

130 CMR 404.000: ADULT DAY HEALTH SERVICES

Section

- 404.401: Statement of Purpose
- 404.402: Definitions
- 404.403: Eligible Members
- 404.404: Provider Eligibility
- 404.405: Clinical Eligibility Criteria
- 404.406: Clinical Assessment and Prior Authorization
- 404.410: ADH Administrative Reporting Requirements
- 404.411: Withdrawal by an ADH Provider from MassHealth
- 404.412: Quality Management
- 404.413: Transportation Services
- 404.414: Conditions of Payment
- 404.415: Noncovered Days
- 404.416: Prohibited Marketing Activities

404.401: Statement of Purpose

130 CMR 404.000 establishes MassHealth requirements for providers of adult day health services. All providers participating in MassHealth must comply with all MassHealth regulations including, but not limited to, 130 CMR 404.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

404.402: Definitions

The following terms used in 130 CMR 404.000 have the meanings given in 130 CMR 404.402 unless the context clearly requires a different meaning.

Activities of Daily Living (ADL) — fundamental personal care tasks performed daily as part of an individual's routine self-care. ADLs include, but are not limited to, eating, toileting, dressing, bathing, transferring, and mobility/ambulation.

Adult Day Health (ADH) — a community-based and non-residential service that provides nursing care, supervision, and health related support services in a structured group setting to MassHealth members who have physical, cognitive, or behavioral health impairments. The ADH service has a general goal of meeting the ADL, and/or skilled nursing therapeutic needs of MassHealth members delivered by a MassHealth agency approved ADH provider that meets the conditions of 130 CMR 404.000.

Adult Day Health Program — a site-based program that is licensed by the Department of Public Health (DPH) under 105 CMR 158.00: *Licensure of Adult Day Health Programs* and that has been reviewed and approved by the MassHealth agency and by other appropriate authorities for the provision of ADH for a specific number of daily participants. If a provider offers ADH in more than one location, each location is a separate ADH program and must meet the provisions of 130 CMR 404.000.

Basic Payment Level — the payment rate established by MassHealth for a ADH provider's provision of ADH services to members who meet the criteria set forth in 130 CMR 404.414(D)(1).

Capitated Program — An ICO, SCO, or PACE organization, or any other entity that, pursuant to a contract with EOHHS, covers ADH and other medical services for members on a capitated basis.

Clinical Assessment — the screening process of documenting a member's need for ADH using a tool designated by the MassHealth agency and which assessment forms the basis for prior authorization of ADH.

404.402: continued

Complex Payment Level — the payment rate established by the MassHealth agency for an ADH provider's provision of ADH services to members who meet the criteria set forth in 130 CMR 404.414(D)(2) .

Department of Public Health (DPH) — an agency of the Commonwealth of Massachusetts, established under M.G.L. c. 17, § 1.

EOHHS — the Executive Office of Health and Human Services established under M.G.L. c. 6A.

Hospital — a facility that is licensed or operated as a hospital by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health that provides diagnosis and treatment on an inpatient or outpatient basis for patients who have any of a variety of medical conditions.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) — a facility, or distinct part of a facility, that provides intermediate care facility services as defined under 42 CFR § 440.150, and that meets federal conditions of participation, and is licensed by the State primarily for the diagnosis, treatment, or rehabilitation for individuals with intellectual disabilities; and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health or rehabilitative services to help individuals function at their greatest ability.

Integrated Care Organization (ICO) — an organization with a comprehensive network of medical, behavioral health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with EOHHS and the Centers for Medicare and Medicaid Services (CMS) and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrolled members with the full continuum of Medicare- and MassHealth-covered services.

Marketing — any communication from an ADH provider, or its agent, to a member, or his or her family or caregivers, that can reasonably be interpreted as intended to influence the member's choice of ADH provider, whether by inducing that member

- (1) to retain that ADH provider to provide ADH services to the member,
- (2) not to retain ADH services from another ADH provider, or
- (3) to cease receiving ADH services from another ADH provider.

Marketing shall not include choice counseling or navigation services provided by community partners pursuant to their contracts with EOHHS.

MassHealth — the medical assistance and benefit programs administered by EOHHS pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

Member — a person determined by the MassHealth agency to be eligible for MassHealth.

Nursing Facility — an institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured people, people with disabilities, or sick persons, or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services that meets the requirements of Sections 1919(a), (b), (c) and (d) of the Social Security Act and is licensed under and certified by the Massachusetts Department of Public Health.

Programs of All-inclusive Care for the Elderly (PACE) — the Programs of All-inclusive Care for the Elderly (PACE), as described in 42 CFR 460 and 130 CMR 519.007(C): *Program of All-inclusive Care for the Elderly (PACE)*.

404.402: continued

Primary Care Provider (PCP) — a physician or a physician assistant or nurse practitioner who practices under the supervision of a physician.

Senior Care Organization (SCO) — a managed care organization that participates in MassHealth under a contract with the MassHealth agency to provide coordinated care and medical services through a comprehensive network to eligible members 65 years of age or older. SCOs are responsible for providing enrolled members with the full continuum of MassHealth-covered services, and for dual eligible members, the full continuum of MassHealth and Medicare covered services.

Significant Change — a major change in the member's status that

- (1) is permanent or will not normally resolve itself without further interventions;
- (2) impacts more than one area of the member's health status; and
- (3) requires an interdisciplinary review or revision of the care plan.

A significant change is presumed when a member authorized to receive ADH does not receive ADH for 90 days or more, or when the provider is seeking a change in service payment level.

Unfair or Deceptive Acts or Practices — any unfair or deceptive acts or practices, as that term is defined in M.G.L. c. 93A, § 2, and the regulations promulgated thereunder by the Massachusetts Attorney General.

404.403: Eligible Members

(A) MassHealth Members. MassHealth-eligible members 18 years of age or older, are subject to the restrictions and limitations described in 130 CMR 450.105: *Coverage Types* that specifies for each MassHealth coverage type which services are covered and which members are eligible to receive those services.

(B) Recipients of Emergency Aid to the Elderly, Disabled, and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled, and Children Program, see 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

(C) For information on verifying MassHealth member eligibility and coverage type, see 130 CMR 450.107: *Eligible Members and MassHealth Card*.

404.404: Provider Eligibility

(A) An organization seeking to participate in MassHealth as an ADH provider must

- (1) enter into a provider contract with the MassHealth agency;
- (2) be licensed by the Department of Public Health under 105 CMR 158.00 *Licensure of Adult Day Health Programs*;
- (3) accept MassHealth payments as payment in full for all ADH;
- (4) establish, maintain, and comply with written policies and procedures to comply with 130 CMR 404.000;
- (5) agree to periodic inspections, by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 404.000;
- (6) agree to comply with all the provisions of 130 CMR 404.000, 450.000: *Administrative and Billing Regulations*, and all other applicable MassHealth rules, regulations, and sub-regulatory guidance; and
- (7) participate in any ADH provider orientation required by EOHHS.

(B) The MassHealth agency requires documentation from applicants seeking to become ADH providers. All required application documentation must be submitted and approved in order to participate as an ADH provider in MassHealth. All required MassHealth application documentation will be specified by the MassHealth agency.

404.405: Clinical Eligibility Criteria

(A) The MassHealth agency pays for ADH provided to members who meet all of the following clinical eligibility criteria:

- (1) ADH has been ordered by the member's PCP;
- (2) The member has one or more chronic or post-acute medical, cognitive, or mental health condition(s) identified by the member's PCP that require active monitoring, treatment or intervention and ongoing observation and assessment by a nurse, without which the member's condition will likely deteriorate;
- (3) The member requires one or both of the following be provided by the ADH program:
 - (a) at least one skilled service listed in 130 CMR 404.405(B); or
 - (b) at least daily or on a regular basis hands-on (physical) assistance or cueing and supervision, throughout the entire activity, with one or more qualifying ADLs listed in 130 CMR 404.405(C) when required at the ADH program as determined clinically appropriate by the ordering PCP and the ADH program nurse developing the plan of care.

(B) Skilled Services. Skilled services are those services ordered by a physician that fall within the professional disciplines of nursing, physical, occupational, and speech therapy. Examples of skilled services include

- (1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding;
- (2) nasogastric-tube, gastrostomy, or jejunostomy feeding;
- (3) nasopharyngeal aspiration and tracheostomy care. However, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services;
- (4) treatment and/or application of dressings when the physician has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions);
- (5) administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema);
- (6) skilled-nursing intervention including observation, evaluation or assessment, treatment and management to prevent exacerbation of one or more chronic medical and/or behavioral health conditions at high risk for instability. Intervention must be needed at frequent intervals throughout the day;
- (7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery, safety and the stabilization of the member's complex social determinants of health;
- (8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter. A urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled-nursing care. However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled-nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection);
- (9) Administration oversight, and management of medication by a licensed nurse including monitoring of dose, frequency, response and adverse reactions;
- (10) Evaluation, implementation, oversight and supervision by a licensed nurse of a behavior management plan and staff intervention required to manage, monitor, or alleviate the following types of behavior:
 - (a) wandering: moving with no rational purpose, seemingly oblivious to needs or safety; ongoing exit seeking behaviors; or elopement or elopement attempts;
 - (b) verbally abusive behavioral symptoms: threatening, screaming, or cursing at others;
 - (c) physically abusive behavioral symptoms: hitting, shoving, or scratching;
 - (d) socially inappropriate or disruptive behavioral symptoms: disruptive sounds, noisiness, screaming, self-abusive acts, disrobing in public, smearing or throwing food or feces, rummaging, repetitive behavior, eating non-food items, or causing general disruption, including difficulty in transitioning between activities;

404.405: continued

- (e) inability to self-manage care;
- (f) pattern of disordered thinking, impaired executive functioning, confusion, delusions or hallucinations, impairing judgment and decision-making leading to lack of safety awareness and unsafe behavior and requiring frequent intervention during the day to maintain safety.
- (11) medically necessary measurements of intake and output based on medical necessity to monitor and manage a chronic medical condition;
- (12) gait evaluation and training administered or supervised by a registered physical therapist while at the ADH provider for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame;
- (13) certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical-therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record);
- (14) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications; and
- (15) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame.

(C) Qualifying Activities of Daily Living for ADH Services. The list of ADLs in 130 CMR 404.405(C)(1) through (5) is for the purpose of clinical eligibility for receipt of ADH services.

- (1) bathing — a full body bath or shower or a sponge (partial) bath which may include washing and drying of face, chest, axillae (underarms), arms, hands, abdomen, back and perianal area that may include personal hygiene such as combing or brushing of hair, oral care, shaving, and when applicable applying make-up;
- (2) toileting — member is incontinent (bladder or bowel) or requires scheduled assistance or routine catheter or colostomy care;
- (3) transferring — member must be assisted or lifted to another position;
- (4) mobility (ambulation) — member must be physically steadied, assisted or guided in mobility, or is unable to self-propel a wheelchair appropriately without the assistance of another person; and
- (5) eating — member requires constant supervision and cueing during the entire meal or physical assistance with a portion or all of the meal.

404.406: Clinical Assessment and Prior Authorization

(A) Clinical Assessment. As part of the prior authorization process, members seeking ADH must undergo a clinical assessment to assess the member's clinical status and need for ADH. Completed clinical assessment documentation must be submitted to the MassHealth agency or its designee in the form and format requested by the MassHealth agency. A new clinical assessment is required annually and upon significant change.

(B) Prior Authorization.

- (1) As a prerequisite for payment of ADH, the ADH provider must obtain prior authorization from the MassHealth agency or its designee before the first date of service delivery and annually thereafter, or upon significant change.
- (2) Prior authorization determines the medical necessity for ADH services as described under 130 CMR 404.405 and in accordance with 130 CMR 450.204: *Medical Necessity*.
- (3) Prior authorization may specify the level of payment for ADH (as described under 130 CMR 404.414(D)).
- (4) Prior authorization does not establish or waive any other prerequisites for payment such as the member's financial eligibility described in 130 CMR 503.007: *Potential Sources of Health Care* and 517.008: *Potential Sources of Health Care*.

404.406: continued

(5) When submitting a request for prior authorization for payment of ADH to the MassHealth agency or its designee, the ADH provider must submit requests in the form and format as required by MassHealth. The ADH provider must include all required information, including, but not limited to, documentation of the completed clinical assessment conducted by the MassHealth agency or its designee; other nursing, medical or psychosocial evaluations or assessments; and any other documentation that the MassHealth agency or its designee requests in order to complete its review and determination of prior authorization.

(6) In making its prior authorization determination, the MassHealth agency or its designee, may require additional assessments.

(C) Notice of Determination of Prior Authorization.

(1) Notice of Approval. If the MassHealth agency or its designee approves a request for prior authorization, it will send written notice to the member and the ADH provider.

(2) Notice of Denial or Service Modification. If MassHealth or its designee denies, or approves with a service modification, a request for prior authorization of ADH, the MassHealth agency or its designee will notify both the member and the ADH provider. The notice will state the reason for the denial or service modification and contain information about the member's right to appeal and the appeal procedure.

(3) Right of Appeal. A member may appeal a service denial or modification by requesting a fair hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(D) Review Requirement. The MassHealth agency or its designee may at any time review prior authorization of MassHealth members including, but not limited to, instances in which there has been a significant change in the member's status as defined in 130 CMR 404.402.

404.410: ADH Administrative Reporting Requirements

(A) The ADH program director or designee is responsible for notifying the MassHealth agency immediately in writing if there is a change in telephone or fax number or e-mail address of the ADH program.

(B) The ADH program must inform notify the MassHealth agency or its designee before relocating a program or expanding the certified capacity at an existing program.

(C) The ADH provider must document transportation utilization as follows.

(1) When a private carrier is used, the ADH provider must submit to the MassHealth agency or its designee a copy of the contract or agreement with the carrier.

(2) The ADH provider must submit, per the MassHealth agency's requirements, a transportation report.

(D) At the request of the MassHealth agency, or its designee the ADH provider must submit clinical and statistical reports to demonstrate the medical necessity of services, the frequency and duration of the service, and the payment level.

(E) The MassHealth agency reserves the right to conduct program reviews or to appoint a designee to conduct program reviews of all ADH programs and member records at any time without notice.

404.411: Withdrawal by an ADH Provider from MassHealth

An ADH provider that intends to withdraw from MassHealth must satisfy all of the following obligations:

(A) MassHealth Notification.

(1) An ADH provider electing to withdraw from participation in MassHealth must send written notice to the MassHealth agency or its designee, of the provider's intention to withdraw from the ADH program. The ADH provider must send the withdrawal notice by certified or registered mail (return receipt requested), to the MassHealth Adult Day Health Unit. The notice must be received by the MassHealth agency or its designee, no fewer than 90 days before the effective date of withdrawal.

404.411: continued

(2) Emergency Withdrawal. In the instance of alleged emergency withdrawal, the ADH provider must contact the MassHealth agency, or its designee, within one business day of the emergency withdrawal and follow-up, in writing, within the next three business days informing MassHealth, or its designee, of the reasoning for such emergency withdrawal, and must provide proof in documentation or other form as the MassHealth agency may require.

(B) Notification to Member and Authorized Representatives.

(1) The ADH provider must notify all members, authorized representatives of members, and other funding sources in writing of the intended closing date no fewer than 90 days from the intended closing date and specify the assistance to be provided to each member in identifying alternative services (*see* 105 CMR 158.024(A): *Voluntary Closure*).

(2) On the same date on which the ADH provider sends a withdrawal notice to the MassHealth agency, the provider must give notice, in hand, to all members to whom it is providing ADH services and the member's authorized representatives. The notice must advise that any member who is eligible for MassHealth on the effective date of the withdrawal must relocate to another ADH provider participating in MassHealth to ensure continuation of MassHealth payment of services and must be determined eligible to continue to receive the services. A copy of this notice must be forwarded to the MassHealth agency or its designee.

(3) The notice must also state that the ADH provider will work promptly and diligently to arrange for the relocation of members to MassHealth-participating ADH providers or, if appropriate, alternative community-service providers.

(C) Admission Requirements and Relocation Requirements.

(1) An ADH provider must not admit any new MassHealth members after the date on which a withdrawal notice was sent to the MassHealth agency or its designee, and Provider Enrollment Center. Members of the ADH program, for whom prior authorization was sought prior to the withdrawal notice being sent, who are then authorized for ADH after the notice of withdrawal are not considered newly admitted members.

(2) An ADH provider that withdraws from participation in MassHealth must assist members to whom it has been providing ADH services to identify and locate another ADH provider, and must continue to provide its current level of ADH until all members receiving ADH from the ADH provider have been admitted with a new ADH provider or another qualified MassHealth provider.

(3) The ADH provider seeking to withdraw from MassHealth must work promptly and diligently to arrange for the relocation of members to MassHealth-participating ADH programs or other qualified MassHealth providers.

(4) The ADH provider must forward a list of all members currently receiving services at the ADH program. The ADH provider must notify the MassHealth agency or its designee in writing as members are placed in other programs or begin to receive alternative services, including the name of the new program or service and the members' start date in the new program or service.

404.412: Quality Management

ADH providers must participate in quality management and program integrity processes established by the MassHealth agency including making any necessary data available and access to the provider's place of business upon request by the MassHealth agency or its designee.

404.413: Transportation Services

(A) Transportation Service. Transportation service provides for transporting members from the member's home to the ADH provider or from the ADH provider to the member's home, including assisting the member while entering and exiting the vehicle, as appropriate. For the purposes of this section, a home includes a temporary housing environment where the member is being sheltered.

(B) Provision of Transportation.

(1) ADH providers may provide transportation as required at 130 CMR 404.414(C)(4) either directly or through a subcontractor;

404.413: continued

(2) The transportation plan must be documented in the participant's enrollment agreement pursuant to 105 CMR 158.034(D)(5): *Participant Enrollment Agreement*.

(C) Rates of Payment. The MassHealth agency pays ADH providers for transportation in accordance with the applicable payment methodology and rate schedule established by EOHHS.

(D) Other Requirements. The ADH provider must ensure that all transportation provided by the ADH program or its subcontractor meets the following criteria:

- (1) all vehicles used for transporting members are licensed by the Massachusetts Registry of Motor Vehicles;
- (2) the operation of these vehicles is in accordance with all local, state, and federal statutes and ordinances; and
- (3) drivers of these vehicles
 - (a) possess valid Massachusetts driver's licenses;
 - (b) have undergone a Criminal Offender Records Information (CORI) check and drug and alcohol testing;
 - (c) are certified in cardiopulmonary resuscitation (CPR) and first aid;
 - (d) have experience with or demonstrated competence in safely transporting people;
 - (e) have received training in meeting the needs, including the transportation-related needs of elderly persons and persons with disabilities;
 - (f) have received training in wheelchair securement and tie down procedures;
 - (g) have received training prior to contact with MassHealth members of the rules and procedures for the mandated reporting of abuse or neglect of members; and
 - (h) have received training on universal precautions and first aid, prior to contact with MassHealth members.

(E) Travel Distance and Time. The ADH provider and the transportation provider should attempt to minimize travel distance and travel time.

(F) Critical Incident Reporting. In addition to critical incident reports required by the Department of Public Health, the ADH provider is responsible for reporting critical incidents related to transportation, or that occur during transportation, to the MassHealth agency or its designee in the form and format requested by the MassHealth agency.

404.414: Conditions of Payment

(A) The MassHealth agency pays an ADH provider for ADH in accordance with the applicable payment methodology and rate schedule established by EOHHS at 101 CMR 310.00: *Adult Day Health Services*. Rates of payment for ADH do not cover or include any amount for room and board.

(B) Payment for ADH is subject to the conditions, exclusions, and limitations set forth in 130 CMR 404.000 and 450.000: *Administrative and Billing Regulations*.

(C) The MassHealth agency pays ADH providers for ADH only if the

- (1) MassHealth agency or its designee determines that the ADH provided is medically necessary;
- (2) member meets the clinical eligibility criteria for MassHealth payment for ADH as described in 130 CMR 404.405;
- (3) ADH provider has obtained prior authorization for MassHealth payment for ADH in accordance with the requirements set forth in 130 CMR 404.406; and
- (4) ADH provider bills at the payment level authorized by the MassHealth agency or its designee.

(D) ADH Payment Levels.

(1) Basic Payment Level.

- (a) The MassHealth agency pays the Basic Payment Level rate to ADH providers for each date of service billed that the member meets the clinical eligibility criteria set forth in 130 CMR 404.405 and the provider meets at least one of the qualifying needs of the member while the member is in attendance at the ADH program.

404.414: continued

(b) The ADH provider must document how a qualifying need or needs were met for each member in a manner consistent with the member's plan of care on each date for which services are billed and make this information available to the MassHealth agency or its designee upon request. Such documentation must include evidence of the following having been provided pursuant to the member's plan of care, as applicable: daily ADL service delivery, daily behavior support or evaluation, daily activity participation, and/or evidence of skilled services care.

(2) Complex Payment Level.

(a) The MassHealth agency pays the Complex Payment Level rate for each date of service billed that the member meets the complex payment level criteria set forth in either 130 CMR 404.414(D)(2)(a)1. or 2., and the requirements of 130 CMR 404.414(D)(2) are

1. The member required the provision by the ADH provider of at least one skilled service from 130 CMR 404.405(B)(1) through B(5), or B(8) while in attendance at the ADH; or met:

2. The member required the provision by the ADH provider of a combination of at least three of the following including at least one from 130 CMR 404.414(D)(2)(a)2.b.:

a. qualifying activities of daily living listed at 130 CMR 404.405(C) performed while in attendance at the ADH; and

b. skilled services listed at 130 CMR 404.405(B)(1) through B(5), B(8) through B(12), or B(15) required to be provided while in attendance at the ADH in a manner consistent with the plan of care as directed by the ADH nurse.

(b) The ADH provider must maintain a minimum-staffing ratio of one staff person to four complex payment level members.

(c) The ADH provider must document how qualifying needs and staffing needs set forth in 130 CMR 404.414(D)(2)(b) were met for each member in a manner consistent with the member's plan of care for each date for which services are billed and make this information available to the MassHealth agency or its designee upon request. Such documentation must include evidence of the following having been provided pursuant to the member's plan of care: daily ADL service delivery, daily behavior support or evaluation, daily activity participation, and evidence of skilled services care.

(E) Transition Between Two ADH Providers. If a member changes from one ADH provider to another ADH provider, a new clinical assessment is required and the new ADH provider must obtain prior authorization prior to delivering services to the transferring member. The previous ADH provider must continue to provide ADH to the member while the new ADH provider is obtaining prior authorization and until the member is admitted and receiving services from the new ADH provider. The previous ADH provider must discharge the member from its ADH program before the new ADH provider may bill the MassHealth agency for ADH. The MassHealth agency will pay only one ADH provider per day for the provision of ADH to a member.

(F) The ADH provider must review each member in its care to ensure that the clinical eligibility criteria for MassHealth payment for ADH continues to be met. An ADH provider must not bill and the MassHealth agency will not pay for ADH for any member who does not meet clinical eligibility criteria for MassHealth payment.

(G) The ADH provider must bill the MassHealth agency only at the payment level authorized by the MassHealth agency or its designee.

(H) The ADH provider must maintain documentation of delivered services in the member's medical record.

(I) MassHealth payment to ADH providers begins on the later of:

(1) the effective date of the prior authorization for services from the MassHealth agency; or

(2) the first date on which ADH is provided to the member.

404.414: continued

(J) MassHealth payment to an ADH provider ends on the date which a member no longer meets the clinical requirements for MassHealth payment of ADH described in 130 CMR 404.405 or is no longer receiving ADH, whichever comes first.

404.415: Noncovered Days

The MassHealth agency does not pay an ADH provider

(A) for any portion of a day during which the member is receiving services provided by a Home Health Agency while the member is in attendance at the ADH program under 130 CMR 403.000: *Home Health Agency* that are duplicative of services covered under ADH;

(B) when the member is a resident or inpatient of a hospital, nursing facility, or intermediate care facility for the intellectually disabled; except on dates of admission and discharge;

(C) if the provider has not received prior authorization from the MassHealth agency or its designee;

(D) for any canceled program days or any time periods missed by a member for any reason; and

(E) for any portion of a day during which the member is absent from the site, unless the program documents that the member was receiving services from the program staff outside of the ADH program in a community setting.

(F) The MassHealth agency does not pay for ADH transportation for members on days where the member does not have an ADH service claim for ADH attendance that day.

404.416: Prohibited Marketing Activities

An ADH provider shall not:

(A) with the knowledge that a member is enrolled in a Capitated Program, engage in any practice that would reasonably be expected to have the effect of steering or encouraging the member to disenroll from the Capitated Program in order to retain the ADH provider to provide ADH services on a fee-for-service basis; or

(B) offer to a member, or his or her family or caregivers, in-person or through marketing any inducement to retain the ADH provider to provide ADH services, such as a financial incentive, reward, gift, meal, discount, rebate, giveaway, or special opportunity;

(C) pay a “finder’s fee” to any third-party in exchange for referring a member to the ADH provider; or

(D) engage in any Unfair or Deceptive Acts or Practices in connection with any Marketing.

REGULATORY AUTHORITY

130 CMR 404.000: M.G.L. c. 118E, §§ 7 and 12.

(PAGES 133 AND 134 ARE RESERVED FOR FUTURE USE.)