




Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth



MassHealth
Transmittal Letter ADH-25
March 2010

TO: Adult Day Health Providers Participating in MassHealth
FROM: Terence G. Dougherty, Medicaid Director 
RE: Adult Day Health Manual (Emergency Revisions to Program Regulations)

MassHealth is amending the regulations in 130 CMR 404.000 governing adult day health (ADH) services provided to MassHealth eligible members. The emergency amendments modify the circumstances in which MassHealth will pay for ADH services at the basic level of care payment rate. Other revisions include the following:

- removal of personal hygiene as a qualifying activity of daily living; and
- minor revisions designed to provide clarity.

These regulations are effective March 1, 2010.

If you have any questions about the information in this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Adult Day Health Manual

Pages iv, vi, and 4-1 through 4-12

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

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Pages iv, vi, and 4-1 through 4-12 — transmitted by Transmittal Letter ADH-23

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404.401: Statement of Purpose

The regulations at 130 CMR 404.000 establish the MassHealth agency’s requirements for providers of adult day health services. All providers participating in MassHealth must comply with all the MassHealth agency’s regulations including, but not limited to, 130 CMR 404.000 and 130 CMR 450.000.

404.402: Definitions

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

Activities of Daily Living (ADL) — includes but is not limited to the following personal care activities: bathing, dressing, toileting, transfers, ambulation, personal hygiene, and eating.

Adult Day Health (ADH) Program (Site) — a physical location that has been reviewed and approved by the MassHealth agency and by other appropriate authorities for the provision of adult day health services for a specific number of daily members. If a provider offers adult day health services in more than one location, each location is a separate site and must meet the provisions of 130 CMR 404.000.

Adult Day Health (ADH) Provider — a provider of Adult Day Health Services at an ADH program site.

Adult Day Health Services — all services provided by a MassHealth agency-approved ADH provider that meet the conditions of 130 CMR 404.000. The general goal of these services is to provide an organized program of nursing services and supervision, maintenance-therapy services, and socialization.

Basic Level of Care Services — provision by the ADH provider of ADH services when the member requires at least one skilled service from the list contained in 130 CMR 404.407(B), and/or daily assistance with at least one activity of daily living described in 130 CMR 404.407(C).

Case Management — an interdisciplinary, collaborative process to assess, plan, implement, coordinate, monitor, and evaluate the care and services required to meet the member’s health-care needs.

Certified Capacity — a capacity approved by the MassHealth agency as outlined in 130 CMR 404.412(H). Once a provider is approved, the average daily census at the provider site must not exceed the certified capacity.

Complex Level of Care Services — provision by the ADH provider of at least one skilled service daily from the list contained in 130 CMR 404.407(B) or the provision by the ADH provider of a combination of at least three services contained in 130 CMR 456.409(B) and (C), including at least one service described in 130 CMR 456.409(C).

Health Promotion and Prevention Level of Care Services (HPP) — provision by the ADH provider of an organized program of supervision, health promotion and health prevention services that include the availability of nursing services and health oversight, nutritional dietary services, counseling, therapeutic activities, and case management.

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Maintenance-Therapy Services — supplemental or follow-up physical, occupational, or speech therapy to maintain optimal functioning and to prevent regression. These services must be performed by adult day health program staff under the direction of the therapist, the program's registered nurse, or both.

Nursing Assessment — an assessment done by the program registered nurse that includes a review of the member's health status and medical needs.

Program Day — any day during which the ADH provider is in operation.

Professional Staff — the program director, all licensed staff, the social worker, and the activities director.

Significant Change — a major change in the member's status that is due to progressive disease, functional decline, resolution of a problem, or other issues. A significant change assessment must be completed on the form designated by the MassHealth agency no later than 14 days after determining a significant change has occurred. The significant change in the member's condition must represent a consistent pattern of changes with either one or more areas of decline, or one or more areas of improvement that:

- (1) are not self-limiting;
- (2) impact more than one area of the member's health status; and
- (3) require an interdisciplinary review or revision of the care plan.

404.403: MassHealth Member Eligibility Requirements

(A)(1) MassHealth Members. The MassHealth agency covers adult day health services only when provided to eligible MassHealth members, subject to the restrictions and limitations set forth in the MassHealth agency's regulations. The MassHealth agency's regulations at 130 CMR 450.105 specifically state, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

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

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

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404.404: MassHealth Provider Eligibility Requirements

To participate in MassHealth as an ADH provider, an individual or organization must

- (A) enter into a provider contract with the MassHealth agency;
- (B) operate in Massachusetts and meet the Massachusetts Bureau of Buildings and Standards requirements for adult day health programs, local fire department requirements, local board of health requirements, and the requirements of 130 CMR 404.412;
- (C) agree to periodic inspections that assess the quality of member care and ensure compliance with 130 CMR 404.000. Programs found to be out of compliance will be subject to the provisions of 130 CMR 450.000; and
- (D) agree to comply with all the provisions of 130 CMR 404.400, 450.000, and all other applicable MassHealth rules and regulations.

404.405: MassHealth Clinical Authorization

- (A) Clinical Eligibility Requirement. The ADH provider must request and obtain clinical authorization for MassHealth payment of adult day health services from the MassHealth agency as a prerequisite to payment for ADH. In determining clinical authorization, the MassHealth agency applies the criteria set forth in 130 CMR 404.407. Clinical authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment such as member eligibility or resort to health insurance payment.
- (B) An ADH provider must obtain clinical authorization prior to initial service commencement, transfer from one ADH provider to another, or recommencement of services if there has been a six-month gap in the delivery of ADH services.
- (C) The ADH provider must submit requests for authorization of payment for ADH to the MassHealth agency or its designated agent. Requests must include all information required by the MassHealth agency and be submitted in the format designated by the MassHealth agency.
- (D) Notification of Clinical Approval for Adult Day Health Services. If the MassHealth agency or its agent determines that a member is eligible for coverage of adult day health services, the MassHealth agency or its agent issues an authorization and the effective date of coverage. The notification includes the name of the screening agent and effective date of clinical eligibility.
- (E) Notification of Clinical Denial for Adult Day Health Services and Right of Appeal.
 - (1) If the request for clinical authorization of adult day health services is denied, the MassHealth agency or its agent notifies both the member and the referral source. The notice of denial states the reason for the denial and contains information about the member's right to appeal, and of the appeal procedure.
 - (2) If the request for clinical authorization of adult day health services is denied, a member may appeal this decision by requesting a fair hearing from the MassHealth agency. The request for a fair hearing must be made in writing within 30 days of receiving the denial. The Board of Hearings will conduct the hearing in accordance with 130 CMR 610.000.

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(F) Review Requirement. The provider must annually review all MassHealth members for continued eligibility. In addition, the provider must review the member if there has been a significant change in the member's status as defined in 130 CMR 404.402.

404.406: Adult Day Health Program Requirements

All providers of adult day health services must meet the requirements of 130 CMR 404.000 and 450.000 to enroll in MassHealth. To provide adult day health services at the complex level of care, providers must meet the requirements and provide the additional services in accordance with 130 CMR 404.402 and 404.408(A)(3). In addition, those programs serving members with cognitive impairments such as dementia or Alzheimer's disease who require complex level-of-care services must meet the requirements and provide the additional services listed in Appendix D of the *Adult Day Health Manual*.

(A) Administrative Requirements. All adult day health programs must have a mission statement that includes

- (1) the goals and objectives of the program;
- (2) the service components of each level of need;
- (3) an organizational chart describing the lines of authority and communication needed to manage the adult day health program; and
- (4) a description of the governing body.

(B) Administrative and Medical Policies and Procedures. Each program must have written policies and procedures, including, but not limited to, the following issues:

- (1) service commencement criteria;
- (2) discharge criteria;
- (3) medication administration;
- (4) universal precautions;
- (5) communicable disease;
- (6) recognizing abuse;
- (7) grievance procedures for members;
- (8) staff evaluation;
- (9) staff training;
- (10) nondiscrimination;
- (11) annual quality improvement;
- (12) confidentiality;
- (13) member rights;
- (14) cultural competency;
- (15) counseling members and families; and
- (16) personnel policy and procedures.

(C) Hours of Operation. An ADH provider must operate at least Monday through Friday for eight hours a day.

(D) Scope of Services. All adult day health programs participating in MassHealth must provide the following services as part of their adult day health services.

- (1) Nursing Services and Health Oversight. The ADH provider must provide nursing coverage on site for a minimum of eight hours a day, four hours of which must be provided by a registered nurse. The balance of the coverage may be provided by a licensed practical nurse. When the average daily census reaches 35 members or more, the ADH provider must

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provide nursing coverage on site for a minimum of 12 hours, four hours of which must be provided by a registered nurse. When the average daily census reaches 50 members or more, the ADH provider must provide nursing coverage on site for a minimum of 16 hours a day, eight hours of which must be provided by a registered nurse. When the average daily census reaches over 75 members, the ADH provider must increase the nursing coverage in proportion to the requirements listed above. Nursing services must be provided to meet the needs of each member and must include:

- (a) administration of medications and treatments prescribed by the member's physician during the time the member is at the program;
 - (b) education in hygiene and health concerns;
 - (c) development and coordination of each member's care plan;
 - (d) monitoring each member's health status and documenting those findings in the member's medical record at least monthly and more often if the member's condition requires more frequent monitoring;
 - (e) reporting changes in the member's condition to the member's physician;
 - (f) oversight of maintenance-therapy treatment as recommended by a therapist; and
 - (g) coordinated implementation of physician's orders with the member, family, and program staff.
- (2) Therapy Services.
- (a) The program must provide occupational, physical, and speech/language services at a maintenance level based on a physician's order and a therapy assessment. Maintenance services must be supervised by the program's registered nurse.
 - (b) The program must arrange for restorative therapy based on a physician's order and a therapy assessment.
 - (c) The appropriate licensed personnel must review therapy assessments and services every six months. Providers must document this review.
- (3) Activities of Daily Living. The program must provide assistance with the activities of daily living, as described in the adult day health care plan for each member needing such assistance.
- (4) Nutritional and Dietary Services.
- (a) The program must provide to members each day of attendance
 - (i) a hot meal equivalent to at least one-third of the recommended daily dietary allowance established by the American Dietary Association;
 - (ii) special diets, if required by a member and prescribed by a physician;
 - (iii) an alternate food choice; and
 - (iv) two snacks, one in the morning and one in the afternoon.
 - (b) The program must also offer nutrition counseling, consumer-shopping advice, and menu planning provided under the supervision of a registered nurse or dietitian to the member and, if necessary, the member's family.
 - (c) The program must provide dietary services based on a dietary assessment, a physician's order, or both. Dietary services must be supervised by the program's registered nurse.
 - (d) The appropriate licensed personnel must review dietary assessments and services every six months. Providers must document this review.

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- (5) Counseling Services. A social worker must provide individual and group counseling services to members and their families.
- (a) Licensed professional staff may provide this service if the program's daily census is under 24 members and a social worker is not employed by the program. (See 130 CMR 404.408 for personnel requirements.)
 - (b) A staff person who is not a social worker must demonstrate that they have had training, experience, or both, in counseling adults.
 - (c) Counselors must offer assistance with personal, social, family, and adjustment problems the member may experience at the program.
 - (d) If the member or the member's family requires specialized counseling, the program must refer the member or family to the appropriate community resource.
- (6) Therapeutic Activities.
- (a) The program must provide therapeutic activities, on an individual and group basis, designed to improve or maintain the member's self-awareness and level of functioning.
 - (b) Before the start of each month, the program must make available to members and staff a monthly calendar of activities and events.
 - (c) The dignity, interests, and therapeutic needs of individual members must be considered in the development of activities.
- (7) Case Management. If a member needs services from other community agencies, and if no agency is acting as coordinator of services for that member, the ADH provider must assume the role of coordinator.
- (E) Recordkeeping Requirements.
- (1) Administrative Records.
 - (a) The program must make all records available to the MassHealth agency as needed for evaluation and review.
 - (b) The program must maintain documentation of the following:
 - (i) the number of members served;
 - (ii) the number of individuals waiting for service commencement;
 - (iii) the number of staff;
 - (iv) incident reports;
 - (v) complaint and grievance reports;
 - (vi) a personnel file on each staff person and their qualifications;
 - (vii) contracts for therapy, nutritional, and other services;
 - (viii) daily attendance records outlining each member's arrival and departure times; and
 - (ix) other records as may be required by the MassHealth agency.
 - (2) MassHealth Participation Agreement. Once a member has been determined to be clinically eligible for MassHealth payment of adult day health services, the ADH provider must provide a written agreement to the member and, if appropriate, to the member's legal guardian. This agreement must specify
 - (a) the services offered to the member by the ADH provider;
 - (b) the responsibilities of the member and his or her family to the program;
 - (c) the days and hours of the ADH program operation, including
 - (i) a schedule of holidays when the ADH program is closed;
 - (ii) the days per week the member will attend;
 - (iii) the procedures for notifying members of unexpected closing of the ADH program due to disaster or inclement weather; and
 - (iv) arrangements for transporting the member to and from the ADH program;
 - (d) minimum attendance schedule established by the program;

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- (e) emergency procedures; and
- (f) reasons for discharge from the program. (See 130 CMR 404.406(G).)
- (3) Emergency Services. The ADH provider must establish emergency policies and procedures in writing. These procedures must include the following:
 - (a) an emergency file (such as a Kardex or emergency fact sheet) on each member that must contain
 - (i) the name and telephone number of the member's physician;
 - (ii) the member's diagnosis;
 - (iii) any special treatments or medications the member may need;
 - (iv) insurance information; and
 - (v) the name and telephone number of a family member, sponsor, or friend to be notified in case of emergency;
 - (b) a policy for emergency evacuation that is in compliance with local fire department requirements;
 - (c) a procedure for emergency evacuation that is conspicuously posted throughout the ADH program site;
 - (d) monthly evacuation drills, records of which must be kept on file;
 - (e) training and certification of all drivers of vehicles owned by the ADH program or contracted vehicles, in emergency procedures, cardiopulmonary resuscitation (CPR) by an approved CPR instructor, and basic first aid. The ADH provider must keep records of drivers' CPR and first-aid training and certification on file;
 - (f) training of all direct care staff in CPR and first aid. The ADH provider must keep records of all direct care staff CPR and first-aid training on file;
 - (g) a procedure to be followed in the event a member is missing or lost;
 - (h) a procedure for relocation of members in an emergency; and
 - (i) procedures for handling medical emergencies at the ADH program.

(F) Documentation Requirements.

- (1) Member Records. The ADH provider must have available, and maintain on site for at least 12 months, a medical record for each member as required by the MassHealth agency. The ADH provider must maintain the member record for seven years from the date of the member's death or discharge. The record retention rules apply to all members regardless of the member's length of stay. The member record must contain
 - (a) service commencement information, including
 - (i) the member information sheet;
 - (ii) the clinical authorization by the MassHealth agency or its agent; and
 - (iii) the MassHealth Participation Agreement;
 - (b) medical information, including
 - (i) a copy of the most recent physical examination;
 - (ii) the physician orders;
 - (iii) medical history;
 - (iv) tuberculosis screening documentation;
 - (v) a list of any known allergies;
 - (vi) information concerning member's dietary requirements;
 - (vii) the medication administration record (MAR);
 - (viii) the initial nurse's assessment;
 - (ix) the results of the functional assessment annually and at significant change;
 - (x) advanced directives; and
 - (xi) the name of the health-care proxy;
 - (c) progress notes, including

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- (i) nursing notes;
 - (ii) therapy notes;
 - (iii) activity notes;
 - (iv) social service notes;
 - (v) dietary notes; and
 - (vi) ADL daily records (staff log of care received by member);
 - (d) correspondence from family, therapists, physicians, or others pertaining to the care of the member in the ADH program, including
 - (e) the discharge plan;
 - (f) the attendance record;
 - (g) legal documentation, for example, signed authorizations for release of information;
 - (h) the individual plan of care; and
 - (i) documentation supporting the member's level of care.
- (2) Physician's Documentation.
- (a) Before the member's first attendance day, the ADH provider must obtain the necessary documentation from the member's physician.
 - (b) The physician's documentation must include
 - (i) physician orders for adult day health services;
 - (ii) the member's medical history;
 - (iii) results of a physical examination given within the past twelve months. If the individual has been hospitalized in the preceding three months, a complete discharge summary may be used to fulfill the physical examination requirement;
 - (iv) a list of current medications and treatments;
 - (v) a statement of special dietary requirements;
 - (vi) a statement indicating any contraindications or limitations to the individual's participation in program activities; and
 - (vii) recommendations for therapy, when applicable.
 - (c) In the case of an emergency service commencement, the ADH provider must request from the MassHealth agency an extension of the physician's documentation requirements. The program must obtain the physician's signature as evidence of review of the quarterly care plan within three business days.
- (3) Member Care Plan.
- (a) Care Plan Development: Within six business days after a member's date of service commencement, the ADH provider's staff must complete an adult day health care plan for the member. The ADH provider's registered nurse must coordinate the development of the member care plan. The plan must include
 - (i) a treatment plan based on the member's physician's orders;
 - (ii) a nursing assessment;
 - (iii) if applicable, therapy services;
 - (iv) a social service and activity plan designed to meet the member's psychosocial and therapeutic needs; and
 - (v) documentation of any other health or supportive services the member is receiving off-site (for example, homemaker, home health, personal care, or therapy services).
 - (b) Ongoing Care Plan Reviews and Progress Notes for members receiving Health Promotion and Prevention (HPP) Level of Care Services. The ADH provider's professional staff must review and update each member's care plan on an annual basis, or significant change in the member's status as defined in 130 CMR 404.402. In addition to the annual care plan review the ADH provider must ensure that the following progress notes are completed in a timely manner:
 - (i) licensed nursing progress notes completed on a semi-annual basis;
 - (ii) therapist notes: completed on a semi-annual basis;

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- (iii) activity notes: completed on an annual basis; and
- (iv) social service notes: completed on an annual basis.

(c) Ongoing Care Plan Reviews and Progress Notes for Members

Receiving Basic Level of Care Services. The ADH provider's professional staff must review and update each member's care plan, on a semi-annual basis, or if there is a significant change in the member's status as defined in 130 CMR 404.402. In addition to the semi-annual care plan review, the ADH provider must ensure that the following progress notes are completed in a timely manner:

- (i) licensed nursing progress notes completed on a monthly basis;
- (ii) therapist notes completed on a monthly basis;
- (iii) activity notes completed on a quarterly basis;
- (iv) social service notes completed on a quarterly basis; and
- (v) ADL flow sheets reviewed on a quarterly basis.

(d) Ongoing Care Plan Reviews and Progress Notes for Members Receiving Complex

Level of Care Services. The ADH provider professional staff must review and update each member's care plan on a quarterly basis, or significant change in the member's status as defined in 130 CMR 404.402. In addition to the quarterly care plan review the ADH provider must ensure that the following progress notes are completed in a timely manner:

- (i) nursing progress notes completed on a monthly basis;
- (ii) therapist notes completed on a monthly basis;
- (iii) activity notes completed on a quarterly basis;
- (iv) social service notes completed on a quarterly basis; and
- (v) ADL flow sheets reviewed on a quarterly basis.

(e) Physician Review.

(i) For members receiving Basic or Complex Level of Care Services, the ADH provider must forward a copy of the member's care plan to the member's physician, physician assistant, or nurse practitioner every six months.

(ii) For members receiving Health Promotion and Prevention Level of Care Services, the ADH provider must forward a copy of the member's adult day health care plan to the member's physician, physician assistant, or nurse practitioner annually within 15 days of the anniversary of the member's first attendance day.

(iii) The ADH provider must inform the physician, physician assistant, or nurse practitioner of any subsequent change in the member's adult day health care plan. The ADH provider must ensure that the physician, physician assistant, or nurse practitioner reviews, signs, and returns the adult day health care plan.

(G) Member Discharge and Referral.

(1) Discharge from an ADH program may be initiated by either the ADH provider or the member.

(a) A provider may initiate discharge of a member when the ADH provider determines that

- (i) the member's health has improved sufficiently and no longer needs the services provided by the ADH provider; or
- (ii) the intensity of the medical and/or behavioral needs of the member can no longer be met by the ADH provider; or

(b) When the discharge is initiated by the ADH provider, the ADH provider must arrange for the member to be discharged to other appropriate services. The ADH provider may not discharge the member until appropriate services are available.

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(c) A member may choose to discontinue services at any time. In this circumstance, the ADH provider is not responsible for discharge service planning, as outlined in 130 CMR 404.406(G)(2) through (5).

- (2) The ADH provider must develop a written discharge plan that includes
 - (a) a discharge summary;
 - (b) recommendations for sources of continuing care (for example, Aging Service Access Points, home health agencies, and facility-based care); and
 - (c) referrals to community service agencies for appropriate services, for individuals who do not meet minimum ADH coverage criteria.
- (3) The ADH provider must notify a member, the member's family, or authorized representative and the member's physician at least two weeks before discharging the member from the ADH program. This notification must be mailed to the member and the member's family or authorized representative. The ADH provider must also notify the local Aging Service Access Point, if applicable, two weeks prior to discharge, in cases where a member will be referred for alternative community services. The ADH provider may discharge a member in less than two weeks if a sudden change in the member's condition makes continued participation harmful to the member or other members. The ADH provider must document the need for immediate discharge.
- (4) The ADH provider must discuss the discharge with the member's family and coordinate transition to appropriate and available services.
- (5) The ADH provider must make at least one follow-up telephone call between 20 and 25 business days following discharge, and document its findings of the member's post-discharge status and condition in the member's medical record.

(H) Marketing Plan. The ADH provider must establish a marketing plan that describes strategies for informing communities in its service area of the program's services.

(I) Quality Assurance/Quality Improvement Plan. Each ADH provider must develop an annual quality improvement plan that

- (1) identifies specific measurable objectives to assess the clinical outcomes of the care and services;
- (2) identifies a method or methods of evaluation;
- (3) identifies a staff member who is responsible for developing the plan;
- (4) explains how the quality improvement information will be used;
- (5) identifies interventions;
- (6) describes the implementation of interventions;
- (7) evaluates the interventions; and
- (8) addresses additional quality improvement projects as determined by the MassHealth agency.

404.407: Adult Day Health Service Requirement for Clinical Eligibility

(A) To be clinically eligible for MassHealth payment of adult day health services, a MassHealth member must meet all of the following criteria:

- (1) have a medical or mental dysfunction that involves one or more physiological systems and requires nursing care (The dysfunction does not have to be one that can be stabilized.);
- (2) require services in a structured adult day health setting;
- (3) have a personal physician;

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(4) require a health assessment, oversight, monitoring, or services provided by a licensed nurse; and

(5) require one or both of the following:

(a) assistance daily with one or more activities of daily living (see 130 CMR 404.407(C));

or

(b) at least one skilled service (see 130 CMR 404.407(B)).

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

(1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding;

(2) nasogastric-tube, gastrostomy, or jejunostomy feeding;

(3) nasopharyngeal aspiration and tracheostomy care. However, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services;

(4) treatment and/or application of dressings when the physician has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions);

(5) administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema);

(6) skilled-nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the day);

(7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety;

(8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter. A urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled-nursing care. However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled-nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection);

(9) gait evaluation and training administered or supervised by a registered physical therapist while at the ADH provider for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame;

(10) certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical-therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record);

(11) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications; and

(12) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The

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findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame.

- (C) Assistance in activities of daily living include
- (1) bathing when the member requires either direct care or constant supervision and cueing during the entire activity;
 - (2) dressing when the member requires either direct care or constant supervision and cueing during the entire activity;
 - (3) toileting, bladder or bowel, when the member is incontinent of bladder or bowel or requires scheduled assistance or routine catheter or colostomy care;
 - (4) transfers when the member must be assisted or lifted to another position;
 - (5) ambulation when the member must be physically steadied, assisted, or guided in ambulation, or is unable to self-propel a wheelchair appropriately without the assistance of another person; and
 - (6) eating when the member requires constant supervision and cueing during the entire meal, physical assistance by the staff with a portion of, or the entire meal.

404.408: Adult Day Health Personnel Requirements

- (A) Staffing Requirements. Adult day health programs must have available sufficient direct-care staff to meet the needs of their members.
- (1) For HPP level of care services, the ADH provider must maintain a minimum-staffing ratio of one direct care staff person to eight members.
 - (2) For basic level of care services, the ADH provider must maintain a minimum-staffing ratio of one direct care staff person to six members.
 - (3) For complex level of care services, the ADH provider must maintain a minimum-staffing ratio of one staff person to four members.
 - (4) Programs must maintain proportionate direct-care staff ratios to meet the needs of members based on the ratio of members requiring each level-of-care service.
- (B) Pre-employment Requirements.
- (1) Before hiring staff and approving volunteers, the ADH provider must check the candidate's references and job history and ensure that the candidate has had a Criminal Offender Records Information (CORI) check.
 - (2) Each staff person must have a satisfactory pre-employment physical examination within 12 months before employment and a tuberculosis screening. The provider must obtain a copy of these reports within 30 days of employment and keep this report in the employee's personnel record. The personnel policies must specify the intervals at which future physical examinations are required. All staff must have a tuberculosis screening completed every two years.
- (C) Administrative and Training Requirements.
- (1) ADH providers must provide staff training appropriate to the mix of services provided. Staff must have adequate skills, education, and experience to serve the population in a manner