be provided by a single crisis worker or by a team of professionals that are qualified providers who are trained in crisis intervention.

Mobile Crisis Intervention includes the following activities when performed to resolve the immediate crisis:

- Assessment;
- Crisis counseling including individual and family counseling;
- Clinical consultation and coordination with other health care providers;
- Psychopharmacological management, including availability of on-site prescriber;
- Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support;
- Development of a risk management/safety plan. In cases where the youth does not already have such a plan, Mobile Crisis Intervention creates a risk management/safety plan in concert with the parent(s)/guardian(s)/caregiver(s) and any existing service providers (e.g., ICC, In-Home Therapy Services, outpatient therapist); and
- Referral to other services as needed.

Settings: Mobile Crisis Intervention is provided where the child is located.

Providers: Components of Mobile Crises Crisis Intervention are provided by practitioners, as described below. Practitioners must be working under an employment or contractual arrangement with one of the following: outpatient hospitals, community health centers, mental health centers and other clinics.

- **Assessment** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns

- **Crisis counseling including individual and family counseling** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, bachelor-level counselors/paraprofessionals, LADC Is
- **Clinical consultation and coordination with other health care providers** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, bachelor-level counselors/paraprofessionals, LADC Is

- **Psychopharmacological management** - Psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, board-certified or board-eligible child psychiatrists, psychiatry residents.

- **Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, associate-level counselors/paraprofessionals, bachelor-level counselors/paraprofessionals, LADC Is, LADC IIs, LADC IIIs, LSWs, and LSWAs.

- **Development of a risk management/safety plan** -LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns

- **Referral to other services as needed:** LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, associate-level counselors/paraprofessionals, bachelor-level counselors/paraprofessionals, CADACs, CADAC IIs, LADC Is, LADC IIs, LADC IIIs, LSWs, and LSWAs.

b. In-Home Behavioral Services: (Services described in this section are effective October 1, 2009.)

This service provides for the development of a highly specific behavior plan; supervision and coordination of interventions; and training other interveners to address specific behavioral objectives or performance goals in order to treat challenging behaviors that interfere with the youth's successful functioning. An In-Home Behavioral service includes two components: behavior management therapy and behavior management monitoring. It is delivered by one or more members of a team of qualified providers consisting of professional and paraprofessional staff.

1. Behavior management therapy: Behavior management therapy includes activities that are required to develop, implement, monitor and update a behavior plan, including overseeing activities of the behavior management monitor. Behavior management therapy is performed by a licensed clinician who meets the qualifications of a Behavior management therapist as described in the provider qualifications section below.

   Behavior management therapy includes the following:

   - Functional behavioral assessment;
   - Development of a focused behavior plan that identifies specific behavioral and measurable objectives or performance goals and interventions that are designed to diminish, extinguish, or improve specific behaviors related to a youth's behavioral health (mental health or substance abuse) condition(s);
   - Development or revision of a youth's risk management/safety plan to address the specific behavioral needs of the youth;
   - Counseling the parent(s)/guardian(s)/caregiver(s) on how to implement strategies identified in the behavior plan;
   - Working closely with the behavior management monitor to ensure the behavior plans and risk management/safety plan are implemented as developed, and to make any necessary adjustments to the plans;
   - Clinical consultation and coordination with other behavioral health (mental health or substance abuse) care providers; and
   - Referral to other services as needed.

2. Behavior management monitoring. This service includes activities related to the implementation of the behavior plan and a risk management/safety plan as needed. Behavioral management monitoring also includes monitoring the youth's behavior, reinforcing implementation of the behavior plan by the parent(s)/guardian(s)/caregiver(s), and reporting to the behavior management therapist on implementation of the behavior plan and progress toward behavioral objectives or performance goals.

   Behavioral management monitoring is performed by a paraprofessional who meets the qualifications of a behavior management monitor as described in the definitions section below.

   Behavior management monitoring includes the following:

   - Monitoring the youth's progress on implementation of the goals of the behavior plan developed by the behavior management therapist;
   - Assisting the youth in implementing the goals of the behavior plan developed by the behavioral management therapist;
   - Providing guidance to the parent(s)/guardian(s)/caregiver(s) in implementing the plan; and
   - Working closely with the behavior management therapist to ensure the behavior plans and risk management/safety plan are implemented as developed.

Settings: In-Home Behavioral Services may be provided in any setting where the child is naturally located including, but not limited to, the home (including foster homes and therapeutic foster homes), schools, child care centers, and other community settings.

Providers The following practitioners may provide any component of behavior management therapy as described above: Developmental-behavioral pediatricians, developmental-behavioral pediatric fellows, LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns and social work interns. Behavior management monitors may provide any component of behavior management monitoring as described above.

Qualified Practitioners of behavior management therapy also must have two years relevant experience providing direct services to youth and families who require behavior management to address behavioral health (mental health or substance abuse) needs; course work and training in conducting functional behavioral assessments, and selecting, implementing and evaluating intervention strategies; supervised experience conducting functional behavioral assessments and designing, implementing, and monitoring behavior analysis programs for clients and other qualifications established by the state. Practitioners must be working under an employment or contractual agreement with one of the following: outpatient hospitals, community health centers, mental health centers, other clinics, and private agencies certified by the Commonwealth. .

c. In-Home Therapy Services: (Services described in this section are effective November 1, 2009.)

This service provides for the development of an individualized treatment plan; supervision and coordination of interventions for the purpose of treating the youth's mental health and substance abuse needs. The intervention is designed to enhance and improve the family's capacity to improve the youth's functioning in the home and community and may prevent the need for the youth's admission to an inpatient hospital, psychiatric residential treatment facility or other treatment setting. This service is delivered by one or more members of a team of qualified providers consisting of professional and paraprofessional staff, offering a combination of medically necessary in home therapy and therapeutic training and support.

1.

In Home Therapy: In-home therapy is a structured, consistent, strength-based therapeutic relationship between a licensed clinician and the youth and family. The licensed clinician, in collaboration with the family and youth, develops an individualized treatment plan and, using established psychotherapeutic techniques, and intensive family therapy works with the entire family or a subset of the family to implement focused structural or strategic interventions to advance therapeutic goals. In addition, the clinician assists in identifying and utilizing community resources and develops and maintains natural supports for the youth and parent(s)/guardian(s)/caregiver(s) in order to promote sustainability of treatment gains. Phone contact and consultation are provided as part of the intervention. In-Home therapy is performed by a licensed clinician who meets the qualifications of an in-home therapist as described section below.

In-Home Therapy includes the following:

- Assessments;
- Development of an individualized treatment plan by the qualified practitioner in partnership with the youth and parent(s)/guardian(s)/caregiver(s) and, with required consent, in consultation with other providers that is designed to address the youth's mental health or substance abuse condition;
- Ongoing monitoring and modification of the individualized treatment plan as indicated;
- Review/development of a risk management/safety plan;
- Phone and face-to-face consultation with other providers, individuals and entities who may impact the youth's treatment plan;
- Family counseling through which the licensed clinician works with the entire family, or a subset of the family, to advance therapeutic goals; and
- Referral to other services as needed.

2. Therapeutic training and support is a service provided by an associate-level or bachelor-level paraprofessional working under the supervision of a clinician to support implementation of the in-home therapists treatment plan in order to achieve the goals of the that plan. The paraprofessional assists a licensed clinician in implementing the therapeutic objectives of the individualized treatment plan. Phone contact and consultation may be provided as part of the intervention.

   Therapeutic training and support includes the following:

   - Providing guidance to the youth and parent(s)/guardian(s)/caregiver(s) in implementing the treatment plan;
   - Providing skills training for youth and parent(s)/guardian(s)/caregiver(s) in support of the treatment plan goals; and
   - Monitoring the youth's and parent(s)/guardian(s)/caregiver(s) progress on achieving treatment plan goals and communicating regularly with the clinician so that the treatment plan can be modified and necessary.

   Settings: In home therapy services may be provided in any setting where the child is naturally located including, but not limited to, the home (including foster homes and therapeutic foster homes), schools, child care centers, and other community settings.

   Providers: The following practitioners may provide any component of in-home therapy as described above: In-home therapy services are delivered by the following practitioners: LICSW, LCSW, LMFT, LMHC, Licensed psychologist, Master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinic specialists trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns. The following practitioners may provide any component of therapeutic training and support as described above: Associate-level counselors / paraprofessionals, bachelor-level counselors / paraprofessionals. Practitioners must be working under an employment or contractual arrangement with one of the following outpatient hospitals, community health centers, mental health centers, other clinics and private agencies certified by the Commonwealth. .

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d. Therapeutic Mentoring Services: (Services described in this section are effective October 1, 2009.)

Therapeutic mentoring services are structured, one-to-one, strength-based services that are designed to help ameliorate behavioral health (mental health or substance abuse) related conditions which prevent the youth from appropriate social functioning. These services must be delivered according to an individualized treatment plan developed by either an outpatient clinician, an in-home therapy clinician or, for youth enrolled in Intensive Care Coordination, a care planning team. Progress toward meeting the identified goal(s) must be documented and reported regularly to the provider responsible for the youth's treatment plan.

The therapeutic mentor does not provide social, educational, artistic, athletic, recreational or vocational services.

Settings: Therapeutic mentoring services are provided to youth in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), school, child care centers and other community settings. .

Providers: Therapeutic mentoring services are delivered by therapeutic mentors. Practitioners must be working under an employment or contractual arrangement with on of the following: outpatient hospitals, community health centers, mental health centers, other clinics, and private agencies certified by the Commonwealth**.** Providers of therapeutic mentoring utilize therapeutic mentors to provide these services.

e **Family Support and Training:** (Services described in this section are effective July 1, 2009.)

A family support and training partner addresses goals established in an individualized treatment plan in order to resolve or ameliorate the youth's mental health, behavioral and emotional needs through enhancing the capacity of the parent(s)/guardians/caregivers) to implement activities required to meet the goals of the plan. Family support and training is a skill-building support and not a form of therapy or counseling. The individualized treatment plan must be developed by either an outpatient clinician, an In-home therapy clinician or, for youth enrolled in Intensive Care Coordination, a care planning team. These services include the following when they are relevant to the goals in the youth's individualized care plan:

- providing guidance to parent(s)/guardians(s)/caregiver(s) on navigating systems that support youth with mental health, behavioral and emotional needs, such as working effectively with state agency case managers, school system officials, provider agency staff and clinicians;
- fostering empowerment of parent(s)/guardian(s)/caregiver(s) by offering supportive guidance for parents of youth with mental health needs and encouraging participation in peer/parent support and` self-help groups;
- providing guidance to the parent(s)/guardian(s)/caregiver(s) how to find, access and use formal and informal community-based resources (e.g., after-school programs, food assistance, housing resources, youth-serving systems, etc.); and
- modeling these skills for parent(s)/guardians(s)/caregiver(s).

Family support and training services do not include respite care or child care services.

Settings: Family support and training services are provided in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and other community settings.

Providers: Family support and training services are delivered by a family support and training partner. A family support and training partner must be working under an employment or contractual arrangement with one of the following: outpatient hospitals, community health centers, mental health centers, other clinics and private agencies certified by the Commonwealth. .

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Definitions:

Associate-level counselors/paraprofessional
Associate-level counselors/paraprofessionals must have an associate's degree in a human services field from an accredited academic institution and one (1) year of relevant experience working with families or youth. If the associate's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Associate-level counselors/paraprofessionals are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Bachelor-level counselors/paraprofessional
Bachelor-level counselors/paraprofessionals must have a bachelor's degree in a human services field from an accredited academic institution and one year of relevant experience working with families or youth. If the bachelor's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Bachelor-level counselors/paraprofessionals are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Behavior Management Monitor
Behavioral management monitors must have a bachelor's degree in a human services field from an accredited university and one (1) year of relevant experience working with families, children or adolescents who require behavior management, or an associate's degree and a minimum of two (2) years of relevant experience working with families, children or adolescents who require behavior management. Behavior management monitors are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist..

Certified Alcoholism/Drug Abuse Counselor (CADAC)
Certified by the private Massachusetts Board of Substance Abuse Counselor Certification (MBSACC). CADAC certification requires a combination of either a Master's degree in a "behavioral science area" and 2,000 hours of supervised experience or a Bachelor's degree in a behavioral science area and 4,000 hours of supervised experience or an Associates' degree in a behavioral science area and 6,000 hours of supervised experience. Certification also requires documentation of having received a minimum of 270 clock hours of continuing education related to the five domains for alcohol and other drug abuse. Consistent with applicable state licensure requirements, certified alcoholism/drug abuse counselors are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Certified Alcoholism/Drug Abuse Counselor II (CADAC II)
Certified by the private Massachusetts Board of Substance Abuse Counselor Certification (MBSACC). CADAC II certification requires a master's degree (or higher) from a regionally accredited academic institution in a human services behavioral sciences field with a clinical application (i.e., practicum); 2,000 hours of supervised experience and documentation of completion of 300-hour practicum. Consistent with applicable State licensure requirements, certified alcoholism/drug abuse counselor IIs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist..

Developmental-Behavioral Pediatrician
A person with a current, valid, unrestricted license to practice medicine issued by the Massachusetts Board of Registration in Medicine, who is board-certified in Pediatrics and either board-eligible or board-certified in Developmental-Behavioral Pediatrics

Developmental-Behavioral Pediatric Fellow
A person with a current, valid, unrestricted license to practice medicine issued by the Massachusetts Board of Registration in Medicine, who is board-certified in Pediatrics and enrolled in a training program in Developmental-Behavioral Pediatrics accredited by the Accreditation Council for Graduate Medical Education (ACGME). Services provided by the Developmental-Behavioral Pediatric Fellow must be provided in a setting approved for training by the sponsoring training institution, under supervision of a board certified or eligible Developmental-Behavioral Pediatrician, consistent with applicable state licensure requirements.

Family Support and Training Partner
A family support and training worker must have experience as a caregiver of a youth with special needs, preferably youth with behavioral health needs, experience in navigating any of the youth and family-serving systems and teaching family members who are involved with the youth and family serving systems, and either: a bachelor's degree in a human services field from an accredited academic institution, or an associate's degree in a human services field from an accredited academic institution and one (1) year of experience working with children/adolescents/transition-age youth and families, or a high school diploma or General Education Development (GED) and a minimum of two (2) years of experience working with children/adolescents/transition age youth and families. If the bachelor's or associate's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Family partners are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Alcohol and Drug Counselor I – LADC I
A person licensed by the Department of Public Health to conduct an independent practice of alcohol and drug counseling, and to provide supervision to other alcohol and drug counselors, as defined in 105 CMR 168.000. These requirements include: a master's or doctoral degree in behavioral sciences, a minimum of 270 hours of training in substance abuse counseling, 300 hours of supervised practical training and 6,000 hours of supervised alcohol and drug counseling work experience.

Licensed Alcohol and Drug Counselor II – LADC II
A person licensed by the Department of Public Health to practice alcohol and drug counseling under clinical supervision, as defined in 105 CMR 168.000. These requirements include: a high school diploma or equivalent, a minimum of 270 hours of training in substance abuse counseling, 300 hours of supervised practical training and 6,000 hours of supervised alcohol and drug counseling work experience (4,000 if applicant holds a bachelor's degree). Consistent with applicable state licensure requirements, LADC IIs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Alcohol and Drug Counselor Assistant – LADC III
A person licensed by the Department of Public Health to provide recovery based services under direct clinical and administrative supervision, as defined in 105 CMR 168.000. These requirements include a high school diploma or equivalent, 2,000 hours of work experience in the alcohol or drug abuse field and a minimum of 50 hours of training in substance abuse counseling. Consistent with applicable state licensure requirements LACD IIIs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Independent Clinical Social Worker (LICSW)
A person with a current, valid, unrestricted license to practice as an LICSW, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: master's or doctoral degree in Social Work from a program accredited by the Council on Social Work Education and two years supervised experience.

Licensed Clinical Social Worker (LCSW)
A person with a current, valid, unrestricted license to practice as an LCSW, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: master's or doctoral degree in Social Work from a program accredited by the Council on Social Work Education. Consistent with applicable state licensure requirements, LCSWs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Social Worker (LSW)
A person with a current, valid, unrestricted license to practice as an LSW, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: a bachelor's degree in Social Work from a program accredited by the Council on Social Work Education or a bachelor's degree in any subject and 3500 hours of supervised experience providing social work services. Consistent with applicable state licensure requirements, LSWs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Social Work Associate (LSWA)
A person with a current, valid, unrestricted license to practice as an LSWA, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: an associate degree, or at least sixty credit hours of college education, in the fields of social work, psychology, counseling or other similar human services field, from an accredited college or university; or a baccalaureate degree in any field from an accredited college or university; or a minimum of one thousand (1000) hours of education in social work theory and methods in courses or programs approved by the Board of Registration of Social Workers. Consistent with applicable state licensure requirements, LSWAs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Marriage and Family Therapist (LMFT)
A person with a current, valid, unrestricted license to practice as a LMFT, issued by the Massachusetts Board of Registration of Allied Mental Health Professionals. These requirements include: a master's degree in the mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university and two years supervised experience.

Licensed Mental Health Counselor (LMHC)
A person with a current, valid, unrestricted license to practice as a LMHC, issued by the Massachusetts Board of Registration of Allied Mental Health Professionals. These requirements include: a master's degree in the mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university and two years supervised experience.

Licensed Psychologist
A person with current, valid, unrestricted license to practice psychology issued by the Massachusetts Board of Registration in Psychology. These requirements include a doctoral degree from a program accredited by the American Psychological Association and two years supervised experience .

Marriage and Family Therapy Intern
The marriage and family therapy intern must be a second-year, clinical-track student in a structured field placement that is a component of a master's in marriage and family therapy or a master's in a counseling program that is fully accepted by the Board of Allied Mental Health and Human Services Profession. The marriage and family therapy intern must provide services under the direct supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse, or Nurse Clinical Specialist consistent with applicable state licensure requirements.

Master's Level Counselor
A person with a master's or doctoral degree in a mental health field (including, but not restricted to, counseling, family therapy, social work, psychology, etc.) from an accredited college or university who is supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse, or Nurse Clinical Specialist.

Mental Health Counselor Intern
The Mental Health Counselor Intern must be a second-year, clinical-track student in a structured field placement that is a component of a master's in mental health counseling or a master's in a counseling psychology program that is fully accepted by the Board of Allied Mental Health and Human Services Profession Consistent with applicable state licensure requirements, the Mental Heath Counselor Intern provides services under the supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Psychiatric Nurse
A person with a current, valid, unrestricted license to practice as a registered nurse issued by the Board of Registration in Nursing, a master's degree in the mental health fields and one (1) year of experience delivering mental health services to families and youth. Consistent with applicable state licensure requirements, the Psychiatric Nurse provides services under the supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Psychiatric Nurse Mental Health Clinical Specialist
A person with a current, valid, unrestricted license to practice as a registered nurse issued by the Massachusetts Board of Registration in Nursing and current, valid, unrestricted authorization by the Massachusetts Board of Registration in Nursing to practice as a Psychiatric Nurse Mental Health Clinical Specialist.

Psychiatric Nurse Mental Health Clinical Specialist Trainee
A person with a current, valid, unrestricted license to practice as a registered nurse issued by the Massachusetts Board of Registration in Nursing who is enrolled in a Psychiatric Nurse Mental Health Clinical Specialist training program recognized by the Massachusetts Board of Registration in Nursing. Consistent with applicable state licensure requirements, services provided by the Psychiatric Nurse Mental Health Clinical Specialist trainee are provided under supervision of a Psychiatric Nurse Mental Health Clinical Specialist.

Psychiatric Resident
A person with a current, valid, full or limited license to practice medicine issued by the Massachusetts Board of Registration in Medicine, who is enrolled in an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency training program in either adult psychiatry or child and adolescent psychiatry. Services provided by the Psychiatric intern are provided in a setting approved for residency training by the sponsoring training institution, under supervision of a board certified or eligible child psychiatrist, consistent with applicable state licensure requirements.

Psychiatrist
A person with a current, valid, unrestricted license to practice medicine issued by the Massachusetts Board of Registration in Medicine. Psychiatrists treating youth ages 0 to 19 shall be board-certified or board-eligible in child and adolescent psychiatry. Psychiatrists treating youth ages 19 to 21 shall be trained in adult psychiatry.

Psychology Intern
The psychology intern must be admitted to doctoral candidacy in a structured clinical, or counseling, American Psychological Association (APA)-approved doctoral program. Consistent with state licensure requirements, services provided by a psychology intern are provided under the direct supervision of a licensed psychologist.

Social Work Intern
The Social Work Intern must be a second-year, clinical-track student in a structured field practicum that is a component of an MSW program that is fully accredited by the Council on Social Work Education. Consistent with applicable state licensure requirements, services are provided under the direct supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Therapeutic Mentors
Therapeutic mentors must be 21 years of age or older and have either: a bachelor's degree in a human service field from an accredited academic institution and one (1) year of relevant experience working with children/adolescents/transition age youth; or, an associate's degree in a human services field from an accredited academic institution and one (1) year of relevant experience working with children/adolescents/transition age youth; or, a high school diploma or General Educational Development (GED) and a minimum of two (2) years of experience working with children/adolescents/transition age youth. If the bachelor's or associate's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Therapeutic mentors must be supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist. .

In addition to all other medically necessary services covered for individuals under age 21, the following services are covered as services provided by Other Licensed Practitioners as defined in 42 USC 1396d (a) (6).

Applied Behavior Analyst Services
Coverage is for services for individuals under age 21 that are provided by a licensed applied behavior analyst or licensed physician, psychologist or psychiatrist working under the scope of his or her practice, or provided directly by a licensed assistant applied behavior analyst or non-licensed para-professional under the supervision of a licensed applied behavior analyst or licensed physician, psychologist or psychiatrist working under the scope of his or her practice.

Non-licensed paraprofessionals must be 18 years old and must have either: (1) a high school diploma or a General Education Development (GED) and have 12 months experience working with persons with developmental disabilities/children/adolescents/transition age youth and families; or (2) must have either an associate's degree in either a human, social, or educational services discipline, or a degree or certification related to behavior management, from an accredited community college or educational institution, and have six months experience working with persons with developmental disabilities/ children/adolescents/transition age youth and families.

The supervising provider ensures that all ABA staff under their supervision completes training related to the clinical and psychosocial needs of the target population upon employment and annually thereafter.

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Pursuant to MGL Chapter 112 §165, applied behavior analysts must be licensed by the Commonwealth of Massachusetts Board of Registration of Allied Mental Health and Human Services Professions. Licensed applied behavior analysts or licensed physicians, psychologists or psychiatrists working under the scope of their practices may bill for applied behavior analyst services provided directly by a licensed assistant applied behavior analysts or a non-licensed para-professional, when the services are performed under the supervision of the licensed applied behavior analyst or licensed physician, psychologist or psychiatrist working under the scope of his or her practice and the provided services are within the scope of practice for a licensed applied behavior analyst.

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Item 5: **Physician's Services**

Physician services are provided in accordance with 42 CFR 440.50.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Services that are subject to prior authorization include certain surgery services, including reconstructive surgery and gender reassignment surgery; and certain practitioner-administered drugs. MassHealth covers one application of fluoride varnish every three months for members under 21 years of age without prior authorization; additional applications are covered with medical justification.

See also Supplement to Attachment 3.1-B, p.1, Item 1.

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G. School-Based Services:

School-Based Services (SBS) are services that are listed in a recipient student's Individualized Education Plan (IEP), a section 504 accommodation plan pursuant to 34 C.F.R. § 104.36, an Individualized Health Care Plan, an Individualized Family Service Plan, or are otherwise medically necessary, that are coverable under one or more of the service categories described in Section 1905(a) of the Social Security Act, and that are necessary to correct or ameliorate defects or physical or mental illnesses or conditions discovered by an EPSDT screen.

Service providers shall be licensed or otherwise qualified under the applicable State practice act or comparable licensing criteria by the State Department of Public Health, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them is done by practitioners qualified to make those determinations within their licensed scope of practice.

Covered services include: physical therapy, occupational therapy and other services, including services provided by audiologists and services for individuals with speech, hearing and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR § 440.110; physician services under 42 CFR § 440.50(a); optometry services provided by a qualified professional under 42 CFR § 440.60; respiratory therapy provided by a qualified professional under 42 CFR § 440.60; nursing services coverable under 42 CFR § 440.80 and 42 CFR § 440.60 ordered by a licensed physician and performed by a registered nurse or licensed practical nurse; nursing services provided on a restorative basis under 42 CFR § 440.130(d), including services delegated to individuals who receive appropriate teaching, direction, and supervision from a Registered Nurse or Practical Nurse; fluoride varnish performed by a dental hygienist under 130 CMR § 420.424(b) in accordance with 42 CFR § 440.100; personal care services coverable and performed by individuals qualified under 42 CFR § 440.167; services performed by licensed practitioners within the scope of their practice for individuals with behavioral health (mental health and substance abuse) disorders, as defined under state law, and coverable as medical or other remedial care under 42 CFR § 440.60; diagnostic, screening, preventive, and rehabilitative services covered under 42 CFR § 440.130; medical nutritional services provided by a qualified professional under 42 CFR § 440.60; and sports related or other injury assessment and therapy provided by a qualified professional under 42 CFR § 440.60. Assessments and independent evaluations are covered as necessary to assess or reassess the need for medical services in a child's treatment plan and must be performed by any of the above licensed practitioners within the scope of practice.

Item 6: **Licensed Practitioners Services**

Licensed Practitioner Services are provided in accordance with 42 CFR 440.60.

a. **Podiatrists' Services** – Coverage is for podiatry services that are considered medically necessary. Office visits are limited to one initial visit, one limited visit per 30 day period, one extended visit per 30 day period, and one follow up visit per week. Out of office visits are limited to one visit in a 30 day period in a long-term-care facility or the member's home and two visits in a 30 day period in a hospital setting.

b. **Optometrists' Services** –

Members under age 21 are limited to one comprehensive examination within a 12 month period; additional services are provided when medically necessary. . Members aged 21 or older are limited to one comprehensive eye examination within a 24 month period; additional services are provided when medically necessary.

Services that are subject to prior authorization include: fundus photography; non-plastic prosthetic eyes; unlisted services; and vision training.

Exclusions consist of treatment for congenital dyslexia.

c. **Chiropractic Services** – include chiropractic manipulative treatment and radiology services. Services are limited to medically necessary treatment related to a neuromusculoskeletal condition. The MassHealth agency limits payment for chiropractor services for any combination of office visits and chiropractic manipulative treatments. Any office visits or chiropractic manipulative treatments in excess of 20 per member per calendar year are subject to prior authorization.

d. **Other Practitioners' Services** – Other practitioners' services also include psychologists' services, which are limited to psychological testing only; hearing instrument specialist services and public health dental hygienist services. Hearing instrument specialist services are limited to the practice of fitting and dispensing of hearing aids which means the measurement of human hearing solely for the purpose of making selections, adaptations or sales of hearing aids intended to compensate for impaired hearing. The MassHealth agency does not pay for more than one hearing aid per ear per member in a 60 month period without prior authorization.

Public health dental hygienist services are limited to services provided in public health settings within the scope of practice governed by the Massachusetts Board of Registration in Dentistry and covered by the MassHealth agency.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided to the Medically Needy

Item 6: **Licensed Practitioners Services (continued)**

f. Midlevel Practitioner Services – Midlevel practitioner services include the services of certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and psychiatric clinical nurse specialists licensed under state law. The services of all midlevel practitioners are limited to their scope of practice authorized by state law and must be provided in accordance with applicable state licensure and other applicable federal and state requirements.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Limits on covered services can be exceeded when medically necessary, with prior authorization.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided

Item 7: **Home Health Services**

c. Medical supplies, equipment, and appliances must be prescribed or ordered by the recipient's physician and must be furnished and claimed directly by appropriate vendors in accordance with the Division's regulations relative to drugs, restorative services, and rehabilitative services. Home health agencies must transmit such prescriptions and orders to vendors who are providers in the Medical Assistance Program.

Item 8: Private Duty Nursing Services

a. Private duty nursing services are provided in accordance with 42 CFR 440.80
b. Private duty nursing services are not provided in a hospital or skilled nursing facility.
c. Private duty nursing services are subject to prior authorization

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy Groups

Item 9: **Clinic Services**

Clinic Services are covered with limitations, including those specified in Item 9. MassHealth does not cover experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments, or nonmedical services (e.g., vocational and educational services, research).

Specific clinic services covered by MassHealth include the following:

a. Designated Emergency Mental Health Provider

Designated Emergency Mental Health Providers/Emergency Services Programs (DEP/ESPs) provide crisis assessment, interventions, and stabilization services in advance of a hospital admission for psychiatric treatment. Such services are available 24 hours a day, 7 days a week in order to ensure appropriate access to inpatient hospitalization and diversion from inpatient hospitalization when possible. DEP/ESP services are provided in freestanding facilities. DEP/ESPs operate under the direction of a psychiatrist. To qualify as a DEP/ESP, a provider must be designated as such by the Commonwealth.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy Groups

(Item 9 Clinic Services, continued)

b. Freestanding Ambulatory Surgery Centers

MassHealth covers the following services in freestanding ambulatory surgery centers (FASCs) - outpatient same-day surgical, diagnostic, and medical services requiring general, local or regional anesthesia, a dedicated operating room, and a postoperative recovery room to patients who require constant medical supervision for a limited amount of time upon completion of the surgery or procedure, and are not expected to require hospitalization or overnight services. FASC services also include anesthesia, laboratory, radiology, drugs, biologicals, equipment, and supplies, related to the provision of the surgery or procedure.

MassHealth covers sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing – and sterilization-related services (including anesthesia, laboratory, radiology, drugs, equipment, and supplies) in FASCs when the member has voluntarily given informed consent in the manner and at the time required by federal law.

MassHealth does not cover the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does cover diagnosis of male or female infertility.

FASCs must obtain prior authorization for FASC services provided out of state when the FASC is located more than 50 miles from the Massachusetts border.

(Item 9 Clinic Services, continued)

c. Family Planning Clinics

MassHealth covers family planning-related services, including medical examinations, counseling, follow-up health care, laboratory tests, procedures, supplies and drugs, including contraceptive supplies and drugs, provided in a family planning clinic.

MassHealth covers sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing – and sterilization-related services (including anesthesia, laboratory, radiology, drugs, equipment, and supplies) in family planning clinics when the member has voluntarily given informed consent in the manner and at the time required by federal law.

MassHealth does not cover the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does cover diagnosis of male or female infertility.

The family planning agency may be paid for a maximum of one HIV pre-test counseling visit and one HIV post-test counseling visit per member per test per day. The MassHealth agency pays for a maximum of four HIV pre-test counseling visits and four HIV post-test counseling visits per calendar year.

(Item 9 Clinic Services, continued)

d. Sterilization Clinics

MassHealth covers sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing – and sterilization-related services, including anesthesia, laboratory, radiology, drugs, equipment, and supplies provided in sterilization clinics.

Sterilization is covered in sterilization clinics when the member has voluntarily given informed consent in the manner and at the time required by federal law.

MassHealth does not cover the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does cover diagnosis of male or female infertility.

(Item 9 Clinic Services, continued)

e. Radiation Oncology Centers

MassHealth covers radiation oncology and related services provided in radiation oncology centers, including radiologic procedures, drugs, equipment and supplies, and routine laboratory tests necessary for the diagnosis, detection, and treatment of disease, and for the maintenance of the health of MassHealth members.

(Item 9, Clinic Services continued)

f. Renal Dialysis Clinics

MassHealth covers renal dialysis and related services, including supplies, drugs and routine laboratory tests, provided in renal dialysis clinics. MassHealth covers home dialysis training, including self-dialysis (hemodialysis, intermittent peritoneal dialysis, and continuous cycling peritoneal dialysis) and continuous ambulatory peritoneal dialysis training only when the MassHealth member attends such training at the clinic site.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy Groups

(Item 9 Clinic Services, continued)

g. Rehabilitation Centers

MassHealth covers the following services in freestanding rehabilitation centers for individuals requiring physical rehabilitation: rehabilitation evaluations conducted by physicians; and physical, occupational and speech/language therapy visits and evaluations performed by licensed therapists to improve or prevent the worsening of a congenital or acquired condition.

MassHealth covers maintenance therapy performed by a licensed therapist when the therapist's specialized knowledge and judgment are required to perform services that are part of a maintenance program.

MassHealth requires the rehabilitation center to obtain prior authorization for more than 20 occupational therapy visits, 20 physical therapy visits, or 35 speech/language therapy visits, including group therapy visits, for a member within a 12-month period. Diversional and recreational therapy are not covered.

(Item 9 Clinic Services, continued)

h. Speech and Hearing Centers

MassHealth covers the following services in a freestanding speech and hearing center: audiological services, and speech, hearing or language services performed by a licensed, certified audiologist or licensed, certified speech therapist.

MassHealth covers maintenance therapy performed by a licensed therapist when the therapist's specialized knowledge and judgment are required to perform services that are part of a maintenance program.

MassHealth requires the speech and hearing center to obtain prior authorization for more than 35 speech and language pathology visits, including group therapy visits, for a member in a 12-month period. Diversional and recreational therapy are not covered.

MassHealth covers up to one individual treatment and one group therapy session per member per day at the speech and hearing center.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy Groups

(Item 9 Clinic Services, continued)

i. Mental Health Centers

MassHealth covers diagnosis and treatment of mental and emotional disorders at mental health centers. Such services include diagnostic services, psychological testing, individual therapy, couple therapy, family therapy, group therapy, medication visit, case consultation, family consultation and psychotherapy for crisis/emergency services.

MassHealth does not cover nonmedical services provided by mental health centers (e.g., vocational, educational, recreational, community, and life-enrichment services) or diagnostic or treatment services provided at a mental health center as an integral part of a planned and comprehensive program (e.g., a residential, day activity, or drop-in program) that is organized to provide primarily non-medical or other nonreimbursable services. Play therapy, as an alternative to strictly verbal expression, is not considered a recreational service and is covered.

MassHealth covers multiple treatment modalities for a member on the same day, except for diagnostics. MassHealth does not cover more than one session of a single type of service provided to an individual member on the same day, except for the provision of psychotherapy for crisis.

Group Therapy is limited to a maximum of 12 members per group.

Psychotherapy for crisis is limited to one initial unit of service and up to three add-on units of service per date of service.

(Item 9 Clinic Services, continued)

j. Substance Use Disorder Treatment Clinics

MassHealth covers individual, group, and family/couple substance abuse rehabilitative counseling, case consultation, and acupuncture detoxification at substance abuse outpatient counseling programs.

MassHealth covers medication assisted treatment for opioid dependency at opioid treatment service centers, in accordance with applicable clinical standards. Prior authorization is required for buprenorphine.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

(Item 9 Clinic Services, continued)

k. **Limited Services Clinic**

MassHealth covers vaccines and immunizations, as well as medical evaluation, testing, screening, treatment, and clinical laboratory services for episodic, urgent care relating to an illness provided in state-licensed limited services clinics.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy Groups

Item 10: **Dental Services**

A. For members under age 21, all medically necessary dental services, including comprehensive and periodic oral evaluations and all dental services needed for maintenance of dental health, restoration of teeth, and relief of pain and infections are covered.

B. For members age 21or over the following dental services are covered:

- diagnostic services including oral evaluation (comprehensive and periodic) and radiographs;
- preventive services including prophylaxis;
- emergency care visits;
- certain restorative services (fillings);
- certain prosthodontic services (full and partial dentures including repairs);
- extractions;
- anesthesia;
- treatment of complications related to surgery;
- certain oral surgery such as biopsies and soft-tissue surgery; and
- certain periodontal services, including gingivectomies, gingivoplasties, and periodontal scaling and root planing.

In addition, for members age 21 or over, there are limited exceptions that allow for topical fluoride when documented as medically necessary.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided to the Categorically Needy

Item 17: **Nurse-Midwife Services**

Nurse-midwife services are provided by certified nurse-midwives in accordance with 42 CFR 440.165.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Limits on covered services can be exceeded when medically necessary, with prior authorization.

See also Supplement to Attachment 3.1-B, p.1, Item 1.

Item 23: Pediatric or Family Nurse Practitioners' Services

Pediatric and family nurse practitioner services are provided by certified nurse practitioners in accordance with 42 CFR 440.166.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Limits on covered services can be exceeded when medically necessary, with prior authorization.

See also Supplement to Attachment 3.1-B, p.1, Item 1.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided to the Categorically Needy

Item 11: **Therapies and Related Services**

Speech, occupational and physical therapies to improve or prevent the worsening of a congenital or acquired condition are provided in accordance with 42 CFR 440.110. MassHealth pays for maintenance therapy performed by a licensed therapist when the therapist's specialized knowledge and judgment are required to perform services that are part of a maintenance program. Diversional and recreational therapy are not reimbursable services.

Services that are subject to prior authorization include more than 20 occupational therapy visits, 20 physical therapy visits, or 35 speech/language therapy visits, including group therapy visits, for a member within a 12 month period.

Audiologist Services are provided in accordance with 42 CFR 440.110. The MassHealth agency does not pay for more than one hearing aid per ear per member in a 60-month period without prior authorization.

Item 12: **Prescribed Drugs, Dentures, Prosthetic Services, and Eyeglasses**

a. **Prescribed Drugs** - Legend FDA-approved drugs and certain non-legend over-the-counter drugs are reimbursable subject to the conditions specified in 130 CMR 406.000. Prescribers must obtain prior authorization for non-generic multiple source drugs, and for any drug identified by the Division in accordance with 130 CMR 450.303. Insulins are reimbursable for recipients without restrictions.

Active pharmaceutical ingredients (APIs) and excipients that are included in an extemporaneously compounded prescription written by an authorized prescriber and dispensed by MassHealth pharmacy providers are covered if medically necessary.

The state is in compliance with Section 1927 of the Social Security Act. Based on the requirements of Section 1927 of the Social Security Act, the state has the following policies for the supplemental rebate program for the Medicaid population:

1. The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates.

2. A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on March 31, 2016, and entitled, "State of Massachusetts Supplemental Rebate Agreement" has been authorized by CMS, and a value-based rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on March 12, 2019, and entitled, "State of Massachusetts Value-Based Supplemental Rebate Agreement" has been authorized by CMS..
3. Manufacturers with supplemental rebate agreements are allowed to audit utilization data. Supplemental rebates received by the state in excess of those required under the National Drug Rebate Agreement (NDRA) will be shared with the federal government on the same percentage basis as applied under the NDRA.
4. The unit rebate amount under the NDRA is confidential and cannot be disclosed in accordance with Section 1927(b)(3)(D) of the Social Security Act. No substantial changes will be made to the supplemental rebate agreement without CMS authorization. Supplemental rebates received pursuant to these agreements are only for the MassHealth program.
5. All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provisions of the NDRA.
6. The prior authorization process for covered outpatient drugs conforms to Section 1927(d)(5) of the Social Security Act. The prior authorization process provides for a turnaround response by either telephone or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a seventy-two hour supply of medication.
7. The state may agree within the terms of a supplemental rebate agreement that the covered drug(s) may or may not be subject to prior authorization, for as long as the agreement is in effect, and that the state may obtain supplemental drug rebates in either case. This may include instances in which the state imposes prior authorization on a drug or drugs for clinical purposes, instances in which the state imposes prior authorization on a drug or drugs as part of a "step-edit" approach, and instances in which the state imposes prior authorization on a drug or drugs (which may include a generic drug) when the application of the supplemental rebate on the preferred drug or drugs results in a lower net cost to the state. The state may also enter value- or outcome-based agreements.
8. Only drugs supplied to MassHealth members will be covered under these agreements. In addition to collecting supplemental rebates for fee-for-service claims, the state may, at its option, also collect supplemental rebates for MassHealth member utilization through MCE(s) under an agreement.
9. The state may continue to collect supplemental rebates under agreements that are currently in process or effect based on the form of agreement approved by CMS as part of MA-TN-012-005 until those agreements are otherwise terminated or amended to align with the CMS-approved forms referred to in paragraph 2, above.

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the

Medicare Prescription Drug Benefit –Part D.

☑ **The following excluded drugs are covered:**

☑ (a) agents when used for anorexia, weight loss, weight gain (for medically necessary appetite stimulants only)

☐ (b) agents when used to promote fertility

☑ (c) agents when used for the symptomatic relief cough and colds (covered only when dispensed to members residing in a nursing facility)

☑ (d) prescription vitamins and mineral products, except prenatal vitamins and fluoride-containing products

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
And Remedial Care and Services Provided to the Medically Needy

☑ (f) nonprescription drugs, as follows:

Allergy Agents, Ophthalmic
Analgesics
Anthelmintic Agents
Antihistamines/Decongestants
Antimicrobials, Topical
Contraceptives, Oral
Dermatologic Agents, Topical
Gastrointestinal Products
Nonoxynol-9
Otic Agents
Pediculicides/Scabicides

☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

b. **Dentures** - Dentures are provided in accordance with 42 CFR 440.120. See **Supplement to Attachment 3.1-A**, page 3, Item 10, above.

c. **Prosthetic Devices** Prosthetic devices (including orthotics) are provided in accordance with 42 CFR 440.120.

MassHealth covers medically necessary prosthetics and orthotic services, including repairs after exhaustion of manufacturer warranties.

Prosthetic services that are subject to prior authorization include: addition to lower extremity prosthesis, endoskeletal ankle foot system, microprocessor controlled, lower extremity prosthesis not otherwise specified, external power device, electronic elbow and accessories, upper extremity prosthesis not otherwise specified, breast prosthesis, unlisted procedures for miscellaneous prosthetic services.

Orthotic services that are subject to prior authorization include: compression garments, protective helmet, foot pressure off loading device, spinal orthosis not otherwise specified, lower extremity orthosis not otherwise classified, orthopedic foot wear and upper limb orthosis not otherwise specified.

Members of any age may obtain prior authorization for units in excess of the limits for service codes for all other prosthetic and orthotic services.

d. **Eyeglasses** Eyeglasses are provided in accordance with 42 CFR 440.120. The following are covered services: eyeglasses, eyeglass parts, eyeglass dispensing, contact lenses and other visual aids

Services that are limited to members who meet certain clinical criteria include: tinted lenses, coated lenses, and two pairs of eyeglasses instead of bifocals, cataract lenses and contact lenses..

Services that are subject to prior authorization include: extra or spare eyeglasses; the following types of contact lenses--PMMA color vision, deficiency, gas permeable or hydrophilic toric prism ballast, gas permeable or hydrophilic bifocal; low vision aids; glass lenses; special-needs lenses; tints other than “pink 1” and “pink 2” that are available for plastic lenses only, and, polycarbonate lenses for members aged 21 or older or for any member who is amblyopic or monocular.

Exclusions consist of absorptive lenses of greater than 25% absorption, prisms obtained by decentration; contact lenses for extended wear use; invisible bifocals; and Welsh 4-drop Lens.

The volume purchase of eyeglasses limits the selection of frames and lenses to a basic assortment from the optical supplier.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Item 16: Inpatient Psychiatric Facility Services for Individuals under 22 Years of Age

Preadmission screening will be required for all non-court-ordered admissions of Medicaid recipients (as per 42 CFR 441.152). Such certification of the need for services for conversion cases (people applying for Medicaid eligibility while hospitalized in an inpatient psychiatric facility) will be made by the team responsible for the plan of care (42 CFR 441.153(b)). Periodic reviews of use will be performed by the Medicaid agency or its designee.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Item 15: **Intermediate Care Facilities**

Effective November 1, 1993, coverage is limited to state school ICF/MR (these schools have more than 15 beds). The reimbursement methodology for these services is described in Attachment 4.19-D (4).

Item 20: **Extended Services for Pregnant Women**

The major categories of services available to pregnant women as pregnancy-related services include inpatient hospital, outpatient hospital, laboratory and X-ray, family planning, physician, clinic, dental, prescription drug, and nurse-midwife services.

Extended services to pregnant women may be provided by physicians and community health centers. Such extended services include coordinated medical management, health-care counseling, obstetrical-risk assessment and monitoring and rehabilitation services including treatment for alcoholism and drug dependency.

Item 23.d: **Nursing Facility Services for Patients under 21 Years of Age**

Skilled nursing facility services for patients under 21 years of age are covered if a Department of Public Health review team approves the facility.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Case Management Services

A. Target Group:

See pages 1a through 1q

B. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of Section 1919 (g) (1) of the Act is invoked to provide services less than statewide:

C. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (100 (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

D. Definition of services:

See pages 1a through 1q

E. Qualifications of provider:

See pages 1a through 1q

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

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State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

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State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Reserved

H. **Children Served by the Department of Social Services**

1. Target Group

The target group consists of Medicaid eligible children who have been reported to the Department of Social Services as potentially abused or neglected, or are receiving services from the Department of Social Services after being determined to either be at risk of abuse or neglect or substantiated as being abused or neglected children.

2. Definition of Services

Targeted case management is a set of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the case management provider agency. The purpose of case management is to assist individuals in gaining access to needed medical, social, and other services.

Case management will include:

1. collection of assessment data;
2. development of an individualized plan of care;
3. coordination of needed services and providers;
4. home visits and collateral contracts as needed;
5. maintenance of case records; and
6. monitoring and evaluation of client progress and service effectiveness.

3. Qualifications of Providers

The case manager must be a qualified social worker according to the requirements of the Massachusetts Department of Social Services.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Reserved

K. Children Provided Case Management Services by the Department of Youth Services

1. Target Group

The target group consists of Medicaid recipients who (1) are between the ages of 7 through 22, (2) are committed to the Department of Youth Services (DYS) by a court of competent jurisdiction in the Commonwealth until the age specified in their commitment (up to their 21st birthday), or voluntarily agree to the continuation of DYS case management services beyond their eighteenth birthday up to their 22nd birthday, and (3) as a result either of their original placement or conditional release from a public institution, reside in placements that include, but are not limited to, their own homes, the homes of relatives, community based residences or residential treatment facilities.

2. Definition of Services

Targeted case management is a set of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with the specific persons within case management provider agency. The purpose of case management is to assist individuals in gaining access to needed medical, social educational and other services.

3. Case management will include:

1. Collection of assessment data;
2. Development of an individual plan of care;
3. Coordination of needed services and providers;
4. Home visits and collateral contacts as needed
5. Maintenance of case records; and
6. Monitoring and evaluating client progress and service effectiveness

4. Qualifications of Providers

The case manager must have, or work directly under the supervision of an individual with, at least three years of full or equivalent part-time, professional or paraprofessional experience in social work, social casework, guidance, vocational counseling, employment counseling, or educational counseling, the major duties of which include providing such services to juveniles, or in corrections institution work, the major duties of which include the custodial care, treatment counseling and/or rehabilitation of juveniles.

Case Management Services (cont.)

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Medically Needy Groups

1. Target Group

Target group includes Medicaid beneficiaries who are either:

A. 18 years of age or older,
   a. With intellectual disability, meaning significantly sub-average intellectual functioning existing concurrently and related to significant limitation in adaptive functioning that manifests before 18.

B. under 18 years of age,
   a. with a verified diagnosis of intellectual disability or a closely related developmental condition or, with respects to persons from birth to age five, a developmental delay. Developmental delay means a substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in a developmental disability if services are not provided; and
   b. who demonstrate severe functional impairments, with severe functional impairments meaning functional impairments in at least three specified areas of adaptive functioning, based upon normative expectations of the types of skills normally acquired as the child develops, as measured by standardized assessment or comparable data. The areas of adaptive functioning are: self-care, communication, learning, mobility , and self-direction and, for individuals age 14 years or older, capacity for independent living and economic self-sufficiency.

☒ Target group includes individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are in Institutions for Mental Disease or individuals who are inmates of public institutions.

2. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

3. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

4. Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

1. Comprehensive Assessment and at least annual periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. Reassessments are conducted annually, or more frequently if necessary, to address changes in an individual's condition. These assessment activities include:

- Taking client history;
- Identifying the individual's needs and completing related documentation; and
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link an individual with
  - Medical, social, educational providers or
  - Other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities typically occur monthly and include at least one annual monitoring meeting to adequately address the needs of the eligible individuals, and care plan services may be reevaluated at any time. The Monitoring and follow up activities include:

- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring meeting, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - There are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

Case management services are coordinated with and do not duplicate activities provided as a part of institutional services and discharge planning activities.

5. Qualifications of provider:

The Department of Developmental Services (DDS) has been designed to serve as the exclusive source of case management services with respect to the target group. Case management services will be provided by qualified personnel hired into state positions at the Department of Developmental Services in the Human Services Coordinator series. Minimal entrance requirements for the Human Services Coordinator position include at least three years of full-time, or equivalent part-time professional experience in human services work or social work. One year of professional work experience must have involved working with individuals with intellectual or other developmental A Bachelor's or higher degree in social work, psychology sociology, counseling, counseling education, education of the physically or emotionally handicapped, education of the multiple handicapped, education or the learning disabled, human services, rehabilitation, rehabilitation counseling, nursing, recreation therapy, art therapy, dance therapy, music therapy, or physical education may be substituted for years of the required experience on the basis of two years of education for one year of experience.

6. Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

A. Eligible recipients will have free choice of any qualified Medicaid provider of case management services within the specified geographic area identified in this plan.
B. Eligible recipients will have free choice of the providers of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception:

☒ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. Consistent with 42 CFR 441.18(b) Massachusetts designates the Department of Developmental Services as the provider of services covered under this section of the State Plan.

7. Access to Services:

The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Medically Needy Groups

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other
services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Medically Needy Groups

1. Target Group

To be eligible for this target group, an individual must meet the following criteria:

Clinical Criteria

An individual who is 19 year of age or older must: have a mental illness, as determined by the Department of Mental Health (DMH) in accordance with DMH regulations and meet the following criteria:

1. Includes a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life;
2. Has lasted or is expected to last at least one year;
3. Has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and
4. Meets diagnostic criteria specified within the current edition of Diagnostic and Statistical Manual of Mental Disorders, which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by substance related disorders, mental retardation or organic disorders due to a general medical condition not elsewhere classified.

An individual who is under 19 years of age must have a mental illness as determined by DMH which meet the following criteria:

1. Has lasted, or is expected to last, at least one year;
2. Has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities; and
3. Meets diagnostic criteria specified within the current edition of the Diagnostic and Statistical Manual of Mental Disorders, but is not solely within one or more of the following categories:
    a. Developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation;
    b. Cognitive disorders, including delirium, dementia or amnesia;
    c. Organic disorders due to a general medical condition not elsewhere classified; or
    d. Substance-related disorders.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Medically Needy Groups

☒ Target group includes individuals transitioning to a community setting and case-management services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between ages 22 and 64 who are in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

2. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

3. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

4. Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Assessment and reassessment of individual needs to determine the need for any medical, educational, social or other services. Reassessments are conducted at least annually, or more frequently if necessary, to address changes in an individual's condition. These assessment activities include:

- Taking client history; and
- Identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

Development (and periodic revision) of a specific care plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link an individual with:
  - Medical, social, educational providers; or
  - Other programs and services that are capable of providing needed services, to address identified needs and achieve goals specified in the care plan, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities are conducted at least annually, or more frequently as necessary, to adequately address the needs of the eligible individual, and care plan services may be reevaluated at any time. These Monitoring and follow-up activities include:

- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - There are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

5. Qualifications of providers:

The Department of Mental Health (DMH) has been designated to serve as the exclusive source of case management services with respect to the target group. Case management services will be provided by qualified personnel hired into state positions in the Human Services Coordinator series. Qualified personnel must have demonstrated applicable education and/or professional work experience with the target population.

6. Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

A. Eligible recipients will have free choice of any qualified Medicaid provider of case management services within the specified geographic area identified in this plan.
B. Eligible recipients will have free choice of the providers of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception:

☒ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. Consistent with 42 CFR 441.18(b), Massachusetts designates the Department of Mental Health as the provider of services covered under this section of the State Plan.

7. Access to Services:

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

8. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, and whether goals specified in the care plan have been achieved; whether the individual has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

9. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted care management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

10. Limitations:

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred; and
- Activities for which third parties are liable to pay as described in 42 USC 1396n(4)(A)

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Medically Needy Groups

1. Target Group

A Medicaid member is eligible for targeted case management services described below if the member:

A. is eighteen years of age or older;

B. receives a statement from a physician verifying the AIDS diagnosis. Such a diagnosis shall be based on the most recent AIDS definition published by the Federal Center for Disease Control (CDC) as it may from time to time be amended. The following is a list of conditions on which the CDC currently bases an AIDS diagnosis; however, such diagnosis must at all times be consistent with the most recently published definition of amendments to that definition:

i. The development of an opportunistic disease process indicating defective cell-mediating immunity (i.e. PCP, Kaposi's Sarcoma); or
ii. Lack of an established cause of profound immunosuppression; or
iii. HIV infection and CD4+ T-lymphocyte count<200 cells/ul (or CD4+ percent<14); or
iv. HIV infection and pulmonary tuberculosis; or
v. HIV infection and recurrent pneumonia (within a 12 month period); or
vi. HIV infection and invasive cervical cancer;

C. lives in a staffed, congregate residential program which meets the Department of Public Health (DPH) funding requirements for the AIDS/HIV Bureau, Supportive Residential Services program which require that a person be HIV positive, and in which no more than three mentally and/or physically impaired individuals share a single bedroom and bathroom; and

D. requires and receives from the congregate residential program staff assistance with either activities of daily living (ADL) such as bathing, dressing/grooming, mobility/transfer, eating or toileting and/or instrumental activities of daily living (IADL) such as laundry, shopping, transportation and housekeeping.

☐ Target group includes individuals transitioning to a community setting during a covered stay in an institutional setting.

2. Areas of state in which services will be provided:

☒ Entire state .

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Medically Needy Groups

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

3. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (100 (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

4. Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include

- taking client history and
- identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- to help an eligible individual obtain needed services including activities that help link an individual with
  - medical, social, educational providers or

- other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

5. Qualifications of provider:

To be qualified to provide case management services, a provider must be on the staff of a congregate residential program which meets the Department of Public Health (DPH) funding requirements for the AIDS/HIV Bureau, Supportive Residential Services program. Such a program must assure that each client is managed by a case manager who possesses the following minimal qualifications: a Masters degree in social work or related field, a registered nurse, or three or more years of documented case management experience working with the disabled in a community setting.

6. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

A. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
B. Eligible recipients will have free choice of the providers of other medical care under the plan.

7. Access to Services:

The State assures that case management services will not be used to restrict an individual's access to other services under the plan.

The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

8. Case Records:

Providers maintain case records that document for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, and whether goals specified in the care plan have been achieved; whether the individual has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

9. Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

10. Limitations:

Case Management does not include the following:

- Case management activities that are an integral component of another covered Medicaid service;
- The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;
- Activities integral to the administration of foster care programs; and

- Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Medically Needy

M. Targeted Case Management – Individuals under 21 with Serious Emotional Disturbance (SED)

1. Target Group: The target group includes individuals under 21 with a Serious Emotional Disturbance (SED) including individuals with co-occurring conditions.

2. Areas of State in Which Services Will be Provided

Services are available state-wide

3. Comparability of Services

Services are not comparable in amount, duration and scope. (Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B)

4. Definition of Services

Targeted Case Management Services (Intensive Care Coordination) is defined as follows:

1. Assessment: The Care Manager, working with the Care Planning Team, may use multiple tools, including a strengths-based standardized assessment instrument, in conjunction with a comprehensive psychosocial assessment and other clinical information to organize and guide the development of an individualized care plan. The Care Planning Team is a source for information needed to form a complete assessment of the child. The Care Planning Team includes, as appropriate, the Care Manager, providers, case managers from state agencies that provide services to the child, family members, and natural supports such as neighbors, friends and clergy. Assessment activities include, without limitation: the Care Manager 1) assisting the family to identify appropriate members of the Care Planning Team; 2) facilitating the Care Planning Team to identify strengths and needs of the child and strengths and needs of family in meeting the child's needs and 3) collecting background information and plans from other agencies. The assessment process will determine the needs of the child for any medical, educational, social or other services. Further assessments will be provided as medically necessary.

2. Development of an individualized care plan: Using the information collected through an assessment, the Care Manager, convenes and facilitates the Care Planning Team, together with the Team develops a person and family-centered, Individual Care Plan that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The Care Manager works directly with the child, the family (or the child's authorized health care decision maker) and others to identify the strengths, needs and goals of the child and the strengths, needs and goals of the family in meeting the child's needs. .

3. Referral and Related Activities: Using the individual Care Plan, the Care Manager (1) convenes, coordinates and communicates with the Care Planning Team to implement the Individual Care Plan; (2) works directly with the child and family to implement elements of the Individual Care Plan; (3) prepares, monitors and modifies the Individual Care Plan in concert with the Care Planning Team; (4) coordinates the delivery of available services, including services reimbursable under 42 USC 1396d(a) and educational, social or other services; (5) develops, in concert with the Care Planning Team, a transition plan when the child has achieved the goals of the Individual Care Plan; and (6) collaborates with other service providers on the child and family's behalf.

4. Monitoring and follow-up activities include reviewing the Individual Care Plan every quarter and convening the Care Planning Team at least annually to update the Plan of Care to reflect the changing needs of the child. The Care Manager and the Care Planning Team perform such reviews and include (1) whether services are being provided in accordance with the Individual Care Plan (2) whether the services in the Individual Care Plan are adequate and (3) whether there are changes in the needs or status of the individual and if so, adjusting the Care Plan as necessary.

Services may include contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individuals to access services.

5. Qualifications of Providers:

Providers are agencies known as Community Service Agencies (CSAs) that meet requirements established by the single state Medicaid Agency. To meet such requirements, CSAs must have at least three years' experience providing behavioral health services to youth, from birth to 21 years old, and their families. CSAs are community based child and family service organizations such as community mental health centers, not-for-profit social service agencies and other service providing agencies. CSAs must employ or contract with licensed behavioral health clinicians or non-licensed staff or paraprofessionals supervised by licensed behavioral health clinicians to provide case management services known as Intensive Care Coordination (ICC). Non-licensed staff or paraprofessionals include staff members with a master's degree or a bachelor's degree or with an associates degree and at least five years of experience working with the target population. The case manager, known as the Care Manager, develops and coordinates a child specific care planning team that develops an individualized, child centered, family and strengths-based Plan of Care.

6. Free Choice of Providers

a. Free choice of providers of case management services may be restricted in accordance with the provision of 1915(g)(1) of the Medicaid Act as amended by Section 4118(i) of the Omnibus Budget Reconciliation Act of 1987 and 42CFR 431.51.

b. Eligible members will have free choice of providers of other medical care under the plan

7. Non-Duplication of Payment

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

8. Intensive Care Coordination Services To Individuals in Institutions

Nothing in the definition excludes the provision of Intensive Care coordination to individuals who are in hospitals, ICF-MRs, Institutions for Mental Disease (IMDs), Psychiatric Residential Treatment Facilities (PRTFs), and Skilled Nursing Facilities who meet the definition of the target population described above.

a. Such Intensive Care Coordination Services may by provided to individuals transitioning to a community setting. Intensive Care Coordination Services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

b. These activities shall be coordinated with, and not duplicate, institutional discharge planning.

c. The amount, duration, and scope of Intensive Care Management activities will be documented in the Member's Individual Care Plan

d. Transitional Intensive Care Coordination is provided by and reimbursed only to CSAs

e. The Commonwealth will monitor compliance with these provisions through a system that includes periodic audits and claims reviews.

9. Limitations on Qualified Providers

Providers are limited to regionally based, Community Service Agencies that MassHealth determines are most qualified to provide Intensive Care Coordination to members with SED including co-occurring disorders. These limitations will ensure that individuals within the target group receive needed services by establishing a defined group of providers who have and maintain expertise in the special service needs of this population.

10. Additional Assurances

The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or conditional receipt of other Medicaid services on receipt of case management services;
- Providers of case management services do not exercise the agency's authority to authorize or

deny the provision of other services under the plan.

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred.
- Activities for which third parties are liable to pay as described in 42 USC 1396n (4) (A).

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Medically Needy

M. Targeted Case Management – Individuals under 21 with Serious Emotional Disturbance (SED)

1. Target Group: The target group includes individuals under 21 with a Serious Emotional Disturbance (SED) including individuals with co-occurring conditions.

2. Areas of State in Which Services Will be Provided

Services are available state-wide

3. Comparability of Services

Services are not comparable in amount, duration and scope. (Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B)

4. Definition of Services

Targeted Case Management Services (Intensive Care Coordination) is defined as follows:

1. Assessment: The Care Manager, working with the Care Planning Team, may use multiple tools, including a strengths-based standardized assessment instrument, in conjunction with a comprehensive psychosocial assessment and other clinical information to organize and guide the development of an individualized care plan. The Care Planning Team is a source for information needed to form a complete assessment of the child. The Care Planning Team includes, as appropriate, the Care Manager, providers, case managers from state agencies that provide services to the child, family members, and natural supports such as neighbors, friends and clergy. Assessment activities include, without limitation: the Care Manager 1) assisting the family to identify appropriate members of the Care Planning Team; 2) facilitating the Care Planning Team to identify strengths and needs of the child and strengths and needs of family in meeting the child's needs and 3) collecting background information and plans from other agencies. The assessment process will determine the needs of the child for any medical, educational, social or other services. Further assessments will be provided as medically necessary.

2. Development of an individualized care plan: Using the information collected through an assessment, the Care Manager, convenes and facilitates the Care Planning Team, together with the Team develops a person and family-centered, Individual Care Plan that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The Care Manager works directly with the child, the family (or the child's authorized health care decision maker) and others to identify the strengths, needs and goals of the child and the strengths, needs and goals of the family in meeting the child's needs. .

3. Referral and Related Activities: Using the individual Care Plan, the Care Manager (1) convenes, coordinates and communicates with the Care Planning Team to implement the Individual Care Plan; (2) works directly with the child and family to implement elements of the Individual Care Plan; (3) prepares, monitors and modifies the Individual Care Plan in concert with the Care Planning Team; (4) coordinates the delivery of available services, including services reimbursable under 42 USC 1396d(a) and educational, social or other services; (5) develops, in concert with the Care Planning Team, a transition plan when the child has achieved the goals of the Individual Care Plan; and (6) collaborates with other service providers on the child and family's behalf.

4. Monitoring and follow-up activities include reviewing the Individual Care Plan every quarter and convening the Care Planning Team at least annually to update the Plan of Care to reflect the changing needs of the child. The Care Manager and the Care Planning Team perform such reviews and include (1) whether services are being provided in accordance with the Individual Care Plan (2) whether the services in the Individual Care Plan are adequate and (3) whether there are changes in the needs or status of the individual and if so, adjusting the Care Plan as necessary.

Services may include contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individuals to access services.

5. Qualifications of Providers:

Providers are agencies known as Community Service Agencies (CSAs) that meet requirements established by the single state Medicaid Agency. To meet such requirements, CSAs must have at least three years' experience providing behavioral health services to youth, from birth to 21 years old, and their families. CSAs are community based child and family service organizations such as community mental health centers, not-for-profit social service agencies and other service providing agencies. CSAs must employ or contract with licensed behavioral health clinicians or non-licensed staff or paraprofessionals supervised by licensed behavioral health clinicians to provide case management services known as Intensive Care Coordination (ICC). Non-licensed staff or paraprofessionals include staff members with a master's degree or a bachelor's degree or with an associates degree and at least five years of experience working with the target population. The case manager, known as the Care Manager, develops and coordinates a child specific care planning team that develops an individualized, child centered, family and strengths-based Plan of Care.

6. Free Choice of Providers

a. Free choice of providers of case management services may be restricted in accordance with the provision of 1915(g)(1) of the Medicaid Act as amended by Section 4118(i) of the Omnibus Budget Reconciliation Act of 1987 and 42CFR 431.51.

b. Eligible members will have free choice of providers of other medical care under the plan

7. Non-Duplication of Payment

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

8. Intensive Care Coordination Services To Individuals in Institutions

Nothing in the definition excludes the provision of Intensive Care coordination to individuals who are in hospitals, ICF-MRs, Institutions for Mental Disease (IMDs), Psychiatric Residential Treatment Facilities (PRTFs), and Skilled Nursing Facilities who meet the definition of the target population described above.

a. Such Intensive Care Coordination Services may by provided to individuals transitioning to a community setting. Intensive Care Coordination Services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

b. These activities shall be coordinated with, and not duplicate, institutional discharge planning.

c. The amount, duration, and scope of Intensive Care Management activities will be documented in the Member's Individual Care Plan

d. Transitional Intensive Care Coordination is provided by and reimbursed only to CSAs

e. The Commonwealth will monitor compliance with these provisions through a system that includes periodic audits and claims reviews.

9. Limitations on Qualified Providers

Providers are limited to regionally based, Community Service Agencies that MassHealth determines are most qualified to provide Intensive Care Coordination to members with SED including co-occurring disorders. These limitations will ensure that individuals within the target group receive needed services by establishing a defined group of providers who have and maintain expertise in the special service needs of this population.

10. Additional Assurances

The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or conditional receipt of other Medicaid services on receipt of case management services;
- Providers of case management services do not exercise the agency's authority to authorize or

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State: Massachusetts
Case Management Services Provided to the Medically Needy

deny the provision of other services under the plan.

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred.
- Activities for which third parties are liable to pay as described in 42 USC 1396n (4) (A).

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts

Program of All-Inclusive Care for the Elderly (Pace) Providers

1. Target Group

All medically needy and categorically needy individuals who are at least 55 years old, live in the PACE service area, and are certified as eligible for nursing home care by the appropriate State agency. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.

2. Definition of Services

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participant's needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services), which are integrated for a seamless provision of total care. PACE organizations provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare and Medicaid covered services.

3. Qualification of Providers

PACE providers must meet with all the requirements found at 42 CFR Part 460.

Program of All-Inclusive Care for the Elderly (PACE) Providers (cont.)

Name and address of State Administering Agency, if different from the State Medicaid Agency.

I. **Eligibility**

The state determines eligibility for PACE enrollees under rules applying to community groups. Spousal income and resources are not counted.

☐ A. The state determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The state has elected to cover under its State Plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the state determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

☒ B. The state determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.)

☐ C. The state determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the state's approved HCBS waiver(s).

Program of All-Inclusive Care for the Elderly (PACE) Providers (cont.)

Regular Post Eligibility

☐ 1. SSI State. The state is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) Sec. 435.726 — States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A) Individual (check one)

☐ 1. The following standard included under the State Plan (check one):

☐ (a) SSI
☐ (b) Medically Needy
☐ (c) The special income level for the institutionalized
☐ (d) Percent of the Federal Poverty Level: ___%
☐ (e) Other (specify):_____

☐ 2. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ 3. The following formula is used to determine the needs allowance:
_____
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):

☐ 1. SSI Standard
☐ 2. Optional State Supplement Standard
☐ 3. Medically Needy Income Standard
☐ 4. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
☐ 5. The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.
☐ 6. The amount is determined using the following formula:
_____
_____
☐ 7. Not applicable (N/A)

(C) Family (check one):

☐ 1. AFDC need standard

Program of All-Inclusive Care for the Elderly (PACE) Providers (cont.)

☐ 2. Medically needy income standard
The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

☐ 3. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ 4. The following percentage of the following standard that is not greater than the standards above:_____%
of_____ standard.

☐ 5. The amount is determined using the following formula:
_____
_____

☐ 6. Other

☐ 7. Not applicable (N/A)

(b) Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

☐ 2. 209(b) state, a state that is using more restrictive eligibility requirements than SSI. The state is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735** — States using more restrictive requirements than SSI.

1. Allowances for the needs of the:

(A) Individual (check one)

☐ 1. The following standard included under the State Plan (check one):

☐ (a) SSI
☐ (b) Medically Needy
☐ (c) The special income level for the institutionalized
☐ (d) (Percent of the Federal Poverty Level: _____%
☐ (e) ___Other (specify): _____

☐ 2. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ 3. The following formula is used to determine the needs allowance:_
Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a

Program of All-Inclusive Care for the Elderly (PACE) Providers (cont.)

PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B) Spouse only (check one):

- ☐ 1. The following standard under 42 CFR 435.121:
  _____
- ☐ 2. The medically needy income standard
  _____
- ☐ 3. The following dollar amount: $_____
  Note: If this amount changes, this item will be revised.
- ☐ 4. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
- ☐ 5. The amount is determined using the following formula:
  _____
  _____
- ☐ 6. Not applicable (N/A)

(C) Family (check one):

- ☐ 1. AFDC need standard
- ☐ 2. Medically needy income standard
  The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.
- ☐ 3. The following dollar amount: $_____
  Note: If this amount changes, this item will be revised.
- ☐ 4. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
- ☐ 5. The amount is determined using the following formula:
  _____
  _____
- ☐ 6. Other
- ☐ 7. Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Program of All-Inclusive Care for the Elderly (PACE) Providers (cont.)

Spousal Post Eligibility

☐ 3. State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:

1. Individual (check one)

☐ (A) The following standard included under the State plan (check one):

- ☐ 1. SSI
- ☐ 2. Medically Needy
- ☐ 3. The special income level for the institutionalized
- ☐ 4. Percent of the Federal Poverty Level: _____%
- ☐ 5. Other (specify): _____

☐ (B) The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ (C) The following formula is used to determine the needs allowance:

_____

_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the Individual's maintenance needs in the community:

_____

_____

_____

_____

_____

_____

Program of All-Inclusive Care for the Elderly (PACE) Providers (cont.)

II. **Rates and Payments**

See **Attachment 4.19-B**.

III. **Enrollment and Disenrollment**

The state assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the state and the state Administering Agency. The state assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the state's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

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State: Massachusetts

The following is a description of the methods that are used to assure that the medical and remedial care and services are of high quality.

a) The State agency has an agreement with the DPH to recommend appropriate standards for high quality care. The agreement also includes utilization review of all Tile XIX skilled nursing homes, intermediate care facilities, home health agencies, special nursing homes for disabled children under 18, and facilities for the mentally retarded under 18.

b) The Department continues to develop and has developed many conditions of participation with the cooperation of the DPH, providers, and special consultants, affecting the quality as well as scope of services provided under the MA Program

c) The Department conducts open-mouth review of dental patients whenever there is reason to question the quality and extent of dental services under the program

d) Professional Standards Review Organizations (PSROs) review length of hospital stay in an increasing number of acute hospitals: the review affects the quality as well as duration of treatment in acute care facilities. The Department monitors PSROs with trained Utilization Review coordinators through sample reviews

e) The quality of items and services and supplies under the pharmacy program are under increasing scrutiny by administration and support staff.

f) Participation in the program and issuance of provider numbers are withheld from neighborhood health centers, and mental health rehabilitation, and hearing clinics until certification standards have been met.

g) The staff is aware and constantly involved in provisions for and development of policy in new program areas such as renal dialysis and Early and Periodic Screening, Diagnosis and Treatment.

h) The Department works closely with Medicare, the medical and dental societies and other provider groups in maintaining surveillance of individual providers as well as expectations and general standards of medical services.

i. PACE organizations shall adhere to the federal regulations for Quality Assessment and Performance Improvement found at 42 CFR 460.130.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Transportation

MassHealth assures necessary transportation for eligible members to and from providers of medically necessary MassHealth covered services. MassHealth provides for cost-effective, suitable transportation as follows within a reasonable geographic area.

1. Brokered Transportation – see Attachment 3.1-A, item 24.a, and Attachment 3.1-B, item 23.a. for a description of brokered transportation

2. Non-brokered Transportation

MassHealth provides non-brokered in-state non-emergency and emergency transportation through MassHealth transportation providers, which is claimed as medical assistance. MassHealth also provides for non-brokered transportation to School-Based Medicaid services, which is claimed as an administrative expense. MassHealth claims school-based transportation expenditures only when the need for transportation is provided on a specially equipped or adapted vehicle. MassHealth uses an allocation method to approximate reasonable costs for time spent receiving transportation services to Medicaid-covered services. Delivery methods for in-state non-brokered, non-emergency transportation include chair car, ground ambulance, or other methods suitable to the member's condition. For in-state non-brokered non-emergency transportation claimed as medical assistance, all qualified and willing providers may participate as MassHealth providers. Such transportation is provided state-wide for any member eligible for non-emergency transportation services for whom such service is medically necessary and not otherwise furnished to such member under a selective broker contract. MassHealth makes direct payments to the MassHealth provider for such transportation services. Delivery methods for in-state non-brokered emergency transportation include ground ambulance, air ambulance, or other methods suitable to the member's condition.

MassHealth also provides for out-of-state non-brokered, non-emergency and emergency transportation by licensed carriers, which is claimed as an administrative expense. Delivery methods for out-of-state non-brokered, non-emergency transportation include airplane, bus, train, or other methods suitable to the member's condition. Prior authorization is required for out-of-state non-brokered, non-emergency transportation. Delivery methods for out-of-state non-brokered, emergency transportation include ground ambulance, air ambulance, or other methods suitable to the member's condition.

Members who use public transportation to MassHealth covered medically necessary services may receive reimbursement for their public transportation expenses. Members may also be reimbursed for expenses incurred for transportation other than public transportation. Personal reimbursement is claimed as an administrative expense.

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The State reimburses those facilities that have received a Determination of Need from the Department of Public Health. The Determination of Need approval is evaluated against the guidelines developed by the Massachusetts Task Force on Organ Transplantation (October 1984). The Determination of Need conditions assure that similarly situated individuals are treated alike and that services are accessible and of high quality care.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Standard Alternative Benefit Plan

See TN-014-007, TN-015-008
Standard ABP MMDL

And TN-014-008, TN-015-007
Care Plus ABP MMDL

The following method is used to provide the entire range of benefits under Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

☒ A. Buy-in agreements with the Secretary of HHS. This agreement covers:

1. ☒ Individuals receiving SSI under Title XVI or state supplementation, who are categorically needy under the state's approved Title XIX plan.

   Persons receiving benefits under Title II of the Act or under the Railroad Retirement System are included:

   ☒ Yes ☐ No

2. ☐ Individuals receiving SSI under Title XVI, state supplementation, or a money payment under the state's approved Title XIX plan.

   Persons receiving benefits under Title II of the Act of under the Railroad Retirement System are included:

   ☐ Yes ☒ No

3. ☐ All individuals eligible under the state's approved Title XIX plan.

☐ B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

☒ C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups:

All Title XIX recipients who are also eligible for Part B of Title XVIII.

This relates only to comparability of devices – benefits under XVIII to what groups – not how XIX pays. …if state has buy-in (which covers premium), it does not check #3 for same group-only if it does #3 for another group., e.g. deductibles and coinsurance for money payment receipts is a matter for reimbursement attachment.