130 CMR 419.000: DAY HABILITATION CENTER SERVICES

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419.401: Introduction

130 CMR 419.000 establishes the requirements for the provision of services by day habilitation programs under MassHealth. All day habilitation providers must comply with the regulations governing MassHealth including, but not limited to, 130 CMR 419.000 and 450.000: *Administrative and Billing Regulations*.

419.402: Definitions

The following terms used in 130 CMR 419.000 have the meanings given in 130 CMR 419.402 unless the context clearly requires a different meaning.

Activities of Daily Living (ADLs) - 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 or ambulation.

Clinical Assessment - the screening process of cataloging a member's need for DH using a tool designated by the MassHealth agency and that forms the basis for prior authorization.

Day Habilitation (DH) - a service, for individuals with an intellectual disability (ID) or a developmental disability (DD), that is based on a day habilitation service plan that sets forth measurable goals and objectives, and prescribes an integrated program of activities and therapies necessary to reach the stated goals and objectives.

Day Habilitation Provider (DH Provider) - the entity with responsibility for the day-to-day operation of facilities and programs subject to 130 CMR 419.000.

Day Habilitation Service Plan (DHSP) - a written plan of care for each member that sets forth realistic and measurable behaviorally based goals that prescribe an integrated program of individually designed activities and/or therapies necessary to achieve these goals. The objective of the plan is to help the member reach his or her optimal level of physical, cognitive, psychosocial, occupational capabilities, and wellness.

Department of Developmental Services (DDS) - an agency of the Commonwealth of Massachusetts established under M.G.L. c. 19B.

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

Developmental Disability - a severe, chronic disability that

(1) is attributable to other conditions found to be closely related to ID, apart from mental illness, which results in the impairment of general intellectual functioning or adaptive behavior similar to that of persons with ID, and which requires treatment or services similar to those required for such persons;
(2) is manifested before a person reaches 22 years of age;
(3) is likely to continue indefinitely; and
(4) results in substantial functional limitations in three or more of the following major areas:
    (a) self-care;
    (b) understanding and use of language;
    (c) learning;
    (d) mobility;
    (e) self-direction; or
    (f) capacity for independent living.

Developmental Skills Training - a series of planned, coordinated, goal-oriented services that are designed to improve the functional abilities of a person with an intellectual or developmental disability. Such services include, but are not limited to, self-help skills, sensorimotor skills, communication skills, independent living skills, affective development skills, social development skills, and behavioral skills.

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

Full-time Equivalent (FTE) - a standardized measure of a program's personnel resources used by the EOHHS. One FTE equals coverage by one staff member for 40 hours per week.

Functional Level - the degree to which individuals can perform daily living activities and manage their lives independently. Functional level is measured through professional clinical assessments.

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.

Instrumental Activities of Daily Living (IADLs) - activities related to independent living that are incidental to the care of the member and that include, but are not limited to, household-management tasks, laundry, shopping, housekeeping, meal preparation and cleanup, transportation, care and maintenance of medical equipment and adaptive devices, medication management or any other need determined by the DH provider as being instrumental to the health care and general well-being of the member.

Intellectual Disability (ID) - significantly sub-average intellectual functioning existing concurrently with and related to significant limitations in adaptive functioning. ID originates before 18 years of age. The meaning of ID is consistent with the standard contained in the 11th edition of the *American Association on Intellectual and Developmental Disabilities's Intellectual*

Disability: Definition, Classification, and Systems of Supports (2010) or any subsequent publication.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) - 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 Commonwealth 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.

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Level II Preadmission Screening and Resident Review (Level II PASRR) - a comprehensive evaluation and determination performed by DDS for any individual seeking admission or continued stay in a Medicaid nursing facility, in accordance with 42 CFR 483.100, to determine whether an individual suspected of having intellectual or other developmental disability has such a condition and if so, whether the individual requires the level of services provided by a nursing facility, and if so, whether specialized services are required.

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 (NF) - 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 the 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.

Primary Care Provider (PCP) - a physician, physician assistant, or nurse practitioner who operates under the supervision of a physician.

Rolland Integrated Service Plan (RISP) - a comprehensive service plan developed by an interdisciplinary team consisting of the DDS service coordinator where applicable, the member (or authorized representative), NF staff representatives, the specialized services provider, and other relevant professionals (such as physical therapists, speech pathologists, occupational therapists, dieticians, and medical staff). The purpose is to address care in all settings for persons with ID or DD who reside in NFs and receive specialized services.

Service Needs Assessment (SNA) - a compilation of evaluations by qualified professionals that determine a member's level of functioning, needs, and strengths, and makes specific recommendations for day habilitation to address identified needs.

Significant Change - a major change in the member's status that:
(1) impacts more than one area of the member's health status; and
(2) requires the professional interdisciplinary team's review or revision of the DHSP.

Specialized Services - services specified by EOHHS for an NF resident with ID or DD which, combined with services provided by the nursing facility or other service providers, result in treatment that meets the requirements of 42 CFR 483.440(a)(1).

419.403: Eligible Members

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

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

419.404: Provider Eligibility

An organization seeking to participate in MassHealth as a day habilitation provider must

(A) be located in Massachusetts;

(B) enter into a contract with the MassHealth agency through submission of an application that includes all documentation specified by the MassHealth agency or its designee and be certified by the MassHealth agency or its designee in accordance with the requirements set forth in 419.000 and 450.000: *Administrative and Billing Regulations* to conduct a business in Massachusetts that delivers health and human services to individuals with ID/DD;

(C) accept the MassHealth agency payments as payment in full for DH;

(D) be in operation at least five business days a week, six hours per day;

(E) contract with DDS in accordance with EOHHS guidelines, to ensure coordination of services to DDS clients;

(F) be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership;

(G) meet all provider participation requirements described in 130 CMR 419.400 and 450.000: *Administrative and Billing Regulations*.

(H) participate in any DH provider orientation required by EOHHS;

(I) submit to the MassHealth agency or its designee a written description of DH offered by the DH provider and its service plan; and

(J) agree to periodic inspections by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 419.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

419.405: Scope of Day Habilitation

(A) A DH provider must have the services described in 130 CMR 419.408 available on-site and sufficient to meet the needs of MassHealth members.

(B) A DH provider must provide the following services.

(1) Nursing Services and Health Care Supervision. The DH provider must provide nursing coverage on site. Nursing services must be provided to meet the needs of each member and must include the following:

(a) administration of medications and treatments prescribed by the member's PCP during the time the member is at the program;

(b) education in hygiene and health concerns;

(c) coordination of each member's DHSP with other health care professionals including the NF where the member resides, if applicable;

(d) monitoring each member's health status and documenting those findings in the member's medical record at least monthly and every six months as part of the interdisciplinary team review, and more often if the member's condition requires more

frequent monitoring;

(e) reporting changes in the member's condition to the member's PCP;

(f) oversight of therapy treatment as recommended by a licensed therapist and, as applicable, PCP order; and

(g) coordinated implementation of the PCP's orders with the member, authorized representative, and DH provider staff.

(2) Developmental Skills Training. The DH provider must provide skills training in the following areas: self-help development, sensorimotor development, communication development, social development, independent living development, affective development skills, social development skills, and behavior development.

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(3) Therapy Services. The DH provider must provide therapy services when recommended through the service needs assessment. Therapy services include:
(a) speech/language therapy;
(b) occupational therapy;
(c) physical therapy; and
(d) behavior management.
(4) Assistance with Activities of Daily Living (ADL). The DH provider must have sufficient staff at its site to provide assistance with ADLs.
(5) Day Habilitation Service Management. The DH provider must undertake activities that ensure implementation of the member's day habilitation service plan including required reviews described in 130 CMR 419.419.

419.406: Clinical Eligibility Criteria

(A) All members, except those who are residents of an NF, must meet the following clinical eligibility criteria for receipt of DH:
(1) have ID or DD as defined in 130 CMR 419.402 and as certified by a PCP;
(2) need DH to acquire, improve, or retain their maximum skill level and independent functioning.

(B) In order for a member residing in an NF to be eligible for receipt of DH, DDS must have determined *via* a Level II PASRR that the member requires specialized services.

419.407: Clinical Assessment and Prior Authorization

(A) Clinical Assessment. As part of the prior authorization process, a DH provider must assess the member's clinical status, need for DH, and appropriate DH service level. 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 every two years or sooner if the member experiences a significant change.
(1) Assessment Period. Members newly seeking DH may receive DH for up to 45 business days, not subject to prior authorization, concurrent with the provider's completion of the member's initial clinical assessment for DH.
(2) Assessment Criteria. Providers must include the following as part of the clinical assessment or reassessment of a member:
(a) Confirm that the member had a physical examination by a PCP within 12 months prior to seeking authorization for services;
(b) Confirm that within 12 months prior to seeking authorization for services, the member has had a comprehensive evaluation by a referring entity that includes, at a minimum, the following:
1. a written assessment of the member's social skills; and
2. a written assessment of the member's medical, mental, functional, and developmental status.
(3) Obtain the written approval of the clinical assessment from the member, the member's clinical authorized representative, and PCP or medical clinic.
(4) For members residing in NFs for whom the Level II PASRR conducted by DDS concluded that the member requires specialized services, the DH provider must obtain a copy of the DDS Level II PASSR determination notice and maintain a copy of this notice in the member's record.

(B) Prior Authorization.

(1) A DH provider must obtain prior authorization from the MassHealth agency or its designee as a prerequisite to payment for the provision of DH provided to the member after the 45th business day of the member's receipt of DH from the DH provider, and every two years thereafter, and upon significant change.

(2) Prior authorization determines the medical necessity for DH as described under 130 CMR 419.406 and in accordance with 130 CMR 450.204: *Medical Necessity*.

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(3) Prior authorization specifies the level of payment for the service.
(a) The MassHealth agency pays DH providers for DH provided from the first date on which DH is provided to an eligible member through the date of prior authorization approval at the moderate rate of payment;
(b) After prior authorization the MassHealth agency pays DH providers for DH services provided to an eligible member at one of three levels of payment reflecting the member's assessed need for DH in accordance with the member's prior authorization for DH;
(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*.
(5) When submitting a request for prior authorization for payment of DH to the MassHealth agency, or its designee, the DH provider must submit requests in the form and format as required by the MassHealth agency. The DH provider must include all required information including, but not limited to, documentation of the completed clinical assessment; other nursing, medical, or psychosocial evaluations or assessments; and any other documentation that the MassHealth agency, or its designee, requests in order to complete the review and determination of prior authorization.
(6) In making its prior authorization determination, the MassHealth agency or its designee may require additional assessments of the member or require other necessary information in support of the request for prior authorization.

(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 DH provider.
(2) Notice of Denial or Service Modification. If the MassHealth agency or its designee denies, or modifies, a request for prior authorization of DH, the MassHealth agency or its designee will notify both the member and the DH 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: *Fair Hearing Rules*.

(D) Review. The MassHealth agency, or its designee, may at any time review the medical necessity of the provision of DH to 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 419.402.

419.408: Quality Management

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

419.409: Conditions of Payment

(A) The MassHealth agency pays for DH in accordance with the applicable payment methodology and rate schedule established by EOHHS, including supplemental staffing for those who reside in an NF and attend a community-based DH and for DH provided in NFs. Rates of payment for DH do not cover or include any room and board.

(B) Payment for services is subject to the conditions, exclusions, and limitations set forth in 130 CMR 419.000 and 450.000: *Administrative and Billing Regulations*.

(C) The MassHealth agency pays a DH provider for DH only if

(1) the member receiving DH is eligible under 130 CMR 419.403;

(2) the member meets the clinical eligibility criteria for DH in accordance with 130 CMR 419.406;

(3) the DH provider has obtained prior authorization for DH provided on or after the 46th business day following the initial date of service in accordance with 130 CMR 419.407;

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(4) the DH provider is not billing for days that are non-covered under 130 CMR 419.431; and

(5) for members who reside in a NF, the member's Level II PASRR conducted by DDS determines that the member requires specialized services.

(D) Transition between Two DH Providers. If a member changes from one DH provider to another DH provider, a new clinical assessment is required and the new DH provider must obtain a new prior authorization. The previous DH provider when possible may continue to provide and bill for DH to the member if the provision of such services is permissible under 130 CMR 419.407, while the new DH provider is obtaining prior authorization and until the member, if eligible for DH, is admitted and receiving services from the new DH provider. The previous DH provider must discharge the member from its day habilitation program before the new DH provider may bill the MassHealth agency for DH. The MassHealth agency will pay only one DH provider per day for the provision of DH to a member.

(E) The DH provider must review each member in its care to ensure that the clinical eligibility criteria for DH continue to be met. A DH provider may not bill and the MassHealth agency will not pay for any member who does not meet the clinical criteria for DH.

(F) The MassHealth agency's payment to a DH provider ends on the date on which a member no longer meets the clinical criteria for DH described in 130 CMR 419.406, is no longer receiving DH, or no longer has a prior authorization in effect, whichever comes first.

(G) The MassHealth agency pays for DH provided by a participating DH in an NF where the member resides if the conditions of 130 CMR 419.409 and 419.433 are met.

(H) The MassHealth agency pays for DH delivered at an approved site and census.

419.410: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary day habilitation services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction*, without regard to service limitations described in 130 CMR 419.000, and with prior authorization.

419.416: Day Habilitation Provider Responsibilities

In addition to meeting all of the qualifications set forth in 130 CMR 419.000 and 450.000: *Administrative and Billing Regulations*, the DH provider must meet all of the following requirements.

(A) Policies and Procedures Manual. Each DH provider must develop, maintain, and periodically review and update policies and procedures governing the delivery of DH. The policy and procedures manual must at minimum include a mission statement; the goals and objectives of the program; an organizational chart describing the lines of authority and communication needed to manage the DH program including the lines of authority for delegation of responsibility down to the member care level; job descriptions that include titles, reporting authority, qualifications and responsibilities; a description of the governing body; and a description of the fiscal/business management system that clearly specifies the use of funds

within budgetary constraints and fiscal restrictions and fiscal reporting by month, reflecting all sources of income and program expenses. All documentation must be kept on site or readily accessible. Additionally, each policy and procedure manual must contain written policies and procedures for the following:

(1) administrative policies and procedures including, but not limited to

(a) human resources and personnel;

(b) staff and staffing requirements;

(c) backup staff in the event coverage is required due to illness, vacation, or other reasons;

(d) staff education and training;

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(e) DH provider staff evaluation and monitoring;
(f) emergencies including fire, safety, and disasters, including notifying the fire department and police in emergencies and relocating members during an emergency;
(g) MassHealth basics and MassHealth member rights;
(h) human rights and nondiscrimination;
(i) incident and accident reporting;
(j) staff and member grievances;
(k) cultural competency;
(l) quality assurance and improvement;
(m) emergency services and plans;
(n) first aid and cardiopulmonary resuscitation requirements;
(o) Health Insurance Portability and Accountability Act (HIPAA);
(p) food storage and preparation areas;
(q) coordination of DH with other services the member is receiving; and
(r) procedures to be followed if a member is missing or lost.

(2) clinical policies and procedures including, but not limited to,
(a) evaluations and assessments;
(b) privacy and confidentiality;
(c) medication administration, management, and storage;
(d) universal precautions;
(e) infection control and communicable diseases;
(f) recognizing and reporting abuse (physical, sexual, emotional, psychological) neglect, self-neglect and financial exploitation;
(g) description and use of positive behavioral supports (PBS);
(h) admission criteria; and
(i) discharge planning and follow-up.

(B) Recordkeeping and Reporting Requirements.

(1) Recordkeeping. The DH provider must maintain records in compliance with the requirements set forth in 130 CMR 450.000: *Administrative and Billing Regulations* and all other applicable state and federal laws. All records including, but not limited to, the following must be accessible and made available on site for inspection by the MassHealth agency or its designee:

(a) Member Records. The record must contain information necessary to identify the member. Each member's record also must include all documentation pertaining to the DHSP and the design of an appropriate DHSP including, but not limited to, the following:

1. the member's name, member identification number, address, telephone number, sex, age, marital status, next of kin or authorized representative, school or employment status, the date of initial contact with the program, and the emergency fact sheet in accordance with 130 CMR 419.430(D);
2. a member profile that includes a brief history including diagnoses, and clinical and behavioral needs. If applicable the member profile must also include: specialized service needs, the reason for referral to DH, the name of the DHSM assigned to the member and, the name and contact information of the DDS service coordinator;
3. an educational, social, medical, and vocational history with assessment reports from qualified providers and an updated record of past and present immunizations and tuberculin tests;
4. a copy of the clinical assessment that was submitted as part of the prior

authorization process, and copies of any reassessments;
5. a report of the member's most recent annual physical examination and the PCP's recommended service plan based on their review of this report;
6. the name, address, and telephone number of the PCP serving the member;
7. the written approval of the DHSP plan from the professional interdisciplinary team, the PCP, the member or the member's authorized representative;
8. documentation supporting the member's level of payment;
9. documentation by the DHSM of all conferences with the member, the member's authorized representatives, and with outside professionals;
10. daily attendance records;

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11. progress notes updated monthly by the DHSM, the health-care supervisor, and, when appropriate and available, by other people significantly involved in implementing the DHSP;
12. reports of all semiannual reviews conducted in accordance with 130 CMR 419.405(B)(1) and 419.419(D)(3) and any other reports generated in compliance with 130 CMR 419.000;
13. written authorization from the member or the member's authorized representative for the release of information;
14. the discharge notice, if the member is discharged; and
15. a copy of the Level II PASRR notice, if applicable.

(b) Administrative Records. The DH provider must maintain
1. payroll records;
2. personnel records, that include the requirements set forth in 130 CMR 419.421(A)(1), including evidence of completed staff orientation and training;
3. financial and billing records;
4. member utilization records, including the number of members being served and number of individuals on a waiting list;
5. records of staffing levels and staff qualifications;
6. records of complaints and grievances; and
7. contracts for subcontracted services.

(c) Incident and Accident Records. The DH provider must maintain an easily accessible record of member and staff incidents and accidents. The record may be kept within the individual member medical record or employee record or within a separate, accessible file.

(2) Reporting Requirements.

(a) Program Reporting.
1. The DH provider must submit all of following information in the format and time frames as requested by the MassHealth agency:
   a. cost and expense information; and
   b. any change in DH provider contact information.
2. The DH provider must make available to the MassHealth agency or its designee, the following:
   a. copies of any and all accreditation correspondence with CARF or Council on Quality and Leadership; and
   b. any additional information requested by MassHealth or its designee related to the provider's provision of DH, including information, such as clinical and statistical or cost and expense information, and other data necessary to measure the quality of the services delivered by the DH provider.
3. The DH provider must comply with all applicable reporting requirements of other state agencies such as DDS.

(b) Clinical Incident Reporting. The DH provider must immediately notify the MassHealth agency of any of the following incidents and follow-up in writing within three business days:
1. fire or other unnatural disaster at the program site;
2. a life threatening accident or serious physical injury to a member that requires medical treatment beyond basic first aid, including self-inflicted injury or when cause of origin of injury is unknown;
3. death of a member at, en route to, or en route from the program;
4. evidence of serious communicable disease contracted by program staff or

members;

5. any allegation of abuse or neglect of or by the member; and

6. a member missing from a DH provider site or missing from any other location during the provision of DH.

(C) Staffing Ratios and Requirements. A DH provider must have sufficient qualified staff in accordance with 130 CMR 419.421 to deliver DH and have specific personnel policies, including procedures for monitoring current licensure or certification of professional staff, staff training, supervision, and evaluation.

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(1) A DH provider must have a full-time program director.
(2) A DH provider with 28 or fewer participants must include on its staff a professional interdisciplinary team of no fewer than four health care professionals as described in 130 CMR 419.421.
(3) A DH with more than 28 participants must have one additional full-time equivalent (FTE) health-care professional for every seven additional participants. The minimum professional FTE staff-to-member ratio is one-to-seven. The maximum professional FTE staff-to-member ratio is one-to-four. For every additional 28 participants, the additional staff members must form a team as described in 130 CMR 419.416(E).
(4) DH providers must have a nurse health care supervisor for at least 0.75 FTE comprised of a licensed registered nurse for 0.5 FTE allowing for the balance of coverage, 0.25 FTE, on-site to be provided by an LPN. RNs must provide supervision of LPNs for a minimum of six hours per week for 28 participants, with an additional two hours per week for every additional 14 participants.
(5) A DH provider may employ direct care staff (paraprofessionals) to help meet the needs of its members. The maximum FTE paraprofessional-to-member ratio is one-to-four.
(6) Staffing ratios will be based on the average daily census of members enrolled with the DH provider at the specific DH site during the rate year, calculated using data from the last quarter.
(7) The DH provider must designate one person as the administrator. The same person, if qualified, may serve as both the administrator and the program director.

(D) Referrals and Written Agreements. To ensure that members receive all the services required in their DHSPs, the DH provider must make prompt and appropriate referrals for those services not provided by the day habilitation program itself. The DH provider must document all referrals in the member's clinical record and coordinate such referrals with DDS in accordance with the requirements of the contract (*see* 130 CMR 419.404(A)(4)).

419.417: Service Needs Assessment

A Service Needs Assessment (SNA) determines a member's functional level, needs, and strengths, and makes specific recommendations to address acquisition, improvement, or maintenance of each identified need area for the member. Each SNA must

(A) be completed within 45 business days of a member's admission and every two years thereafter and upon a significant change in the member's condition;

(B) assess each of the following need areas: self-help skills, sensorimotor skills, communication skills, independent living skills, affective development skills, social development skills, behavioral development skills, and wellness; and

(C) identify which need areas will be addressed in the DHSP.

419.419: Day Habilitation Service Plan (DHSP)

(A) Interim DHSP. Within five business days after the member's admission, the DH provider's professional interdisciplinary team must design an interim DHSP. The plan must outline a temporary schedule of treatment and activities that will be used until the final DHSP is completed.

(B) Final Day Habilitation Service Plan. Together with the SNA, the final DHSP must be completed within 45 business days of the date of the member's admission and updated every two years or upon significant change and must be developed with participation of the member, the member's authorized representatives, where applicable and appropriate, and must be derived from the SNA for each member. The final DHSP describes each training program, measurable goals, and objectives that address the need areas identified in the SNA. The DHSP must be designed in a manner that integrates the various activities, tasks, and, if appropriate, therapies recommended to meet the member's areas of need. The final DHSP must include, but is not limited to, the following:

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(1) a medical plan of care;
(2) a service plan coversheet that outlines the development of the member's DHSP, based on the recommendations from the SNA;
(3) goals and objectives that are written in behavioral and measurable terms.
(a) Goals must
1. be written without the use of ambiguous action verbs;
2. provide for clear means for establishing attainment of the goal within the established time frames.
(b) Objectives must address specific skill acquisition and retention as it relates to a goal and must
1. be written without the use of ambiguous action verbs;
2. measure only one observable behavior; and
3. use performance and stability criterion.

(C) Reviews.
(1) The DHSM must review the member's goals and objectives every six months or upon significant change and must inform the staff, using staff meetings, of any changes in the member's status or DHSP.
(2) The health care supervisor must ensure that monthly progress notes are completed and reflect the member's plan of care. Any significant changes in the member's health status must be discussed with the DH staff.
(3) The core professional interdisciplinary team must conduct, at least two times per year, a review of the member's overall progress. Components of this review, at a minimum, must include
(a) a comprehensive review of the member's goals and objectives (if a change in goals and objectives is indicated by the review, the member's DHSP must be reformulated); and
(b) comprehensive medical review based on the member's DHSP.

419.420: Discharge

(A) Discharge Procedures. The DH provider must coordinate the discharge with the member, member's authorized representative, DDS, if applicable, and with the staff of the DH provider or other agency to which the member is transferred, if applicable.

(B) Discharge Plan. A discharge plan, dated and signed by the program director, must be kept in the member's record for at least four years after the date of discharge and must remain accessible to representatives from the MassHealth agency and other state and federal agencies that are authorized by law to have such information.

419.421: Day Habilitation Staff Qualifications, Responsibilities, and Training

(A) General Staffing Requirements.
(1) Prior to hiring or contracting with any staff, the DH provider must
(a) check the candidate's references and job history and ensure that the candidate meets all of the required experience, education, and qualifications before hiring;
(b) conduct a Criminal Offender Records Information (CORI) check and determine whether any offender records may disqualify the individual for employment;
(c) check the Office of Inspector General (OIG) List of Excluded Individuals and

Entities (LEIE) to determine whether the candidate appears on the LEIE and is thus disqualified from employment;
(d) conduct a national criminal background check in accordance with the administrative procedures described at 115 CMR 12.00: *National Criminal Background Checks*;
(e) conduct license and certification checks and validate that the candidate has obtained all necessary licenses and certifications and that all licenses and certifications are current;
(f) ensure that each DH staff person is not providing direct care to any member whom that staff person is related to or legally responsible for; and
(g) ensure that each DH staff person has received a tuberculosis screening within the previous 12 months.

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(2) On an ongoing basis, the DH provider must

(a) ensure that all staff receive tuberculosis screenings in accordance with current guidelines issued by the Centers for Disease Control and Prevention (CDC) and DPH;

(b) conduct an OIG LEIE check for all staff each month;

(c) ensure that all staff are appropriately trained and managed which must include, but not be limited to, training in recognition and reporting of abuse;

(d) have available at all times a sufficient number of educated, experienced, trained, and competent personnel to provide DH individuals with ID or DD;

(e) evaluate staff annually using standardized evaluation measures;

(f) maintain a separate personnel file for each staff member with all applicable information including performance evaluations; and

(g) include in each staff member's personnel file any staff incident or accident reports.

(B) Professional Interdisciplinary Team.

(1) The DH provider must have a core professional interdisciplinary team that consists of the heath-care supervisor, developmental specialist, DHSM and program director. Responsibilities of the core professional interdisciplinary team include, but are not limited to

(a) completion or submission of member needs based on a clinical assessment using a tool in the form and format established by the MassHealth agency or its designee to the MassHealth agency or its designee.

(b) design implementation, supervision and continued review of the DH provider's provision of DH to members in accordance with members' individual DHSP.

(2) Additional Interdisciplinary Team members.

(a) For the purposes of completing each member's SNA, the interdisciplinary team must also include the following clinicians: physical therapist, speech and language pathologist, occupational therapist, and behavioral specialist as well as other health care professionals as applicable. Definitions and minimum qualifications relating to these disciplines are in 130 CMR 419.419. The composition of the team must be appropriate to the needs of the participants. These additional team members are also responsible for reassessing a member's areas of need in the event of a significant change in the member's condition.

(b) Circumstance for continued participation of interdisciplinary team reviews:

1. If based on a member's SNA the Interdisciplinary team determines that a member receive formal direct therapy, which would be implemented by the therapist, therapy aide, or pathologist, the recommending therapist or pathologist must continue to participate in the member's interdisciplinary team reviews;

2. If based on a member's SNA the Interdisciplinary team determines that a member does not require continued formal direct therapy, the applicable therapist or pathologist does not need to continue to participate in the member's interdisciplinary reviews;

3. If a significant change in the member's condition occurs, the appropriate clinician(s) must reevaluate the member's SNA and the recommendations.

(C) Administrator.

(1) Qualifications. The administrator must hold either a bachelor's degree in business management or a related field or have at least two years of experience in health-care management. One year of that experience must have been in a supervisory capacity.

(2) Responsibilities. The administrator must

(a) manage day-to-day activities, if acting as the program director;

(b) report to the MassHealth agency or its designee and other involved agencies;
(c) monitor compliance with all applicable laws and regulations governing DH; and
(d) implement the DH provider's policies and procedures.

(D) Program Director.

(1) Qualifications. The program director must hold a bachelor's degree in a health related field, with at least three years of relevant health care experience, of which at least two of those years must have been spent in a supervisory role. Six years of relevant health care experience, with three of those years serving in a supervisory role, may be substituted in *lieu* of a bachelor's degree.

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(2) Responsibilities. The program director must
(a) manage the day-to-day activities of the provision of DH;
(b) monitor compliance with all applicable laws and regulations governing the provision of DH;
(c) implement and oversee the DH provider's policies and procedures;
(d) hire, oversee training, supervise, evaluate, and when necessary fire staff members;
(e) oversee member services and participate on all interdisciplinary teams; and,
(f) report to the MassHealth agency and other involved agencies, as requested and required by the agency or agencies.

(E) Health Care Supervisor.
(1) Qualifications. The health care supervisor must be licensed as a registered nurse in the Commonwealth of Massachusetts with at least one year of relevant experience.
(2) Responsibilities. The health care supervisor is responsible for overseeing the indirect and direct nursing care, as defined in 244 CMR 4.00: *Advanced Practice Registered Nursing*, provided to members receiving DH from the DH provider and must
(a) supervise or provide direct care and training in relevant areas;
(b) coordinate medical services with each member's PCP or medical clinic;
(c) oversee all health care services provided to the member while at the program;
(d) complete nursing assessments;
(e) participate on all interdisciplinary teams;
(f) obtain reports and approval of medical care plans from PCPs;
(g) ensure that nurse progress notes are recorded monthly;
(h) ensure that the members' DHSP are documented accordingly;
(i) advise the program director and other DH provider staff of any medical problems that may hinder a member's participation in DH or in a specific activity; and
(j) supervise any other nursing staff.

(F) Developmental Specialist.
(1) Qualifications. Each developmental specialist must have a high school diploma or GED.
(2) Responsibilities. Each developmental specialist must
(a) participate in member interdisciplinary team reviews;
(b) ensure member training programs are implemented according to their DHSP; and
(c) provide assistance with activities of daily living.

(G) Day Habilitation Service Manager (DHSM). Each member must be assigned a DHSM. The DHSM can be the program director or developmental specialist or other personnel that meet the qualifications set forth in 130 CMR 419.421(G)(1).
(1) Qualifications. The DHSM must have experience with case managing and case reviews in a relevant health care setting.
(2) Responsibilities include
(a) supervising the implementation of the DHSP;
(b) reviewing members' DHSP;
(c) ensuring plan updates are made to the DHSP;
(d) participating in interdisciplinary team meetings; and
(e) maintaining member records.

(H) Other Licensed Nursing Staff.

(1) Qualifications. Other licensed nursing staff must be licensed in the Commonwealth of Massachusetts as either a practical nurse or registered nurse and have a minimum of at least one year of relevant work experience.

(2) Responsibilities. Under the direction of the health-care supervisor, other licensed nursing staff must

(a) provide direct care and training in relevant areas;

(b) coordinate medical services with each member's PCP or medical clinic;

(c) complete nursing assessments;

(d) obtain reports and approval of medical care plans from PCPs;

(e) complete all nursing documentation and monthly nursing notes; and

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(f) advise the program director and other DH staff of any medical problems that may hinder a member's participation in DH or in a specific activity.

(I) Other Direct Care Staff (Paraprofessionals).

(1) Qualifications. Have a minimum of at least one year of relevant work experience in a health care setting.

(2) Responsibilities include

(a) assisting with Activities of Daily Living;

(b) assisting with implementation member individual programs; and

(c) providing input for interdisciplinary team reviews.

(J) Behavioral Professionals.

(1) Qualifications.

(a) Behavioral Specialist. The behavioral specialist must have one year of relevant work experience in developing behavioral programming for individuals.

(b) Psychologist. The psychologist must be currently licensed by the Massachusetts Board of Registration of Psychologists, or have at least a master's degree in clinical psychology and at least three years of full-time, supervised, postgraduate experience.

(c) Behavioral Aide. A behavioral aide must have at least one year of experience with data collection and with implementing behavioral programming.

(2) Responsibilities.

(a) Behavioral Specialists. A behavioral specialist must

1. assess each individual's behavioral and affective development need areas, except for those individuals with no documented history of behaviors or who, at the time of assessment are not exhibiting behaviors noted in their history; and

2. make recommendations, based upon assessment, on the behavioral programming and habilitation services necessary to meet the members identified needs.

(b) Psychologist. If the DH provider includes psychological testing, a psychologist must perform such testing.

(c) Behavioral Aides. A behavioral aide must assist with assessment and implementation of behavioral programming to address identified need areas.

(K) Therapists.

(1) Physical Therapist.

(a) Qualifications.

1. A physical therapist must be licensed by the Massachusetts Board of Registration in Allied Health Professions and have one year of relevant work experience in a training program.

2. Any additional physical therapy personnel must be licensed by the Massachusetts Board of Registration in Allied Health Professions or must be graduates of an approved physical-therapy-assistant program and be licensed by the Massachusetts Board of Registration in Allied Health Professions. A physical therapy assistant must work under the direct supervision of the licensed physical therapist.

(b) Responsibilities of the physical therapist include

1. assessing each individual's therapy and developmental skill need areas; and

2. recommending, based upon the assessments, the DH necessary to meet the member's identified areas of need.

(2) Occupational Therapist.

(a) Qualifications.

1. Occupational therapists must be licensed by the Massachusetts Board of Registration in Allied Health Professions, and have one year of relevant work experience.
2. Any additional occupational therapy personnel must be licensed by the Massachusetts Board of Registration in Allied Health Professions or must be graduates of an approved occupational therapy assistant program and be licensed by the Massachusetts Board of Registration in Allied Health professions. An occupational therapy assistant must work under the direct supervision of the licensed occupational therapist.

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(b) Responsibilities of the occupational therapist include
1. assessing each member's therapy and developmental skill need areas; and
2. recommending, based upon the assessments, the DH necessary to meet the member's identified areas of need.

(3) Speech and Language Pathologist.
(a) Qualifications.
1. Speech and language pathologists must be licensed by the Massachusetts Board of Registration in Speech-language Pathology and Audiology and have either a Certificate of Clinical Competence (CCC) from the American Speech, Language, and Hearing Association (ASLHA) or a statement from ASLHA of certification equivalency.
2. Any additional speech and language pathology personnel must work under the direct supervision of the licensed pathologist as a speech therapy assistant (STA). STAs must be enrolled in a professional training program or must have obtained at least a bachelor's degree in speech pathology and audiology.
(b) Responsibilities of the speech and language pathologist include
1. assessing each member's communication needs; and
2. recommending, based upon the assessments, the DH necessary to meet the member's identified areas of need.

(L) DH Staff Training Requirements. The DH provider must provide initial and annual training to all staff members who are responsible for the care of a member. Records of completed training must be kept on file and updated regularly by the DH provider. The initial training must be completed for new staff within three months of hire and must include, but is not limited to, the following topics:
(1) delivery of DH by the DH provider;
(2) DH provider written policies and procedures;
(3) DH provider staff roles and responsibilities;
(4) caring for people with ID/DD, behavioral health issues, including positive behavioral supports (PBS), behavior acceptance, and accommodations;
(5) observation, reporting, and documentation of the member's status;
(6) emergency procedures
(7) universal precautions and infection control practices;
(8) advance directives;
(9) prevention of, and reporting of, abuse, neglect, mistreatment and misappropriation/ financial exploitation;
(10) techniques of providing safe personal care assistance: good body mechanics;
(11) human rights, non-discrimination and cultural sensitivity;
(12) recognizing, responding to, and reporting change in condition, emergencies, and knowledge of emergency procedures, including the DH provider's fire, safety, and disaster plans.
(13) the requirements of 130 CMR 419.000;
(14) information about local health, fire, safety, and building codes;
(15) privacy and confidentiality;
(16) interdisciplinary professional team approach;
(17) communication and interpersonal skills;
(18) completing and filing critical incident reports; and
(19) recognizing the physical, emotional, and developmental needs of the individuals in their care and working in a manner that respects them, their privacy, and their property.

419.430: Emergency Services and Plans

The DH provider must establish plans, policies, and procedures for medical and other emergencies developed with the assistance of local and state fire and safety experts, and posted in offices of staff and conspicuous locations throughout each DH provider site. These plans and procedures must include, at a minimum, the following:

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(A) Written emergency policies and procedures that must include

(1) an emergency evacuation plan that is in compliance with and coordinated with local fire department requirements and that must, at a minimum, require quarterly fire and evacuation drills for all staff members, and which must be documented in accordance with 130 CMR 419.416(B);

(2) a procedure to be followed if participant is missing or lost;

(3) procedures for handling medical emergencies at each DH provider site;

(4) persons and entities to be notified in case of an emergency;

(5) locations of alarm signals and fire extinguishers; and

(6) staff training in emergency procedures including, but not limited to, assignment of specific tasks and responsibilities to the personnel and documentation of such training.

(B) Written procedure for emergency transportation to an acute care hospital must be in accordance with the following requirements.

(1) In the event of a medical emergency, a DH provider must call the emergency access number 911 and arrange for the transport of a member to an acute care hospital for emergency medical care.

(2) The DH provider must provide all pertinent health information to the emergency medical technician(s) and to any hospital to which any member is transported, including the member's Comfort Care/Do Not Resuscitate Verification Form, Massachusetts Medical Orders for Life-sustaining Treatment (MOLST) Form, or other advance directive on file with the DH provider, as applicable.

(3) The DH provider must contact the member's PCP, authorized representative, and, if applicable, DDS service coordinator at the time of the emergency or immediately thereafter to advise of the emergency and all actions taken in response to the emergency.

(4) The DH provider must, immediately after such medical emergency, document in the member's clinical record the following:

(a) the nature of the emergency and actions taken in response to the emergency;

(b) the reason for the member's emergency transport to an acute care hospital, if applicable; and

(c) the name of the member's authorized representative who was notified of the medical emergency and the date and time the member's authorized representative was notified.

(C) A written Continuity of Operations Plan (COOP) in accordance with the resources available from the Massachusetts Department of Public Health's Office of Preparedness and Emergency Management;

(D) An emergency fact sheet on each member, updated biannually, that contains the following information:

(1) the name and telephone number of the member's PCP;

(2) the member's diagnosis;

(3) any special treatments or medications the member may need;

(4) the member's allergies;

(5) insurance information; and

(6) the name and telephone number of the identified contact person, the authorized representative to be notified in case of emergency and, if applicable, DDS service coordinator.

(E) A written policy on staffing that includes at least two staff members certified in first aid and

cardiopulmonary resuscitation (CPR) be on duty at all times. The provider must maintain a current record of training and recertification of staff and post the names of certified individuals in a conspicuous location.

419.431: Noncoverage

The following are considered non-covered days and are ineligible for payment under 101 CMR 419.431:

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(A) Any portion of a day during which the member is absent from the DH program, unless the provider documents that the member was receiving services from the DH provider's staff in a community setting.

(B) Day Habilitation provided to a member when the member's needs can no longer be met by the DH as determined by the PCP and the professional interdisciplinary team in consultation, or by a qualified representative of the MassHealth agency, DDS, or DPH.

(C) Days or any portion of a day on which the following services are provided:
(1) vocational- and prevocational-training services, which include vocational-skills assessment, career counseling, job training, and job placement;
(2) work-related services, which provide participants with work skills and supervised employment for the production of saleable goods;
(3) educational services, which involve traditional classroom instruction of academic subjects, tutoring, and academic counseling; and
(4) social, vocational, and recreational services.

(D) Day Habilitation when provided to members residing in ICF/ID;

(E) Day Habilitation when provided to a member 21 years of age or older who is receiving hospice services;

(F) Day Habilitation when provided more than five days per week and six hours per day per member;

(G) Day Habilitation when provided at a site that has not been approved by the MassHealth agency or its designee or does not have a current approval on file;

(H) Day Habilitation when provided on or after the effective date of the discharge plan; and

(I) Claims billed above the census on file as approved by the MassHealth agency or its designee.

419.432: Physical Site

(A) Physical Site. The MassHealth agency or its designee approves each day habilitation site and census. A DH provider must provide DH at a site that meets all of the requirements in 130 CMR 419.432(A)(1) through (14). In the event of a site change, renovation, new construction, or change in census, the DH provider must forward a copy of all plans to the MassHealth agency or its designee for approval.
(1) The site must be designed with adequate space for the provision of all DH, with a minimum of 50 square feet of programming space per participant. This minimum does not include offices (except nurses' offices if used for member treatment), hallways, storage areas, reception areas, and other areas not used for the provision of DH. For sites with kitchens used for activities other than meal preparation, 100% of the kitchen floor area is counted as part of the participant space requirement.
(2) When located in a building or facility housing other services, the DH provider must provide DH solely within the space allocated for day habilitation.
(3) Within one year of September 7, 2018, the DH provider site must be in a location that

complies with the Americans with Disabilities Act (ADA) and ADA Standards for Accessible Design that include but are not limited to:

(a) The site is on-ground level with at least two means of egress;
(b) The site is free of architectural barriers;
(c) The site is designed to meet the needs of people with disabilities; and
(d) The site is in compliance with local health, fire, and safety codes.

(4) For sites approved on or after September 7, 2018, that occupy multi-level space, the site must have at a minimum one elevator for egress, and evacuation plans must include specific procedures for evacuation of those in wheelchairs and comply with local and state evacuation requirements.

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(5) The site must include adequate outdoor space for members to safely arrive at and depart from the DH provider site.
(6) DH providers must provide a protected and secure environment for members, including members who wander or require increased supervision and security.
(7) The site must include sufficient parking capacity to satisfy the needs of members, staff, and the public.
(8) The site must include a clean and sanitary food preparation area equipped with a refrigerator, a sink, adequate counter space, and adequate storage space.
(9) Adequate artificial lighting must be available in all rooms, stairways, hallways, corridors, bathrooms, and offices.
(10) A DH provider site serving five or more unrelated participants must comply with 780 CMR 3.00: *Use and Occupancy Classification* (State Building Code).
(11) The MassHealth agency must approve each DH site. In the event of a site change, renovation, or new construction, the provider must forward a copy of all plans to the MassHealth agency for approval. Upon completion of renovations, moves, or new construction, the MassHealth agency or its designee must view the site to determine compliance with the requirements.
(12) The kitchen and bathrooms must be designed and equipped for teaching ADL skills to all participants.
(13) In at least one participant area, the site must have a fire extinguisher and a first aid kit, easily accessible to staff.
(14) The site must meet the requirements of all state and local building, sanitary, health, fire, and zoning codes, and all other requirements pertaining to health, safety, and sanitation.
(15) The participants must have access to hand sanitizer dispensers and to at least one handwashing station. Hand sanitizer dispensers and hand washing stations must be conveniently placed and accessible to staff. Hand sanitizer dispensers and handwashing stations must be placed with consideration for participant safety and accessibility.
(16) Participants must have access to natural light and outside views.
(17) Participants must have adequate lighting, heating, and ventilation so that participants are comfortable in all seasons of the year.

419.433: Day Habilitation for MassHealth Members with ID/DD Residing in NFs

For purposes of providing DH to MassHealth members with ID or DD residing in NFs, DH providers must comply with all of the requirements outlined in 130 CMR 419.433 as well as coordinate and communicate with the member, the DDS service coordinator, if applicable, and the NF, actively participate in the development of the RISP, and attend the NF plan of care meetings to ensure that the DHSP complements and reinforces the service plans referenced in the member's RISP.

(A) Admission Criteria. In addition to the criteria outlined in 130 CMR 419.406, a MassHealth member with ID or DDs residing in a NF may receive DH designed to improve the member's level of independent functioning.

(B) Service Needs Assessment (SNA). In addition to the requirements outlined in 130 CMR 419.417, the SNA for a MassHealth member with ID or DD residing in a NF who receives DH must:
(1) be completed by a qualified professional who must possess a master's degree in a human-services-related field or other professional license in a human or health services field;

(2) include any and all applicable therapy or nursing assessments completed by the NF. In *lieu* of utilizing assessments completed by the NF, the provider may complete specialized assessments that take into consideration the member's disabilities;
(3) assess all specialized service need areas to determine if specialized services are needed and if so what day habilitation services are appropriate to meet those needs; and
(4) be completed upon a significant change involving a change in the member's Level II PASRR or as the member's RISP dictates.

419.433: continued

(C) Day Habilitation Service Plan.

(1) The comprehensive DHSP must meet all of the requirements set forth in 130 CMR 419.416 and must

(a) be completed and forwarded to the DDS service coordinator if applicable, together with the SNA, within 90 days of the referral for specialized services;

(b) be completed in conjunction with the DDS service coordinator as applicable, and the NF;

(c) provide DH that is adequate in frequency and intensity to lead to progress; and

(d) ensure, in conjunction with the NF, that the DHSP interventions complement and reinforce the RISP.

(2) DH contained in the DHSP must be available and offered to the member.

(3) To ensure progress toward goals and objectives and to identify significant changes, the DHSP should be evaluated on the following schedule:

(a) Monthly Reviews. In addition to the requirements outlined in 130 CMR 419.417(C), the DHSM must notify the member's DDS service coordinator where applicable, within seven business days, if the monthly review demonstrates a significant change in the member's condition that may affect the Level II PASRR determinations.

(b) Quarterly Reviews. The quarterly review must:

1. include a reevaluation of continued need for in-facility DH; and

2. conduct quarterly reviews with the DDS service coordinator where applicable, in conjunction with the NF quarterly plan of care meeting, when applicable.

(D) Communication and Coordination Requirements. For each NF resident with ID or DD that receives DH, the DH provider staff must

(1) meet with the NF at least twice each year, in addition to the annual plan of care meeting, to coordinate the development and update of the DHSP;

(2) provide copies of the interim DHSP to the members of the RISP interdisciplinary team at least three days prior to the initial RISP meeting;

(3) submit the final DHSP, and any changes to the plan, for approval by the RISP interdisciplinary team;

(4) incorporate any changes recommended by the RISP interdisciplinary team into the final DHSP within 45 days of the initial RISP meeting;

(5) determine what other care plans have been, or are in the process of being, developed by other providers or agencies in an effort to avoid duplication;

(6) ensure that the goals and objectives of the DHSP are consistent with those in the other plans, and forward a copy to the DDS area office, and the NF; and

(7) immediately notify the DDS service coordinator, where applicable, in the event of a disruption of DH.

(E) Ongoing Documentation and Recordkeeping Requirements.

(1) Day Habilitation Providers. In addition to the requirements outlined at 130 CMR 419.416, DH providers must develop and maintain records that document the DH provided to members with ID or DD residing in a NF. Such documentation must include:

(a) the date the member was referred for specialized services in a day habilitation setting; and

(b) documentation that the RISP interdisciplinary team has approved the final DHSP and any subsequent plan revisions.

(2) Nursing Facilities. The DH provider must:

(a) provide to the NF copies of the DHSP and any revisions to it, the SNA, and quarterly

progress notes;

(b) attend the annual NF Plan of Care meeting at the nursing facility to coordinate the development of the two plans; and

(c) accommodate requests from NFs regarding carry-over of the strategies employed in the provision of DH to a member.

(3) DDS Service Coordinators. DH providers must communicate with DDS service coordinators as follows:

(a) contact the DDS service coordinator for instruction in the event that the DH provider determines that it is not appropriate to provide DH to a member in the specialized services need areas;

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(b) communicate with the DDS service coordinator concerning all issues related to DH, including notification of any changes in the DHSP goals, objectives and/or strategies; and

(c) forward a copy of the DHSP and quarterly reviews to the DDS service coordinator for inclusion in the RISP at the NF.

(F) Provision of Day Habilitation in an NF (In-facility). DH may be provided in the NF to a member with ID or DD when

(1) the member is so medically fragile that transport to a DH provider site outside of the NF presents a significant risk to the health and safety of the resident;

(2) the member has declined to receive DH at the DH provider's community site; or

(3) as determined by the RISP interdisciplinary team, DH is the only service that is available to meet the member's specialized services needs.

419.434: Withdrawal of a Day Habilitation Provider from MassHealth

A DH provider that intends to withdraw from MassHealth must satisfy all of the following obligations.

(A) MassHealth Notification.

(1) A DH provider electing to withdraw from participation in MassHealth must send written notice to the MassHealth agency or its designee, and DDS, of the provider's intention to withdraw from participating as a MassHealth DH provider. The DH provider must send the withdrawal notice by certified or registered mail, return receipt requested, to the MassHealth agency or its designee, no fewer than 90 days before the effective date of withdrawal.

(2) The DH provider must forward to the MassHealth agency or its designee a list of all members currently receiving DH. The DH provider must notify the MassHealth agency 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 each member's start date in the new program or service.

(B) Notification to Member and Authorized Representatives.

(1) The DH 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.

(2) On the same date on which the DH provider sends a withdrawal notice to the MassHealth agency or its designee, the provider must give notice, in hand, to all members to whom it is providing DH along with notice to the members' authorized representatives, including for those members who have been transferred to hospitals, or who are on medical or nonmedical leave of absence. The notice must advise that any member who is eligible for MassHealth on the effective date of the withdrawal must relocate to another DH 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 DH provider will work promptly and diligently to arrange for the relocation of members to MassHealth-participating DH providers or, if appropriate, to alternative community-service providers.

(C) Emergency Withdrawal. In the instance of alleged emergency withdrawal, the DH 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 the MassHealth agency, 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. The DH provider must also notify all members, member representatives, the MassHealth agency, and DDS coordinator, if applicable, about the status of all members and any plans for relocation.

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(D) Admission and Relocation Requirements.

(1) A DH provider must not admit any new MassHealth members after the date on which the withdrawal notice was sent to the MassHealth agency or its designee. Members receiving DH from the DH provider, for whom prior authorization was sought prior to the withdrawal notice being sent, who are then authorized for DH after the notice of withdrawal, are not considered newly admitted members.

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

(3) A DH provider seeking to withdraw from the MassHealth program shall work promptly and diligently to arrange for the relocation of members to MassHealth participating DH provider or other qualified MassHealth providers.

REGULATORY AUTHORITY

130 CMR 419.000: M.G.L. c. 118E, §§ 7 and 12.