Medicaid Managed Care Contract Matrix: Massachusetts

Programmatic Element	Standard	Source
Program Name	One Care	
Date of Transition	The program began in October 2013.	Financial Alignment Initiative Massachusetts One Care: Third Evaluation Report, CMS, April 2019.
Total Enrollment	23,493 (reflects enrollment for all eligible members, not just individuals with I/DD)	One Care: September 2019 Enrollment Report
Enrollment Type	Voluntary. Eligible members who do not select an MCO or do not opt out of the CMS Financial Alignment Demonstration are assigned to a One Care plan during passive enrollment.	2.3 Enrollment Activities
Plans Operating in the State	Commonwealth Care Alliance and Tufts Health Unify	Mass.Gov: Learn about One Care plans
Authority for Managed Care	Section 1115	Request for Responses (RFR) for Organizations Interested in Participating as One Care Plans
Eligibility	Individuals ages 21-64 enrolled in Medicare Parts A and B and eligible for Part D and Medicaid (members who turn 65 while enrolled in the MCO may elect to remain in the health plan). Individuals residing in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) or on one of the state's home and community based services (HCBS) waivers *are not eligible* for One Care.[1]	MOU Between CMS and the Commonwealth of Massachusetts
Benefit Design	MCOs must cover Medicaid state plan and Medicare services, including physical health, behavioral health, dental, long term services and supports (LTSS), and pharmacy services. HCBS-like services covered by plans include adult day health, adult foster care, day habilitation, home health, personal care attendant services, day services, home care services, peer support/counseling/navigation, home modifications, and respite. If either Medicare or the Medicaid state plan provides more expansive services than the other	2.4 Covered Services Appendix A – Covered Services

[1] The State offers three HCBS waivers for individuals with I/DD—the Adult Supports Waiver, the Community Living Waiver, and the Intensive Supports Waiver—for adults ages 22 and over. In order to be eligible for these waivers, an individual must be eligible for or enrolled in MassHealth Standard, be at least 22 years of age, be eligible for an Intermediate Care Facility for individuals with intellectual disability, agree to receive services in the community, and require one or more waiver services. *See* Massachusetts Developmental Disabilities Council State Plan, 2017.

	program does for a particular condition, type of illness, or diagnosis, MCOs must provide the most expansive set of services required by either program. MCOs may not limit or deny services to members based on either Medicare or Medicaid providing a more limited range of services than the other program.	
Plan Type	Locally-based, nonprofit MCOs. MCOs currently operate in nine of the state's 14 counties and enroll all eligible populations, the plans are not specific to individuals with I/DD.	Financial Alignment Initiative Massachusetts One Care: Third Evaluation Report, CMS, April 2019.
Integration with Medicare	Fully integrated; an MCO must enter into a three-way contract between the state and CMS to operate as a Medicare-Medicaid Plan (MMP), which provides integrated Medicare and Medicaid benefits to dual eligibles under the CMS Financial Alignment Demonstration.	Financial Alignment Initiative Massachusetts One Care: Third Evaluation Report, CMS, April 2019.
Residential Services	Individuals residing in ICF/IID facilities are excluded from enrollment in the MCOs.	Financial Alignment Initiative Massachusetts One Care: Third Evaluation Report, CMS, April 2019.
Care Coordination Model	*Care Coordination*—MCOs must arrange for the coordination of services provided by the health plan to each member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays and with the services the member receives from community and social support providers. MCOs must offer care coordination to all members through a care coordinator or clinical care manager (for members with complex care needs) for medical and behavioral services and through an LTS coordinator for LTSS. MCOs must complete comprehensive assessments for each member within 90 days of the effective enrollment date and at least annually thereafter. *Comprehensive Assessment*—Plans must complete a comprehensive assessment for each new member an ongoing basis, including within 90 days of the effective date of enrollment (including subsequent attempts if the initial attempt to contact the member is unsuccessful) and at least annually thereafter; or whenever a member experiences a major change that is not temporary or episodic, impacts on more than one area of health status, and required interdisciplinary review or revision of the individualized care plan (ICP). The comprehensive assessment must include completion of an assessment tool, developed by the plan and informed by at least one in-person meeting covering such domains as may be relevant for each member to creation of his or her ICP. This activity may be conducted at the same time as the minimum data set-home care (MDS-HC) assessment (a clinical screening uses to assess key domains of function, health, and service use) or at a different time, and must be completed within the continuity of care period. As appropriate to the member's needs and preferences, the MCO-developed assessment tool must include the following domains and	2.5.2 Interdisciplinary Care Team (ICT) 2.5.3 Care Coordination 2.5.10. Integration and Coordination of Services 2.6.5. ICT Discharge Planning Participation

	special considerations, which may be updated by the state during the period: • Immediate needs and current services, including preventive health, preferred providers, what is working well for the member and what can be improved; • Health conditions, including conditions of known prevalence among subpopulations, such as seizures, aspiration, constipation, dehydration, and pica for individuals with intellectual disabilities; • Current medications, including how long the member has been taking each medication, and any need for immunizations or vaccines; • The ability of the individual to communicate their concerns or symptoms, including if the individual can verbalize issues and/or whether physical symptoms are manifested through behavior; • Functional Status, including ADL and IADL limitations, and what the member identifies as his/her strengths, weaknesses, interests, and choices about daily routine; • Current mental health and substance use, and history of mental health and substance use treatment, including consideration of type, duration and frequency of services, including medications and specialized supports that may be needed, particularly for individuals who utilize the emergency room for a psychiatric or behavioral issue; • LTSS needs; • Earlier onset of dementia for individuals with intellectual disabilities; • Personal goals, including health goals and activities enjoyed by the member and barriers to participating; • Sexual and reproductive health; • At the option of the member, sexual orientation and gender identity; • Accessibility requirements including specific communication needs (such as language interpreters/translators, written materials and support to understand treatment options); needs for transfer equipment; needs for personal assistance; appointment scheduling needs; communications preference; health literacy; additional adaptations for appointment and screenings (such as adaptive equipment); and assistance needed to keep track of appointments and get to them; • Equipment needs including adaptive technology; • Transportation access, including equipment needed during transportation, and both medical and non-medical transportation needs; • Housing/home environment, including needs specific to homeless members, including those who are chronically homeless; risk of homelessness; home accessibility requirements; housing preferences, including who the member lives with; methods for heating and cooling the member's home; home safety; and any services provided in the residential setting • Employment status and interest, including school and volunteer work, employment services currently provided to the member, employment goals and barriers to achieving goals; • Involvement or affiliation with other care coordinators, care teams, or other state agencies, including current and past	

	involvement, use of self-directed services through state agencies, and agency contacts; • Informal supports/caregiver supports, including availability of back-up for informal supports, caregiver needs, and member's caregiver responsibilities (e.g. children, spouse, parents); • Risk factors for abuse and neglect in the member's personal life or finances and for experiences of violence; • Use of leisure time and community involvement, including preferences, goals and barriers; • Social supports, including cultural and ethnic orientation or personal beliefs towards the member's presenting problems that may influence the member's health care and involvement with peer support groups; • Food security and nutrition, including food availability, access barriers to healthy food, oral hygiene, need for food stamps or meals programs, nutritional supplements; • Wellness and exercise, including types of exercise, self-rated wellness, and prevention strategies; • Advance directive/guardianship, including health care proxy and power of attorney; and • Other domains and/or considerations as may be required by state. *Individualized Care Plan (ICP)*—MCOs must develop an ICP for each member and integrate the results of the comprehensive assessment and specify any changes in providers, services, or providers. The ICP must reflect the member's preferences and needs. The ICP must specify how services and care will be integrated and coordinated among health care providers, and community and social services providers where relevant to the member's care, including but not limited to: • A summary of the member's health history; • A prioritized list of concerns, goals and strengths; • The plan for addressing concerns or goals; • The person(s) responsible for specific interventions; and • The due date for each intervention. MCOs must accept a service request or other request for a modification of the ICP from the member at any time; document all service requests and other requests for a modification of the ICP in the member's centralized member record; and educate member about the process and timetable for service requests, including but not limited to how long a member will need to wait before a decision is rendered during the initial welcome call and before the annual review of the ICP. *Interdisciplinary Care Team (ICT)*—The health plan must form an ICT for each member to ensure that care is integrated and coordinated. The ICT must consist of at least the following staff: a primary care physician, a behavioral health clinician, if indicated, a care coordinator or clinical manager, and/or a long-term supports (LTS) coordinator, if indicated. As appropriate, and at the discretion of the member, the ICT may also include a registered nurse, a specialist clinician, and other professional and support disciplines, including social workers and qualified peers, family members, other informal caregivers, advocates, and state or other	

	case managers. The ICT must: • Along with the member, develop an ICP that reflects the member's medical, functional, behavioral, and social treatment goals and measures progress and success in meeting those goals • On an ongoing basis, consult with and advise acute, specialty, LTSS, and behavioral health providers about care plans and clinically appropriate interventions • Provide members with information on how to contact their designated care coordinator(s) MCOs must implement policies and procedures that ensure timely and effective treatment and discharge planning, establish associated documentation standards, involve the member, and begin on the day of admission. Treatment and discharge planning must include: • Identification and assignment of a facility-based case manager for the member that is involved in the establishment and implementation of treatment and discharge planning • Notification and participation of the member's ICT in discharge planning, coordination, and re-assessment as needed • Identification of the member's state agency affiliation, release of information, and coordination with any state agency representative assigned to the member • Identification of non-clinical supports and the role they serve in the member's treatment and after care plans • Scheduling of discharge/aftercare appointments in accordance with the state's access and availability standards • Identification of barriers to aftercare, and the strategies developed to address such barriers • Assurance that inpatient and 24-hour diversionary behavioral health providers provide a discharge plan following any behavioral health admission to ICT member • Ensure that members who require medication monitoring will have access to such services within 14 business days of discharge from a behavioral health inpatient setting • Make best efforts to ensure a smooth transition to the next service or to the community • Document all efforts related to these activities, including the member's active participation in discharge planning *LTS Coordinators*—MCOs must contract with multiple community-based organizations (CBOs) for the provision of LTS coordinator services, including at least one Independent Living Center (ILC), where geographically feasible in the health plan's service area. Additional CBOs may include, but are not limited to Recovery Learning Communities, Aging Service Access Points (ASAPs), and other CBOs serving people with disabilities. MCOs must contract with an adequate number of CBOs to allow members a choice of at least	

	two LTS coordinators, unless the MCO obtains an exception from the state. Members over the age of 60 must be offered the option of receiving LTS coordinator services through an ASAP.[2] As a member of the ICT, LTS coordinators participate in the comprehensive assessments of the health and functional status of members with LTSS and assist with the development of the community-based services component of an ICP as necessary. LTS coordinators: • Arrange, and with the agreement of the ICT, coordinate the authorization and provision of appropriate community LTSS and resources; • Assist members in accessing personal care attendant services; • Monitor the appropriate provision and functional outcomes of community LTSS; • Determine community-based alternatives to long-term care; and • Assess appropriateness for facility-based LTSS, if indicated; including assessing any accommodation or access needs, including accessibility requirements and equipment needs. • Assist in identifying a more appropriate LTS coordinator if, after a comprehensive assessment, it is determined that the member has specific needs outside of the LTS coordinator's expertise. MCOs must establish written qualifications for the LTS coordinator that include, at a minimum: • Bachelor's degree in social work or human services, or at least two years working in a human service field with the population eligible for One Care; • Completion of person-centered planning and person-centered direction training; • Experience working with people with disabilities, behavioral health needs, or elders in need of LTSS; • Knowledge of the home and community-based service system and how to access and arrange for services; • Experience conducting LTSS needs assessments and monitoring LTSS delivery; • Cultural competency and the ability to provide informed advocacy; • Ability to write an ICP and communicate effectively, both verbally and in writing across complicated service and support systems; and • Meet all requirements of their CBO employer. MCOs must provide LTS coordinators with user access to their centralized member records system. Plans may not have a direct or	

[2] Independent Living Centers are private, nonprofit, consumer-controlled organizations that provide services and advocacy for people with disabilities and help individuals live independently in the community. Recovery Learning Communities are consumer-run networks of self help/peer support, information and referral, and advocacy and training activities for individuals with serious mental illness. Aging Service Access Points (ASAPs) are private nonprofit agencies with governing boards that serve and represent 51% of people age 60 and older. ASAPs provide information and referral, interdisciplinary case management, development and implementation of service plans, reassessment of needs, and investigations of abuse and neglect of elders.

	indirect financial ownership interest in an entity that serves as a CBO that is contracted to provide LTS coordinators. Providers of facility- or community-based LTS on a compensated basis by a One Care Plan may not function as LTS coordinators, except if the plan obtains a waiver of this requirement from the state. For the purpose of this provision, an organization compensated by the MCO to provide only evaluation, assessment, coordination, skills training, peer supports, and fiscal intermediary services is not considered a provider of LTSS.	
Dental Services	MCOs must cover preventive, restorative, and emergency oral health services. Operated by the Tufts University School of Dental Medicine since 1976, Tufts Dental Facilities Serving Individuals with Disabilities (TDF) is a nationally-recognized, statewide oral healthcare network for individuals with I/DD. TDF clinics provide direct care to patients and train oral health practitioners. About 95% of TDF's patients are covered through MassHealth.	Appendix B – Covered Services Definitions Tufts Dental Facilities Serving Individuals with Disabilities to Receive National Award, TuftsNow
Optical Services	MCOs must cover vision care services, including eye examinations, vision training, prescriptions, and glasses and contact lenses.	Appendix B – Covered Services Definitions
Workforce	According to the I/DD advocacy group the Arc of Massachusetts, the state is experiencing a workforce shortage crisis for direct support professionals, which affects in-home workers for families and individuals with I/DD. According to the Arc, 72% of the state's human service providers report that it has become increasingly more difficult to fill job openings over the past three years. Legislative proposals to set a minimum wage for direct support professionals have been introduced as a way to help alleviate the workforce shortage.	The Arc of Massachusetts Bill H.3835, An Act Relative to Meeting the Human Workforce Demand
Plan Rates	CMS and the state each contribute to the total capitation payment made to the MCOs. Health plans receive three monthly payments for each member: one amount from CMS reflecting coverage of Medicare Parts A/B services; one amount from CMS reflecting coverage Medicare Part D services; and a third amount from the state reflecting coverage of Medicaid services. Both CMS and the state withhold a percentage of their respective components of the capitation rate (except the part D component). The withholds are repaid once the MCOs demonstrate performance consistent with established quality thresholds. As required by federal regulation, the state has imposed an MLR of 85%. MCOs that fail to meet the MLR may be required to repay funds to the state and CMS (based on each payor's contribution to the total premiums subject to the MLR calculation).	4.1.1. Capitation Payments 4.4.5. Quality Withhold Policy for MassHealth and Medicare A/B Components of the Risk-Adjusted Rate 4.7.4 Medical Loss Ratio (MLR) Requirements
Value-Based Payment Arrangements	MCOs must demonstrate to the state the use of alternative payment methodologies that will advance the delivery system innovations inherent in this model, incentivize quality care, and improve health outcomes for members. MCOs may maintain provider risk arrangements. Any incentive arrangements with providers must exclude any specific payment as an inducement to withhold, limit, or reduce services to members. MCOs cannot impose any reduction in payment for a provider-preventable condition when the condition for a particular member	2.7.1.7 Provider Network 2.15.3.2. Risk Arrangements

	existed prior to the provider's initiation of treatment for that member.	
Employment	Employment services are offered only through state's HCBS waivers. There are not any employment-related benefits in the One Care program.	MA Community Living 1915(c) waiver MA Intensive Supports 1915(c) waiver MA Adult Supports 1915(c) waiver
Assistive Technology	Individuals with I/DD on the state's HCBS waivers can access assistive technology services through the HCBS waivers, but there is not an assistive technology benefit in One Care. Assistive technology service means a service that directly assists a participant in the selection, acquisition, rental, or customization or use of an assistive technology device. This service also covers maintenance, repairs of devices and rental of assistive technology during periods of repair. Assistive technology includes: • The evaluation of the assistive technology needs of the member; • Services consisting of purchasing, leasing or otherwise providing for the acquisition of assistive technology devices for members; • Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; • Coordination and use of necessary therapies, interventions, or services with assistive technology devices; • Training or technical assistance for the member, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the member; and • Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of members. Assistive technology must be authorized by the service coordinator as part of the individual service plan. Assistive technology must be purchased through a self-directed budget through the Fiscal Intermediary.	MA Community Living 1915(c) waiver MA Intensive Supports 1915(c) waiver MA Adult Supports 1915(c) waiver
Utilization Management	MCOs must have in place utilization management (UM) policies and procedures that at a minimum: • Routinely assess the effectiveness and the efficiency of the UM program; • Evaluate the appropriate use of medical technologies, including medical procedures, diagnostic procedures and technology, behavioral health treatments, pharmacy formularies and devices; • Target areas of suspected inappropriate service utilization; • Detect over- and under-utilization; • Routinely generate provider profiles regarding utilization patterns and compliance with utilization review criteria and policies; • Compare member and provider utilization with norms for comparable individuals and network providers;	2.9.5 Utilization Management 2.9.8 Authorization of LTSS, Expanded Services, and Community-based Services 2.9.8 Authorization of LTSS, Expanded Services, and Community-Based Services 2.13.6. QI for Utilization Management Activities

	• Routinely monitor inpatient admissions, emergency room use, ancillary, out-of-area services, and out-of-network services, as well as behavioral health inpatient and outpatient services, diversionary services, and ESPs; • Ensure that treatment and discharge planning are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP, other providers, and other supports identified by the member as appropriate; • Conduct retrospective reviews of the medical records of selected cases to assess the medical necessity, clinical appropriateness of care, and the duration and level of care. MCOs must use quality improvement (QI) activities to ensure that their UM program supports the application of fair, impartial, and consistent UM determinations. Health plans are required to maintain a written document that delineates the structure, goals, and objectives of the UM program and that describes how the MCOs utilize QI processes to support the UM program. MCOs must submit an annual report of members who have been enrolled in the health plan for one year or more with no utilization. The report must include an explanation of outreach activities to engage these members. At a minimum, the plan's authorizations of LTSS listed must comply with MassHealth FFS authorization criteria for those covered services. MCOs must develop authorization criteria and a process for authorizing the expansions of cover PCA, DME, and community-based services that considers the member's entire ICP. The plan has the discretion to authorize such services in a determined amount, duration and scope for a member, if the MCO determines that such authorization would provide sufficient value to the member's care. Value must be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the member in the least restrictive setting and with reduced reliance on emergency department use, acute inpatient care and institutional long term care.	
Enrollee Protections	*Orientation for Members*—MCOs must provide an orientation to members within 30 calendar days of the initial date of enrollment, which must include materials and welcome call, assistance with identifying and if desired retaining the current PCP or choose a new PCP, and working with the member to schedule a comprehensive assessment. For members for whom written materials are not appropriate, MCOs must provide non-written orientation in a format such as telephone calls, home visits, video screenings, or group presentations. *Enrollee Service Representatives (ESRs)*—Plans must employ ESRs trained to answer member inquiries and concerns from members and eligible beneficiaries, be knowledgeable about MassHealth, Medicare, and the terms of the contract, including the covered services, be available to members to discuss and assist with member complaints, provide assistance to member with cognitive impairments; for example, provide written materials in simple, clear language at a reading level of grade six and below, and individualized guidance from enrollee services representatives to ensure materials are understood, and provide any additional information that may be required to understand the requirements and benefits of the One Care Plan.	2.3.2 Disenrollment 2.3.4 Initial Enrollee Contact and Orientation 2.5.5.8 Access to Appropriate Behavioral Health Services 2.6.4 Continuity of Care 2.7.1.9 Provider Network 2.8. Network Management 2.9 Enrollee Access to Services 2.9.2 Provider Availability 2.10 Enrollee Services Section 2.15.2 Financial Stability

	Comprehensive Assessment—MCO's comprehensive assessment tool must capture information regarding the member's understanding of available services, desire to self-manage all or part of his or her care plan regardless of the severity of disability, and the member's understanding of his or her self-management responsibilities, the member's preferences regarding privacy, services, care givers, and daily routine, and understanding of his or her federal rights as a member of the MCO. If, as a result of the development of the ICP, or the comprehensive assessment, the MCO proposes modifications to the member's prior authorized services, the plan must provide written notification to the member about and an opportunity to appeal the proposed modifications. The member is entitled to all appeal rights, including aid pending appeal, if applicable. *Provider Availability*—Plans must provide 24/7 toll-free system access to a registered nurse who has immediate access to the centralized member record, is able to respond to member questions about health or medical concerns, has the experience and knowledge to provide clinical triage, is able to provide options other than waiting until business hours or going to the emergency room, and is able to provide access to oral interpretation services available as needed, free-of-charge. *Provider Terminations*—When a PCP or any medical, behavioral health or LTSS provider is terminated from the MCO's One Care Plan or leaves the network for any reason, the MCO must make a good faith effort to give written notification of termination of such provider, within 15 days after receipt or issuance of the termination notice, to each member who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provider. For terminations of PCPs, the MCO must also report the termination to the state and provide assistance to the member in selecting a new PCP within 15 calendar days. For members who are receiving treatment for a chronic or ongoing medical condition or LTSS, the MCO must ensure that there is no disruption in services provided to the member. *Consumer Advisory Board*—MCOs must establish a Consumer Advisory Board or include MMP consumers on a pre-existing governance board that will provide regular feedback to the MCO's governing board on issues of Demonstration management and member care. The MCO must ensure that the Board meeting at least quarterly, is comprised of family members and other caregivers that reflect the diversity of the Demonstration population, including individual. CMS and the state reserve the right to review and approve Board membership. MCOs must also include Ombudsperson reports, as available, in quarterly updates to the Consumer Advisory Board. *Member Termination Requests*—If the state and CMS determine that the MCO too frequently requests termination of enrollment for members, the state and CMS reserve the right to deny such requests and require the MCO to initiate steps to improve the MCO's ability to serve such members. MCOs must ensure timely access to medically necessary clinically appropriate behavioral health services for members determined by the state to be disproportionately boarded in emergency departments, including but not limited to members with I/DD. *Continuity of Care*—At the time of enrollment, for all services other than Part D drugs, MCOs must develop policies and procedures to ensure continuity of care for all members for whichever is the longer of:	

	○ A period of up to 90 days, unless the comprehensive assessment and the ICP are completed (developed and reviewed with the member, including any changes in providers, services, or medications) sooner and the member agrees to the shorter time period; or ○ Until the comprehensive assessment and ICP are complete (developed and reviewed with the member, including any changes in providers, services, or medications). MCOs must ensure that best efforts are made to contact out-of-network providers, including, within the first 90 days of a member's membership in the MCO, such providers and prescribers which are providing services to members during the initial continuity of care period, and provide them with information on becoming credentialed, in-network providers. If the provider does not join the network, or if the member does not select a new in-network provider by the end of the 90-day period or after the ICP is developed, the MCO will choose one for the member. Providers cannot charge members (or the MCO) for any service that (a) is not a medically necessary covered service or non-covered service; (b) for which there may be other covered services or non-covered services that are available to meet the member's needs; and (c) where the provider did not explain items (a) and (b) and (c), that the member will not be liable to pay the provider for the provision of any such services. Providers are required to document compliance with this provision. MCOs must demonstrate the capacity to deliver or arrange for the delivery of scheduled and unscheduled services in the member's place of residence when office visits are unsafe or inappropriate for the member's clinical status. Service sites must include, but not be limited to the member's private residence, a nursing or assisted-living facility, and day care programs. In case of insolvency, MCOs must provide to members all covered services required by the contract for at least 45 calendar days following the date of insolvency or until written approval to cease providing such services is received from the state, whichever comes sooner. Health plans must also continue to provide inpatient services to members until the date of their discharge or written approval from the state, whichever comes sooner. MCOs must guarantee that members and the state will not incur liability for payment of any expense that is the legal obligation of the MCO, any of its subcontractors, or other entities that have provided services members at the direction of the MCO or its subcontractors. *Single case agreements*—MCOs must offer single-case out-of-network agreements to providers who are: 1) not willing to enroll in the MCO's provider network, 2) currently serving members, 3) willing to continue serving them at the MCO's in-network rate of payment, under the following circumstances: ○ The MCO's network does not have an otherwise qualified network provider to provide the services within its network, or transitioning the care in-house would require the member to receive services from multiple providers/facilities in an uncoordinated manner which would significantly impact the member's condition;	

	○ Transitioning the member to another provider could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or ○ Transitioning the member to another provider would require the member to undertake a substantial change in recommended treatment for medically necessary covered services.	
Provider Protections	If the MCO declines to include individuals or groups of providers in its provider network, the MCO must give the affected providers written notice of the reason for its decision. MCOs cannot include in its provider contracts any provision that directly prohibits or indirectly, through incentives or other means, limits or discourages network providers from participating as network or non-network providers in any provider network other than the MCO's provider network(s). MCOs cannot establish selection policies and procedures for providers that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. MCOs must make timely payments to providers and ensure that: • 90% of payment claims from physicians who are in an individual or group practice are paid within 30 days of the date of receipt of the claim; and • 99% percent of all claims from covered service providers are paid within 90 days from the date the MCO receives the claim. MCOs may enter into mutual agreements with their providers to develop alternative timeframes for payment of covered services.	2.9 Enrollee Access to Services 5.1.9 Timely Provider Payments
Network Adequacy	A plan must demonstrate annually that it has an adequate network as approved by CMS and the state to ensure adequate access to medical, behavioral health, pharmacy, community-based services, and LTSS providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access. The MCO's provider network must be responsive to the linguistic, cultural, and other unique needs of any minority, homeless person, individuals with disabilities (both congenital and acquired disabilities), or other special population served by the plan, including the capacity to communicate with members in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or deaf blind. Members must have a choice of at least two PCPs, hospitals, and nursing facilities within the applicable time and distance standards set by Medicare. MCOs must demonstrate annually that their provider network has sufficient providers to ensure that each member has a choice of at least two outpatient and diversionary behavioral health providers and two community LTSS providers per covered service that are either within a 15-mile radius or 30 minutes from the member's zip code of residence, except that with state's prior approval, the MCO may offer a member only one community LTSS provider per covered service.	2.7 Provider Network 2.9 Provider Availability

	MCOs must ensure that non-English speaking members have a choice of at least two PCPs, and at least two behavioral health providers within each behavioral health covered service category, in the prevalent language in the service area provided that such provider capacity exists throughout the service area. *Availability of LTSS*–MCOs must demonstrate the capacity to deliver or arrange for the delivery of scheduled and unscheduled services in the member's place of residence when office visits are unsafe or inappropriate for the member's clinical status. Service sites must include, but not be limited to the member's private residence, a nursing or assisted-living facility, and day care programs. Plans must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial member or MassHealth FFS if the provider serves only member or other persons eligible for MassHealth. MCOs must have a system in place to monitor and document access and appointment scheduling standards, use statistically valid sampling methods for monitoring compliance with the appointment/access standards, and promptly address any access deficiencies.	
Quality Oversight	MCOs must apply principles of continuous quality improvement (CQI) to all aspects of the service delivery system through ongoing analysis, evaluation and systematic enhancements based on: • Quantitative and qualitative data collection and data-driven decision-making; • Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field; • Feedback provided by members and network providers in the design, planning, and implementation of its CQI activities; and • Issues identified by the plan, state, and/or CMS MCOs must ensure that the QI requirements are applied to the delivery of primary and specialty health care services, behavioral health services, community-based services, and LTSS. Plans must maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. Plans must: • Ensure that QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the MCO's service delivery system • Seek the input of providers and medical professionals representing the composition of the MCO's provider network in developing functions and activities; • Develop a medical record review process for monitoring provider network compliance with policies and procedures, specifications and appropriateness of care. Such process must include the sampling method used which must be proportionate to utilization by service type. The plans must submit its process for medical record reviews and the results of	2.13.1 Quality Improvement Program 2.13.2 QI Program Structure Appendix E – Quality Improvement Project Requirements

	its medical record reviews to state; • Develop a process to measure network providers and member at least annually, regarding their satisfaction with the MCO's One Care Plan. The plan must submit a survey plan to the state for approval and submit the results of the survey to the state and CMS; • Develop process to measure clinical reviewer consistency in applying clinical criteria to UM activities, using inter-rater reliability measures; • Develop a process for including members and their families in quality management activities, as evidenced by participation in Consumer Advisory Boards; and • In collaboration with and as further directed by the state, develop a customized medical record review process to monitor the assessment for and provision of LTSS, including the assessment of care between settings and a comparison of services and supports received with those in the member's treatment/service plan. MCOs must have in place, and submit to the state and CMS annually, a written description of the QI program that delineates the structure, goals, and objectives of the MCO's QI initiatives, including organization-wide policies and procedures that document processes through which the MCO ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. The QI staffing team must include a professional with expertise the assessment and delivery of long term services and supports. *Quality Improvement Project Requirements—LTS Coordinator* MCOs must undertake a number of QI improvement projects, including a project to better understand the use of LTS coordinators by One Care Plan members. Plans must identify a random sample of a minimum of 20 members each year who will be interviewed about use of a LTS Coordinator during that year. An independent quality assurance entity conducts interviews of each member in the sample to determine his or her experience with a LTS coordinator, using a semi-structured interview tool provided by the state. Plans must analyze results of the survey in order to understand member experience with a coordinator, and to identify best practices as well as to understand the underlying reasons why members are or are not engaged with LTS coordinators. MCOs will identify issues within their enrollment and assessment processes which require change and must implement such improvements and report on the results to the state and CMS.	
Telehealth	MCOs must cover certain behavioral health services through teletherapy and telepsychiatry.	MassHealth All Provider Bulletin, January 2019

Self-Direction	MCOs must provide education, choice, and needed supports to promote self-direction of Personal Assistance Services (PAS)[3] by members. Health plans must inform members that they may identify a surrogate to help them if they choose self-directed Personal Care Assistant (PCA) services. MCOs must pay for services rendered by the PCA hired by the member if the PCA meets state regulatory requirements and completes the required Fiscal Intermediary (FI) paperwork. Health plans must pay the FI the PCA rate set by the state, which includes both the PCA collective bargaining wage, payment for employer required taxes, and workers' compensation insurance. MCOs must provide members who don't choose self-directed PCA, or who are not able to find a surrogate to assist them to self-direct, with the option of having their PAS provided by an agency. MCOs must contract with such agencies, and provide members with the choice of at least two PAS agency providers. • MCOs must contract with Personal Care Management (PCM) agencies that are under contract with the state to provide PCM Services to members accessing self-directed PCA services. • Members who are authorized to receive self-directed PCA services at the time of enrollment with the MCO must be granted the option of continuing to receive their PCM services through their current PCM provider, to ensure continuity of self-directed PCA services. Members who are not authorized to receive self-directed PCA services at the time of enrollment must be offered a choice of at least two PCM agencies, at least one of which must be an ILC operating as a PCM where geographically feasible. Members over the age of 60 must be offered the option of receiving PCM services through an ASAP operating as a PCM. • Members who are authorized to receive self-directed PCA services at the time of enrollment with the MCO must have the option to continue to receive their FI services through their current FI. Members who are not authorized to receive self-directed PCA services at the time of enrollment with the MCP will elect a PCM agency. The PCM agency is responsible for electing a single FI to serve all their consumers. Individuals on the state's HCBS waiver services may also self-direct the following HCBS services: • Transportation • Individualized day supports • Individual goods and services • Individual supported employment • Respite	Section 1.8.8. Personal Assistance Services Network MA Community Living 1915(c) waiver MA Intensive Supports 1915(c) waiver MA Adult Supports 1915(c) waiver

[3] Personal Assistance Services are defined as physical assistance, cueing, and/or monitoring with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) provided to a member by a Personal Care Assistant (PCA) in accordance with the member's Individualized Care Plan.

	• Vehicle modification • Family training • Behavioral supports and consultation • Adult companion • Chore • Home modifications and adaptations • Peer support • Assistive technology • Live-in caregiver • Individualized home supports • Specialized medical equipment and supplies • Transitional assistance services • 24-Hour Self Directed Home Sharing Support • Family training • Behavioral supports and consultation	
Additional Information	One of the One Care Plans, CCA, had developed clinics, where members with complex needs can receive primary care from practitioners that are experienced in delivering care to with developmental disabilities. The clinics include DME workshops, where members can have their wheelchairs, lifts, etc. repaired and adjusted in a timely manner.	Commonwealth Community Care