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651 CMR 3.00: HOME CARE PROGRAM

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3.01: Purpose and Scope

The purpose of 651 CMR 3.00 is to set forth policies for the operation, through available resources, of the Home Care Program. The purpose of the Home Care Program is to assist elders in the Commonwealth of Massachusetts to secure and maintain maximum independence in their home environment. 651 CMR 3.00 sets forth the functions and responsibilities of the Executive Office of Elder Affairs, and providers of Home Care Program Services under agreement with or using funds provided by the Executive Office of Elder Affairs. The state Home Care Program is funded with state monies appropriated by the Legislature.

- (1) Legislative and Administrative Authority. The legislative and administrative authorizations for 651 CMR 3.00 are as follows:
 - (a) M.G.L. c. 19A, § 4 providing that the Executive Office of Elder Affairs "shall be the principal agency of the Commonwealth to mobilize the human, physical, and financial resources available to plan, develop, and implement innovative programs to insure the dignity and independence of Elders, including the planning, development, and implementation of a Home Care Program for the elderly in the communities of the Commonwealth".
 - (b) M.G.L. c. 19A, § 6. The general authority and responsibility of Elder Affairs to promulgate regulations for the conduct of the business of the agency.
- (2) The Definitions set forth in 651 CMR 14.00 and as used in 651 CMR 3.00 shall have the stated meaning, unless the context requires otherwise.

Activities of Daily Living (ADLs) - Tasks, including the ability to bathe, dress/undress, eat, toilet, transfer in and out of bed or chair, get around inside the home, and manage incontinence, which are used to measure the Functional Impairment Level of an Applicant or Client.

ASAPs - Aging Services Access Points as authorized in M.G.L. c 19A, § 4B and defined in 651 CMR 14.01.

Applicant - An individual who has applied for Home Care Program services by entering into an intake process by telephone, mail or in person as documented by the ASAP.

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Assisted Living Residence - An entity certified by Elder Affairs under 651 CMR 12.03 defined in 651 CMR 12.02 which provides room, board, and personal care services to residents.

At Risk - Elders who are experiencing substance abuse, mental health problems or cultural or linguistic barriers to care.

Caregiver - A family member regardless of place of residence, or a non-family member living in the same residence as a Client receiving Respite Services, who is 18 years of age or older and who is providing

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Daily Care to the Client without receiving payment for providing such care.

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Certified Home Health Agency - An agency certified by the Department of Public Health that has met the Medicaid and Medicare Conditions of Participation.

Client - An individual who is eligible for and receiving Home Care Program Services.

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Client Record - One record maintained by the ASAP for a Client which contains all required documentation in compliance with Elder Affairs' Documentation Standards.

Congregate Housing - A joint program between Elder Affairs and the Department of Housing and Community Development that offers a shared living environment and integrates housing and support services.

Congregate Meals - A nutrition program for elders where meals are provided at a congregate meal site such as a church, senior center, or other community center.

Copayment - A monthly dollar amount billed to a Client for Home Care Program services based on the Client's income as set forth in 651 CMR 3.00: *Home Care Program*.

Critical Unmet Needs - A Client's Unmet Needs which include one or more of the following: any Activity of Daily Living (ADL), meal preparation, food shopping, transportation for medical treatments, Respite Care, and Home Health Services.

Daily Care - Assistance with Activities of Daily Living and Instrumental Activities of Daily Living, supervision, and social and emotional support as required by the Client for part of each day.

Division of Medical Assistance (DMA) - The Division of Medical Assistance of the Massachusetts Executive Office of Health and Human Services is a governmental agency responsible for the administration of the Title XIX (Medicaid) Program.

Documentation Standards - Standards issued by Elder Affairs regarding the documentation procedures for gathering and maintaining client information.

Elder at Risk Program (EAR) - The EAR Program provides services to persons age 60 and older who, because of mental or physical impairments, substance abuse, or language or cultural barriers, are unable to meet essential needs and can no longer remain safely in the community without assistance.

Elder Affairs - The Executive Office of Elder Affairs of the Commonwealth of Massachusetts.

Enhanced Community Options Program (ECOP) - A program administered by ASAPs for frail elders who are clinically eligible for Nursing Facility services under MassHealth and meet certain criteria set forth by Elder Affairs. ECOP provides a broad range of community services for these elders to remain in the community that includes services available under the Home Care Program.

Family - An adult and his or her spouse.

Functional Impairment Level (FIL) - The degree of functional impairment experienced by an Applicant or Client determined by an inability to complete Activities of Daily Living and Instrumental Activities of Daily Living. Each FIL is defined by the number of tasks an individual is unable to perform.

Home and Community-Based Waiver (Waiver) - A waiver of federal requirements granted to the Commonwealth, by the U.S. Department of Health and Human Services under 42 U.S.C.#1396n(d),

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which allows DMA to pay for home and community-based services for MassHealth members who meet MassHealth criteria for Nursing Facility services but reside in the community.

Home Care Program Services - Home Care Program Services include:

- (a) Adaptive Housing - Home adaptations, modifications or adaptive equipment for Clients who require these adaptations in order to remain independent or to improve independence in the community.

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- (b) Adult Day Health (ADH) - Services provided by an Adult Day Health program approved for operation by the Division of Medical Assistance and operating in accordance with 130 CMR 404.000 *et seq.* ADH services provide health care, supervision, restorative services, and socialization.
- (c) Chore - Services to help Clients maintain their homes and/or to correct or prevent environmental defects that are hazardous to a Client's health and safety. Light chores include vacuuming, dusting, dry mopping, cleaning bathrooms and kitchens. Heavy chores include washing floors and walls, defrosting freezers, cleaning ovens, cleaning attics and basements to remove fire and health hazards, woodcutting, changing storm windows, heavy yardwork and snow shoveling.
- (d) Companion - Services include: socialization; help with shopping and errands; escort to doctor's appointments, to nutrition sites, walks; recreational activities such as playing cards; and assistance with the preparation and serving of light snacks.
- (e) Dementia Day Care - Services provided by a Dementia Day Care Program operating in accordance with Dementia Day Care Standards issued by Elder Affairs. Dementia Day Care provides a structured, secure environment for individuals with cognitive disabilities to maximize the individual's functional capacity, reduce agitation, disruptive behavior, and the need for psychoactive medication, and to enhance cognitive functioning.
- (f) Emergency Shelter - Services designed to provide temporary (for no more than 14 calendar days in a six month period) overnight shelter for a Client, or a Client and the Client's household who are without a home.
- (g) Grocery Shopping/Delivery Services - Includes obtaining grocery order(s), grocery shopping, grocery delivery and assistance as needed with storage and packaging; and may include nutritional information and education.
- (h) Home-delivered Meals - The provision of well balanced meals which meet Elder Affairs' Nutrition Standards and the Client's dietary needs, delivered to Clients who are unable to prepare nutritionally adequate meals or attend a congregate meal site.
- (i) Home Health Services - Those services defined in DMA regulations in 130 CMR 403.000 which include Skilled Nursing Care; Physical, Occupational, and Speech Therapy; and Home Health Aide.
- (j) Home Health Aide - Services provided to Clients under the supervision of a registered nurse, or a speech, occupational, or physical therapist. This includes personal care; simple dressing changes that do not require the skills of a registered nurse; assistance with medications that are ordinarily self-administered and that do not require the skills of a registered or licensed nurse; activities that support the skilled therapies; and routine care of prosthetic and orthotic devices. These services comply with the definitions included in Division of Medical Assistance regulations in 130 CMR 403.000, *et seq.*
- (k) Homemaker - Services to assist a client with Activities of Daily Living and Instrumental Activities of Daily Living which includes shopping, menu planning, meal preparation including special diets, laundry, and light housekeeping. These Services comply with the Homemaker Standards issued by Elder Affairs.
- (l) Laundry - Cleaning services provided by a laundry company.
- m Nutritional Assessment - A comprehensive nutritional assessment conducted by a qualified nutritionist. A nutritional plan of care is developed based on the results of the assessment.
- (n) On-Call - The provision of an on-call capacity to respond to client needs either during or after regular business hours.

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- (o) Personal Care - Activities include: bathing, dressing, and grooming (hair shampoo and combing); foot care (excluding nail cutting); assistance with dentures; shaving (limited to shaving with an electric razor); assisting with bedpan routines; assisting with eating; assisting with ambulating; and assisting with transfers (excluding transfers if the Client is totally dependent). These services comply with the Personal Care Guidelines issued by Elder Affairs.
- (p) Personal Emergency Response System - A medical communications alerting system that allows a Client experiencing a medical emergency at home to activate electronic components which transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station is staffed 24 hours a day, seven days a week by trained attendants who receive and

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process the emergency call and ensure the timely notification needed to dispatch appropriate individuals and/or emergency services to the person in need.

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- (q) Social Day Care Services - Individualized programs of social activity provided to Clients who require daytime supervision at sites other than their homes. Activities include: assistance with walking, grooming, and eating; provision of one meal and two snacks per day; planned recreational and social activities suited to the needs of the participants and designed to encourage physical and mental exercise and stimulate social interaction.
- (r) Supportive Home Care Aide - Services provided to clients with emotional or behavioral problems to assist with Activities of Daily Living and Instrumental Activities of Daily Living. These services include Personal Care (as defined in the Personal Care Guidelines issued by Elder Affairs), shopping, menu planning, meal preparation including special diets, laundry, light housekeeping, escort, and socialization/emotional support. These Services comply with the Supportive Home Care Aide Standards issued by Elder Affairs.
- (s) Translation Services - Translation/interpreting provided to clients in need of such assistance in order to receive services.
- (t) Transportation - Provision of transportation to and from community facilities or services.
- (u) Additional Services - The Secretary may issue Program Instructions to define and approve additional Home Care Program Services available to Clients to secure and maintain maximum independence.

Home Care Management Information System (HOMIS) - The management information system established by Elder Affairs and used by ASAPs to maintain Client demographic and assessment data, service authorization and utilization data and to manage ASAP expenditures.

Information and Referral Services - Activities related to the maintenance of current information with respect to services available to Clients, assessments of the type of assistance needed by an elder requesting information, referral to appropriate services, and follow-up to determine if needed services were received. Information and Referral services may be conducted by mail, by telephone, electronically, or in person.

Instrumental Activities of Daily Living (IADLs) - Those basic environmental tasks, including the ability to prepare meals, do housework, do laundry, go shopping, take medicine, get around outside, use transportation, manage money, and use the telephone, which are used to measure the Functional Impairment Level of an Applicant or Client.

Interdisciplinary Case Management - A client centered approach to assessment, service acquisition, reassessment, and monitoring of services provided to assist elders to live independently in the community. It includes working cooperatively, coordinating service plans and maintaining ongoing communication with the elder, family members, informal supports and formal supports, as necessary. It is provided by registered nurses and case managers working in consultation with physicians, nurses and therapists from home health agencies, hospice providers, nutritionists, housing managers, mental health professionals, and other home and health care professionals. These services comply with the Interdisciplinary Case Management Standards issued by Elder Affairs.

LTC Assessment - The Long Term Care Assessment procedure specified by Elder Affairs to determine eligibility for Home Care Program Services, Community-Based Long Term Care Services and Nursing Facility Services.

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LTC Assessment Tool - An instrument designated by Elder Affairs used to conduct a LTC Assessment.

MassHealth - The Medical Assistance Program administered by the Division of Medical Assistance pursuant to M.G.L. c. 118E and Title XIX of the Social Security Act. MassHealth is the name the Commonwealth uses for the Medicaid Program.

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MassHealth Member - An individual who has been determined eligible to receive benefits under the Medical Assistance Program (MassHealth).

Medicaid - See MassHealth.

Non-Critical Unmet Needs - Unmet Needs which include one or more of the following: laundry, housework, shopping other than food shopping, transportation other than transportation for medical treatment and socialization.

Nursing Facility - A facility that is licensed to provide skilled nursing care to residents which meets the provider eligibility and certification requirements as specified in Division of Medical Assistance regulations, 130 CMR 456.000 *et seq.*.

Peer Review - A process by which ASAPs convene in groups to review Client Records for the purpose of providing feedback to one another regarding how cases were handled and to ensure a more consistent approach among providers. The Peer Review process must be implemented according to the Peer Review Program Instructions issued by Elder Affairs.

Program Instruction - A document issued by Elder Affairs that sets forth required procedures and protocols.

Protective Services - Services provided by an Elder Protective Services Program in accordance with M.G.L. c. 19A, §§ 14 through 26 and regulations at 651 CMR 5.00, which are necessary to prevent, eliminate or remedy the effects of abuse to an elder.

Respite Care - The provision of one or more Home Care Program services to temporarily relieve the caregiver of a Client in emergencies, or in planned circumstances, to relieve the caregiver of the daily stresses and demands of caring for a Client in efforts to strengthen or support the Client's informal support system. In addition to services available under the Home Care Program, Respite Care services may include short term placements in Adult Foster Care, Nursing Facilities, Rest Homes, or Hospitals.

Service Plan - A plan of care that delineates all services from all funding sources to be provided to a Client, developed in conjunction with the Client and/or the Client's designated representative.

Service Priority Matrix - The method used to prioritize Applicants to the Home Care Program which is based on an assessment of Critical Unmet Needs and Non-critical Unmet Needs.

Subcontract - A contract between the ASAP and an organization to provide one or more Home Care Program Services. The subcontracting organization shall not deliver any services to a Client without the authorization of the ASAP.

Suspension - The temporary cessation of Home Care Program services as a result of the Client's unavailability to receive such services for a time period not to exceed 90 calendar days. At the time of suspension, there must be an expectation that services will be resumed on or before the end of 90 calendar days.

Termination - The termination of all Home Care Program Services which results in the closing of a case.

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Transitional Assistance – The provision of services to assist elders in returning to a community setting following discharge from a nursing facility, which may include financial assistance for security deposits, essential furnishings, cooking supplies, moving expenses, and setup fees and deposits for utility services, telephone, etc. Services may also be provided to correct safety or code violations, architectural barriers; or to address health and safety issues related to the home environment.

Uniform Intake - The intake policy and procedures for eligibility for Home Care Program Services as established by Elder Affairs. The Uniform Intake Policy is subject to change by Elder Affairs and the eligibility of an individual under such policy is subject to appropriation of state funds to Elder Affairs.

Unmet Need(s) - The Applicant or Client's identified care needs which are not being met by other sources available to the Client or Applicant as determined by the LTC Assessment.

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Vendor - An entity which has entered into a contract with an ASAP to provide one or more Home Care Program Services.

Voluntary Copayment - A dollar amount which may be donated by a Client whose annual gross income falls at or below the annual gross income levels set forth in 651 CMR 3.03(3)(e)3.

3.02: Functions and Responsibilities of the Executive Office of Elder Affairs in the Administration of the Home Care Program

(1) As the principal agency of the Commonwealth charged with the responsibility to mobilize the human, physical, and financial resources available to plan, develop and implement programs to insure the dignity and independence of Elders in the Commonwealth, Elder Affairs shall carry out the functions and responsibilities related to the Home Care Program as prescribed under these specified authorities within the Commonwealth. Elder Affairs shall be responsible for carrying out ongoing planning, coordination, administration, monitoring, and evaluation activities necessary to implement the Home Care Program in the Commonwealth and will provide for an ongoing program of technical assistance to agencies performing home care functions in the implementation of the Home Care Program.

(2) General Functions and Responsibilities.

- (a) Enter into a Purchase Agreement with the ASAPs which sets forth the conditions under which the ASAP will receive reimbursement from Elder Affairs for the provision of Home Care Program Services to eligible individuals;
- (b) Set forth policies and procedures relative to the appropriate coordination of funding for the Home Care Program;
- (c) Provide ongoing monitoring and evaluation of the operation of the Home Care Program by ASAPs;
- (d) Establish reporting procedures through which ASAPs shall apprise Elder Affairs of program information in order to assist Elder Affairs to effectively carry out its legislative and administrative functions and responsibilities;
- (e) Issue written policy instructions and other technical assistance information to assist ASAPs to effectively carry out their respective functions and responsibilities;
- (f) Establish written policies as to the award of contracts by the ASAP in accordance with applicable Federal and State laws; and
- (g) Perform other functions which relate to the proper and efficient administration of the Home Care Program in the State, including provision for training and manpower development and public information.

3.03: Home Care Program Eligibility Criteria, and Functions and Responsibilities of ASAPs in the Administration of the Home Care Program

ASAPs shall establish administrative procedures for carrying out the functions as required in 651 CMR 14.00 and 3.00.

(1) Application for the Home Care Program.

- (a) The ASAP shall afford any individual the opportunity to apply for the Home Care Program and shall inform each Applicant about the eligibility requirements and his or her rights and obligations under the program.

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- (b) Within three business days from the date of entering into the intake process, an initial assessment shall be conducted for purposes of determining eligibility and assessing the needs of the Applicant in accordance with 651 CMR 3.03(2), (3), (4), and (5). A determination of eligibility shall be made on all applications determined to be emergency cases as soon as possible.
- (c) If the individual is hospitalized or institutionalized, the initial assessment may be conducted prior to discharge. If the Applicant is unable or unwilling to have an initial assessment conducted within three days from the intake date, the ASAP shall make reasonable efforts to conduct the assessment within a reasonable time period.
- (d) An application for services shall be in writing on forms prescribed by Elder Affairs and in compliance with Documentation Standards. The Applicant or his or her

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authorized representative shall sign and date the application and shall certify that the information is correct.

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- (e) At the time of application, the Applicant shall be notified in writing of his/her right to appeal a decision by the ASAP in accordance with 651 CMR 3.03(9).
 - (f) Within ten business days of the initial assessment, the ASAP must determine the Applicant's eligibility for Home Care Program Services; provide a written notification to the Applicant regarding eligibility; and develop and initiate the appropriate service(s).
 - (g) Appropriate Home Care Program Services shall be provided to a Client who is determined to be eligible pursuant to the age and residency requirements set forth in 651 CMR 3.03(2), financial eligibility standards set forth in 651 CMR 3.03(3), the Functional Impairment Level standards as set forth in 651 CMR 3.03(4), and a determination of need for such services as set forth in 651 CMR 3.03(5).
 - (h) Notwithstanding the requirements for the application for and the provision of Home Care Program Services, if the ASAP determines that there is an immediate need for services, services may be implemented prior to the determination of eligibility if it is reasonable to expect the Applicant will be eligible for Home Care Program Services pursuant to 651 CMR 3.03(2), (3), (4), and (5).
- (2) Home Care Program Eligibility: Age and Residency.
- (a) Age. An individual must be age 60 or older. Individuals under the age of 60 with a physician's documented diagnosis of Alzheimer's Disease who meet the eligibility criteria set forth in 651 CMR 3.03(3), (4) and (5) are eligible to receive Respite Care Services.
 - (b) Residency. An individual must reside in Massachusetts. Home Care Program Services shall not be provided to individuals residing in the following settings: a hospital, clinic, or infirmary; a convalescent home, rest home, nursing facility or charitable home for the aged or other facility licensed under M.G.L. c. 111, § 71; state hospitals or facilities licensed under M.G.L. c. 19, § 7 and c. 19B, §§ 7 and 15; or Assisted Living Residences.
- (3) Home Care Program Eligibility: Financial and Cost Sharing.
- (a) An individual must meet the appropriate financial eligibility criteria set forth in non-regulatory guidelines published by Elder Affairs. These guidelines set forth the financial schedule based on gross annual income by family size for Home care program Voluntary Co-payments set forth in 651 CMR 3.03(3)(e)3, the financial schedule based on gross annual income by family size for Home Care Program Cost Sharing set forth in 651 CMR 3.03(3)(f)1, and the financial schedule based on gross annual income by family size for Over Income Co-payments for Respite care set forth in 651 CMR 3.03(3)(g). These guidelines are hereinafter referred to as the Financial Eligibility Guidelines.
- Effective January 1, 2002, the annual gross income by family size schedules of the Financial Eligibility Guidelines shall be increased to incorporate the percentage increase of the Cost of living (COLA) announced by the U.S. Bureau of Labor Statistics and adopted by the U.S. Social Security Administration for Social Security and Supplemental Security Income (SSI) effective each January 1st. Elder Affairs may, in its discretion, not more than once per year, on the first of a month and with at least 30 days advance public notice, amend the Financial Eligibility Guidelines to change the Home Care Program voluntary suggested co-payment schedule as set forth in 651 CMR 3.03(3)(e), and the Home Care Program co-payment schedule as set forth in 651 CMR 3.03(3)(f). Elder Affairs shall make the Financial Eligibility Guidelines available as a public record.
- (b) Information and Referral Services, Protective Services Casework as defined in 651 CMR 5.02 for Clients who are deemed to be abused in accordance with M.G.L. c. 19A, §§ 14 through 26 inclusive, and Emergency Shelter are provided without regard to income.

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- (c) Protective Services Clients and Elder at Risk clients in need of Home Care Program Services shall be subject to Financial Eligibility and Cost Sharing eligibility criteria for the Home Care Program. However, the ASAP may provide Home Care Program Services to these elders regardless of income and/or payment of a copayment if the ASAP determines that discussion of financial eligibility and/or payment of fees would have an adverse effect on the provision of Protective Services or Elder at Risk services. This determination shall be in compliance with procedures issued by Elder Affairs.
- (d) Annual Gross Income. For purposes of determining financial eligibility, annual gross income means the annual rate of income received by an individual or Family from the following sources:
1. Money wages or salary;
 2. Net income from self-employment;
 3. Social Security pensions and survivor's benefits;
 4. Disability insurance payments;
 5. Capital gains, taxable or tax free dividends, taxable or tax free interest income, income from estates or trusts, and royalties;
 6. Net rental income and net income from roomers and boarders (gross rental income, less expenses received from a person other than a spouse or child residing in the home);
 7. Public assistance and welfare payments;
 8. Pensions and annuities;
 9. Unemployment compensation and worker's compensation;
 10. Alimony and child support;
 11. Federal Veteran's pension;

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12. Railroad Retirement benefits;
13. Business income;
14. IRA distributions;
15. Lump sum payments;

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16. Other income; provided that reverse mortgage loan proceeds (pursuant to M.G.L. c. 19A, § 36), and war reparations income shall not be considered income.

Income from an Asset. Income from any asset jointly owned by two or more persons is presumed to be distributed in equal shares unless a different distribution of income is verified. If the Client or Applicant claims less than the proportional share,(s)he shall verify the amount owned with one or more of the following documents: title; purchase contract; documentation of ownership for joint bank accounts; certificate of ownership; financial institution records; other documentation that indicates ownership; or a notarized affidavit signed by all owners of the asset attesting to the distribution of ownership. When such a partial ownership is verified, the income shall be attributed to the Client or Applicant in proportion to the ownership interest.

Verification. The Applicant's/Client's signed declaration that the financial information provided is true, to the best of his/her knowledge and belief shall ordinarily constitute the basis for income verification. Such declaration shall include the amount of gross monthly income, the source(s) of such income and the type of income. The Applicant's or Client's statements will be sufficient to establish his/her eligibility, provided that the information is complete and consistent. If the ASAP determines that the declaration appears insufficient, supportive evidence shall be requested. If the Applicant/Client refuses to make a full declaration, or refuses to supply evidence needed, the application for the Home Care Program shall be denied. This denial shall be subject to the right to appeal.

- (e) Financial Eligibility and Voluntary Co-payments for Home Care Program Services. Individuals whose income falls into the categories defined below in 651 CMR 3.03(3)(e)1. through 651 CMR 3.03(3)(e)3., are asked to make a Voluntary Copayment for Home Care Program Services.

1. MassHealth Members who are age 60 or older;
2. Spouses, age 60 or above and residing together, of any individual referred to in 651 CMR 3.03(3)(e)1., except spouses of MassHealth Members under the Massachusetts Medical Assistance Program whose eligibility for Medical Assistance was determined under the so-called Spousal Waiver of the Home and Community Based Waiver. For purposes of financial eligibility for the Home Care Program, these spouses shall be considered to be a one-person family and the annual gross income shall be determined in accordance with 651 CMR 3.03(3)(e)3. or 651 CMR 3.03(3)(f)1.
3. Elders whose annual gross income does not exceed the amounts set forth in the Voluntary Copayment section of the Financial Eligibility Guidelines shall be requested to make a Voluntary Co-payment toward the cost of Home Care Program Services provided in accordance with the schedule set forth therein
4. An ASAP may not deny an individual who is eligible under 651 CMR 3.03(3)(e)1. through 3. for Home Care Program Services because he/she will not make a voluntary copayment;
5. ASAPs shall not accept voluntary co-payments in excess of the cost of the Client's services;
6. ASAPs shall maintain separate accounts for Voluntary Copayments collected under 651 CMR 3.03(3)(e) and Copayments collected under 651 CMR 3.03(3)(f) and (g) and shall report such collections in a manner determined by Elder Affairs.
7. Income of an Applicant or Client described in 651 CMR 3.03(2)(e)1. and 2. shall be verified by the ASAP through the Division of Medical Assistance verification system. The ASAP shall record the MassHealth number on the Client's financial application.
8. ASAPs shall not seek or accept from a Client receiving services pursuant to the Home and Community-Based Waiver a voluntary co-payment for Home Care Program Services, including without limitation Home Delivered Meals.

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- (f) Financial Eligibility and Cost Sharing for Home Care Program Services. Individuals who are not financially eligible pursuant to 651 CMR 3.03(3)(e), whose income

falls into the Home Care Services Co-payment schedule set forth in the Financial Eligibility Guidelines shall be assessed a co-payment for Home Care program Services based on the schedule set forth therein in effect on the date of his/her initial determination or re-determination of financial eligibility as defined in 651 CMR 3.03(3)(j).

- (g) Respite Care Co-payments. Respite Care Services may be provided under the Home Care Program to Caregivers in accordance with the Voluntary Copayment Schedule and Home Care Program Cost Sharing Schedule set forth in 651 CMR 3.03(3)(e)3. and 3.03(3)(f) and in accordance with the provisions set forth in 651 CMR 3.03(3)(e), (f) and (g). The annual gross income used to determine the Respite Copayment is based on the sum of the annual gross income of the Respite Client and his/her spouse.

If a Client is in need of and eligible for Respite Care, and is over the financial eligibility income categories set forth in 651 CMR 3.03(3)(e) and (f), the following Respite Care Copayment Schedule shall be used.

1. Over-income Cost Sharing for Respite Care. The monthly Co-payment for Respite Services for Over-income clients shall be determined by multiplying the cost of Respite Services by the applicable percentage listed in the Over Income Cost Sharing For Respite schedule set forth in the Financial Eligibility Guidelines in effect during his/her initial determination or re-determination of financial eligibility as defined in 651 CMR 3.03(3)(j).

- (h) Copayments for Home Delivered Meals.

1. Home Delivered Meals may be provided on a per meal copayment at a rate set at the same level as the suggested contribution of the Title III-C nutrition program within the area served by the ASAP, and shall not exceed the cost of the meal.
2. Copayments may be collected and retained by the Home Delivered Meals provider. Nutrition providers not subject to Title IIIC requirements shall not collect copayments.
3. Home Delivered Meals shall not be denied for failure to pay the Copayment for this service.

- (i) Billing of Copayments.

1. The ASAP shall provide a monthly bill for each Client for the Copayment as determined in 651 CMR 3.03(3)(f) or (g). The Copayment shall be due within 30 days of the date of the bill. The ASAP shall make all reasonable efforts to collect Copayments. ASAPs may undertake action to enforce payment of said Copayment up to and including termination of services.
2. If all or part of a Client's Copayment becomes two or more months overdue after the ASAP has made all reasonable efforts to collect the Copayment, the ASAP may send a Notice of Action to the Client in accordance with the 801 CMR 1.00: *Standard Adjudicatory Rules of Practice and Procedure* and the Supplemental Rules to 801 CMR 1.00, 651 CMR 1.00 *et seq.* If the Client fails to pay the Copayment within 14 days after receipt of the Notice of Action, the ASAP may terminate services to the Client. An ASAP shall not send a Notice of Action to terminate services for reasons of non-payment to a Protective Services or Elder at Risk Client receiving Home Care Services unless the procedures established pursuant to 651 CMR 3.03(3) are complied with.
3. When an ASAP terminates Home Care Program Services due to the failure of a Client to pay the Copayment, such Client may reapply and receive Home Care Program Services provided that he/she pays all past due Copayments or agrees to a schedule of repayment of such past due amounts.
4. ASAPs shall use retained Copayments collected to provide Home Care Program Services to Clients.
5. ASAPs shall maintain separate accounts for Voluntary Copayments collected under 651 CMR 3.03(3)(e)3., and Copayments collected under 651 CMR 3.03(3)(f) and (g), and shall report such collections in a manner determined by Elder Affairs.

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(j) Determination and Redetermination of Financial Eligibility.

1. Redetermination of financial eligibility shall take place annually. If the ASAP is aware of an income change (except cost of living increases in Social Security benefits), the financial redetermination shall take place as soon as possible, or at the next scheduled home visit. An interim (between annual redeterminations) financial redetermination shall not be done solely due to a cost of living increase in Social Security benefits.
2. If the living arrangements of a multi-person Family changes for longer than three months, a redetermination must be carried out. In a case of a married couple who have been determined eligible on the basis of a two-person Family, if one spouse leaves the home for longer than three months, the spouse remaining at home shall be redetermined on the basis of a one-person Family.

(4) Home Care Program Eligibility: Functional Impairment Level.

- (a) A Long Term Care Assessment shall be completed to determine eligibility for the Home Care Program. Such assessment shall be in accordance with forms and procedures as required by Elder Affairs. Initial assessments for Applicants shall entail at least one home visit.
- (b) Functional Impairment Levels (FIL). A FIL shall be determined for each Applicant based on his or her inability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The status of the Client shall be

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reviewed at each reassessment and the Functional Impairment Level changed if appropriate.

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1. The Functional Impairment Levels (FIL) are:
 - FIL 1: 4-7 ADL Impairments.
 - FIL 2: 2-3 ADL Impairments.
 - FIL 3: 6-10 ADL and/or IADL Impairments.
 - FIL 4: 4-5 ADL and/or IADL Impairments.
 2. The FIL is determined by counting the number of ADL and IADL impairments based on the assessment. If an Applicant or Client has two or more ADL impairments, he or she shall receive a FIL of one or two, whichever is appropriate, regardless of the number of IADL impairments. If an Applicant or Client has less than two ADL impairments, the number of ADL plus IADL impairments shall determine the FIL. Applicants or Clients who do not receive a FIL of one through four are not eligible for Home Care Program Services.
- (5) Eligibility For the Home Care Program: Determination of Need. An Applicant's need for Home Care Program Services shall be determined using the LTC Assessment in accordance with 651 CMR 3.03(4) and (5). Individuals receiving services from all-inclusive community based programs are not eligible for the Home Care Program; provided that MassHealth Members whose eligibility was determined under the so-called Spousal Waiver of the Home and Community Based Waiver shall not be deemed ineligible for the Home Care Program based on receiving services from an all-inclusive program. These all-inclusive programs include, but are not limited to Group Adult Foster Care, PACE and Adult Foster Care.
- (a) Long Term Care Assessment for Home Care Program Services. After determining that the Applicant or Client has a FIL of one through four, the ASAP shall determine the extent of need for Home Care Program Services. The assessment shall also determine a Caregiver's need for Respite Services. The ASAP shall determine whether an Applicant or Client should be expected to be maintained at home considering current problems, Unmet Needs and expected availability of other resources including formal services and informal supports. If the possible services authorized and/or arranged for are deemed inappropriate to maintain an Applicant or Client safely in his or her home, the ASAP may not provide purchased services, but must provide assistance in securing the appropriate needed services.
 - (b) Service Priority Matrix. The Service Priority Matrix consists of eight categories with Applicants and Clients in Category 1-C having the highest priority for Home Care Program Services. A Service Priority Matrix category shall be assigned to Applicants/Clients. The Service Priority Matrix is:
 - 1-C FIL 1 with one or more Critical Unmet Need(s).
 - 2-C FIL 2 with one or more Critical Unmet Need(s).
 - 3-C FIL 3 with one or more Critical Unmet Need(s).
 - 4-C FIL 4 with one or more Critical Unmet Need(s).
 - 1-NC FIL 1 with Non-Critical Unmet Needs.
 - 2-NC FIL 2 with Non-Critical Unmet Needs.
 - 3-NC FIL 3 with Non-Critical Unmet Needs.
 - 4-NC FIL 4 with Non-Critical Unmet Needs.

Clients whose Caregivers are in need of Respite Services shall be categorized under the appropriate FIL and shall be determined to have one or more Critical Unmet Needs.
 - (c) Exceptions to the Uniform Intake Policy. An Applicant or Client may qualify for an exemption from the current Uniform Intake Policy when he or she meets the eligibility criteria set forth in the Home Care Program Regulations (651 CMR 3.00, *et seq.*), but is not within a Service Priority

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category open for Uniform Intake. To be considered for an exemption from the Uniform Intake, the Applicant or Client shall meet one or more of the following criteria.

1. At Risk. Elders who are at risk due to a variety of factors, including, but not limited to substance abuse, mental health problems or cultural and linguistic barriers.
2. Protective Services. Elders who are receiving or are eligible to receive Protective Services as defined in 651 CMR 3.01(2) shall be eligible for Home Care Program Services.

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3. Congregate Housing. Clients residing in a Congregate Housing Facility.
4. Waiver Clients. Clients who are eligible for the Home and Community based Waiver Program.

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(6) Home Care Program Eligibility: Service Plan.

- (a) Eligibility. An Applicant shall be eligible for Home Care Programs Services if the Applicant is an Elder who meets the following eligibility criteria: age and residency, set forth in 651 CMR 3.03(2); financial, set forth in 651 CMR 3.03(3); Functional Impairment Level, set forth in 651 CMR 3.03(4); the determination of need requirements set forth in 651 CMR 3.03(5); and is assigned one of the categories within the Service Matrix Priority set forth in 651 CMR 3.03(5)(b) which is open under the current Uniform Intake policy established by Elder Affairs.
- (b) Service Plan. After determining an Applicant's eligibility pursuant to 651 CMR 3.03(2), (3), (4), and (5), if the ASAP determines that the Applicant or Client is in need of Home Care Program Services or the caregiver is in need of Respite Care services, a service plan will be developed. The service plan will identify the services to be provided to the Applicant to meet his or her identified needs and the date on which services shall commence. The ASAP shall initiate the provision of the appropriate service(s) in accordance with the time lines outlined in 651 CMR 3.03(1).
- (c) Service Authorization. The ASAP shall issue a service authorization to all vendors in order to initiate, change, or terminate any Home Care Program Service.

(7) Follow-up and Reassessment. The ASAP shall provide ongoing Interdisciplinary Case Management services to the Client to:

- (a) Assess if the services provided to the Client are meeting his/her needs;
- (b) Ascertain if the services are being provided by the Vendor in a manner acceptable to the Client;
- (c) Determine and make necessary changes in the level, amount, and/or type of services deemed appropriate by the ASAP which have not already been set forth in the initial service plan;
- (d) Reassess each Client's need for services, service level, and service type by conducting in-home reassessments and communicating with the elder, family members, other care givers, informal supports and/or formal supports as necessary. At a minimum, a home visit to reassess Client need shall be conducted at least every six months; and
- (e) Document any changes in the service pattern, including an increase, reduction, termination, or suspension of services other than those set forth in the initial plan, made as a result of this ongoing reassessment process.

(8) Notification of Eligibility.

- (a) The ASAP shall give written notice to each Applicant after a decision is made as to whether such individual is eligible for Home Care Program Services. Such notification shall include a statement of his/her suggested monthly voluntary copayment or a statement of his/her cost sharing copayment.
- (b) If the Applicant has been found ineligible for the Home Care Program, the notice of ineligibility shall contain a statement of reasons supporting the finding of ineligibility, a reference to applicable regulations, and an explanation of the Applicant's right to request an appeal pursuant to the 801 CMR 1.00: *Standard Adjudicatory Rules of Practice and Procedure* and the Supplemental Rules to 801 CMR 1.00, 651 CMR 1.00 *et seq.*

(9) Right to Appeal.

- (a) An Applicant/Client shall be informed in writing of his or her right to request a Review, where the ASAP makes a decision to deny, terminate, or reduce Home Care Program Service.

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- (b) An ASAP shall inform the Client when there has been a change in the source of funding of the Client's services but the type of and amount of such services remain unchanged. The Client shall not have the right to Appeal a decision by the ASAP where there is or has been a change in the source of funding of his or her services.
- (c) The Applicant or Client shall also be informed in writing of his or her right to Appeal a Review decision to Elder Affairs's Hearings Officer as specified in 651 CMR 1.07. The Appeal shall be conducted in accordance with 801 CMR

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1.00: Standard Adjudicatory Rules of Practice and Procedure and 651 CMR 1.00 *et seq.*

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(10) Suspension and Termination of Home Care Services.

- (a) An ASAP may suspend a Client's Home Care Program Services if the Client is temporarily unavailable to receive such services in his or her home for up to 90 calendar days. The ASAP may extend the Suspension of Home Care Services to a Client beyond such 90 day period for reasonable cause. If it appears that the Client's unavailability is likely to end on or before the 90th calendar day of such period, the ASAP shall reassess the Client's need for services when the Client becomes available to receive services in his or her home.
- (b) If it appears during such Suspension period that the Client's unavailability will last longer than 90 calendar days, the ASAP shall forward a notice of action to the Client to terminate Home Care Program Services.
- (c) If the Client no longer meets the eligibility criteria for the Home Care Program set forth in 651 CMR 3.03(2), (3), (4), or (5) the ASAP shall forward a notice of action to the Client to terminate Home Care Program Services.
- (d) The notice of action shall include: the date on which the Client's services were suspended; the reason for the termination; and a statement that the Client's Home Care Services shall be Terminated on the 15th calendar day after the Client receives such notice of action unless the Client takes either of the following actions prior to such date:
 1. The Client notifies the ASAP within 14 calendar days after receiving such notice of action that she or he is available to receive Home Care Services in his or her home. The Client's need for Home Care Program Services shall be reassessed as soon as possible after the ASAP is notified that the Client is available to receive such services; or
 2. If the Client requests a Review of such Termination of Home Care Services which is received by the ASAP on or before the 14th calendar day following the Client's receipt of such notice of action. If the Client files a timely request for Review, the ASAP shall continue the Suspension or continue the provision of Home Care Program Services during the Review and Appeal period. If the Client fails to timely notify the ASAP or request a Review of the notice of action Terminating Services as set forth in 651 CMR 3.03(10), the Client's request for reinstatement shall be treated as a new application for Services.

3.04: Financial and Administrative Responsibilities of ASAPs in the Administration of the Home Care Program

- (1) The ASAP shall comply with regulations set forth in 651 CMR 1.00, 3.00 and 14.00, requirements set forth in the Commonwealth Terms and Conditions for Human and Social Services contracts and all written policies and procedures issued by Elder Affairs.
- (2) Any contractor, sub-contractor or grantee of Elder Affairs shall comply in all respects with 801 CMR 3.00: *Privacy and Confidentiality*, and Elder Affairs' Privacy and Confidentiality Regulations, 651 CMR 5.20, where applicable in Protective Services cases, Supplementary Privacy and Confidentiality Policies and Procedures developed by Elder Affairs' (Program Instruction, PI-97-55 and successors) and Procedures for Protection of Clients Who Are Participants in Research Projects (Elder Rights Review Committee, Program Instruction PI-96- 33 and successors)

3.05: General Provisions

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- (1) The establishment of a comprehensive service plan for an elder shall not establish an entitlement to services for any eligible person for services beyond that established by law or beyond the amounts appropriated for the services.
- (2) Insofar as a waiver of a specific portion of 651 CMR 3.00 would not contradict any applicable state or federal law or regulations, a waiver may be granted by the Secretary. All requests for waivers must be made in writing to the Secretary by the President of the Board of Directors of the ASAP. The waiver request must clearly identify what section of the regulation should be waived; which conditions have made such a waiver necessary; what steps have been taken to resolve current issues

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and to insure future waivers will not be necessary; the consequences to the Clients of the ASAP of not granting the waiver request; and the consequences to the ASAP of not granting the waiver request.

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- (3) All ASAPs and their contractors are subject to audits by Elder Affairs or its authorized agents, the Secretary of the Executive Office of Health and Human Services or his/her authorized agents, or the Commonwealth of Massachusetts or its authorized agents. Furthermore, the Governor or his/her designee, the Secretary of Administration and Finance or his/her designee, and the State Auditor or his/her designee shall have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the ASAPs which pertain to the performance of ASAP requirements. An audit may include but need not be limited to a review of an ASAP's: financial statements, accounting records, procedures, and management practices; compliance with and efficiency in carrying out the terms of the ASAP contract.

REGULATORY AUTHORITY

651 CMR 3.00: M.G.L. c. 19, § 6.

(PAGES 37 THROUGH 56 ARE RESERVED FOR FUTURE USE.)