Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Adult Day Health Bulletin 14
September 2018

TO: Adult Day Health Providers Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: **Immediate Action Required: Adult Day Health Members Clinical Eligibility Criteria**

Background

Recently, MassHealth promulgated amendments to the MassHealth provider regulations for the Adult Day Health (ADH) program at 130 CMR 404.000. These amendments include revisions and clarifications to the definitions for Activities of Daily Living (ADL) and to the clinical eligibility criteria for ADH services.

Please note that this bulletin and the reassessment or validation of service payment levels do not apply to members receiving ADH provided through SCO, PACE, or One Care.

Service Payment Level Reassessment and Validation

The revised regulation includes removal of the Health Promotion and Prevention (HPP) level of service, formerly the lowest level of ADH services. It is anticipated that many members currently receiving the HPP level of service will be placed into the higher Basic level of service, as the clinical eligibility requirements for the HPP level and the Basic level are the same. To ensure that ADH providers bill at the proper service payment level, all ADH providers must reassess members who were previously eligible for ADH services under the HPP level of service by September 14, 2018.

ADH providers must submit the results of their reassessment to MassHealth using the Adult Day Health Service Payment Level Revalidation Form. This form can be found at https://www.masshealthltss.com/s/article/ADH-Provider-Resources?language=en_US. Submit completed forms to MassHealthOLTSS@MassMail.state.ma.us on or before September 14, 2018.

If any member previously eligible under the HPP level is determined by the ADH provider to not be clinically eligible under the Basic level or Complex level, the ADH provider must engage in discharge planning to safely transfer the member to appropriate services by September 28, 2018. Member transfers may be made in consultation with the MassHealth LTSS TPA, as supported by MassHealth and its sister agencies, and as described below.

ADH provider discharge planning must take into account the following, as appropriate for each member being discharged.

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Members Younger Than Age 60

If a member younger than age 60 no longer meets the clinical eligibility requirement for ADH, please refer the member prior to discharge to the following services, as appropriate.

- Adult Foster Care (AFC)
- Massachusetts Rehabilitation Commission (MRC)
- Personal Care Attendant Program (PCA)

Members Age 60 and Older

If a member older than age 60 no longer meets the clinical eligibility requirements for ADH, please refer the member prior to discharge to their local Aging Service Access Point (ASAP), so that an ASAP may assess the member for Executive Office of Elder Affairs Home Care program services. For a list of office locations and phone numbers please refer to the EOEA at www.mass.gov/orgs/executive-office-of-elder-affairs.

Members Receiving Services from the Department of Developmental Services (DDS)

If a member with intellectual or developmental disabilities no longer meets the clinical eligibility requirements for ADH, please refer the member prior to discharge to their DDS Service Coordinator, if they have one, so that DDS may assess the member for DDS services. If the member does not have a DDS Service Coordinator, this should be noted on the Adult Day Health Service Payment Level Revalidation Form.

Members with Behavioral Health Needs

If a member with behavioral health needs no longer meets the clinical eligibility requirements for ADH, please contact the member's DMH case manager, if applicable, or, if the member does not have a DMH case manager, the local Area Service Authorization Specialist. For a list of office locations and phone numbers please refer to the DMH webpage at: https://www.mass.gov/orgs/massachusetts-department-of-mental-health.

Clinical Eligibility for ADH Services

Clinical Eligibility for ADH services is specified at 130 CMR 404.414(D), and restated below.

To be clinically eligible for ADH services, a member must meet the clinical eligibility criteria specified at 130 CMR 404.405(A)-(C), reproduced below:

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

(1) ADH has been ordered by the member's PCP;

(2) The member has one or more chronic or post-acute medical, cognitive, or mental health condition(s) identified by the member's PCP that require active monitoring, treatment or intervention and ongoing observation and assessment by a nurse, without which the member's condition will likely deteriorate;

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Clinical Eligibility for ADH Services (cont.)

(3) The member requires one or both of the following be provided by the ADH program:
(a) at least one skilled service listed in 130 CMR 404.405(B); or
(b) at least daily or on a regular basis hands-on (physical) assistance or cueing and supervision, throughout the entire activity, with one or more qualifying ADLs listed in 130 CMR 404.405(C) when required at the ADH program as determined clinically appropriate by the ordering PCP and the ADH program nurse developing the plan of care.

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

(1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding;
(2) nasogastric-tube, gastrostomy, or jejunostomy feeding;
(3) nasopharyngeal aspiration and tracheostomy care. However, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services;
(4) treatment and/or application of dressings when the physician has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions);
(5) administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema);
(6) skilled-nursing intervention including observation, evaluation or assessment, treatment and management to prevent exacerbation of one or more chronic medical and/or behavioral health conditions at high risk for instability. Intervention must be needed at frequent intervals throughout the day;
(7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery, safety and the stabilization of the member's complex social determinants of health;
(8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter. A urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled-nursing care. However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled-nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection);

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Clinical Eligibility for ADH Services (cont.)

(9) Administration oversight, and management of medication by a licensed nurse including monitoring of dose, frequency, response and adverse reactions;
(10) evaluation, implementation, oversight and supervision by a licensed nurse of a behavior management plan and staff intervention required to manage, monitor, or alleviate the following types of behavior:
(a) wandering: moving with no rational purpose, seemingly oblivious to needs or safety; ongoing exit seeking behaviors; or elopement or elopement attempts;
(b) verbally abusive behavioral symptoms: threatening, screaming, or cursing at others;
(c) physically abusive behavioral symptoms: hitting, shoving, or scratching;
(d) socially inappropriate or disruptive behavioral symptoms: disruptive sounds, noisiness, screaming, self-abusive acts, disrobing in public, smearing or throwing food or feces, rummaging, repetitive behavior, eating non-food items, or causing general disruption, including difficulty in transitioning between activities;
(e) inability to self-manage care;
(f) pattern of disordered thinking, impaired executive functioning, confusion, delusions or hallucinations, impairing judgment and decision-making leading to lack of safety awareness and unsafe behavior and requiring frequent intervention during the day to maintain safety.
(11) medically necessary measurements of intake and output based on medical necessity to monitor and manage a chronic medical condition;
(12) gait evaluation and training administered or supervised by a registered physical therapist while at the ADH provider for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame;
(13) certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical-therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record);
(14) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications; and
(15) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame.

(C) Qualifying Activities of Daily Living for ADH Services. The list of ADLs in 130 CMR 404.405(C)(1) through (5) is for the purpose of clinical eligibility for receipt of ADH services.
(1) bathing—a full body bath or shower or a sponge (partial) bath which may include washing and drying of face, chest, axillae (underarms), arms, hands, abdomen, back and peri-area that may include personal hygiene such as combing or brushing of hair, oral care, shaving, and when applicable applying make-up;
(2) toileting—member is incontinent (bladder or bowel) or requires scheduled assistance or routine catheter or colostomy care;

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Clinical Eligibility for ADH Services (cont.)

(3) transferring—member must be assisted or lifted to another position;
(4) mobility (ambulation)—member must be physically steadied, assisted or guided in mobility, or is unable to self-propel a wheelchair appropriately without the assistance of another person; and
(5) eating—member requires constant supervision and cueing during the entire meal or physical assistance with a portion or all of the meal.

ADH Payment Levels

MassHealth pays for ADH services provided to ADH-eligible members at either the Basic Payment Level or the Complex Payment Level as specified at 130 CMR 404.414(D), restated below:

(D) ADH Payment Levels.
(1) Basic Payment Level.
(a) The MassHealth agency pays the Basic Payment Level rate to ADH providers for each date of service billed that the member meets the clinical eligibility criteria set forth in 130 CMR 404.405 and the provider meets at least one of the qualifying needs of the member while the member is in attendance at the ADH program.
(b) The ADH provider must document how a qualifying need or needs were met for each member in a manner consistent with the member's plan of care on each date for which services are billed and make this information available to the MassHealth agency or its designee upon request. Such documentation must include evidence of the following having been provided pursuant to the member's plan of care, as applicable: daily ADL service delivery, daily behavior support or evaluation, daily activity participation, and/or evidence of skilled services care.

(2) Complex Payment Level.
(a) The MassHealth agency pays the Complex Payment Level rate for each date of service billed that the member meets the complex payment level criteria set forth in either 130 CMR 404.414(D)(2)(a)1. or 2., and the requirements of 130 CMR 404.414(D)(2) are met:
1. The member required the provision by the ADH provider of at least one skilled service from 130 CMR 404.405 (B)(1) through (B)(5) or (B)(8) while in attendance at the ADH; or
2. The member required the provision by the ADH provider of a combination of at least three of the following including at least one from 130 CMR 404.414(D)(2)(a)2.b.:
a. qualifying activities of daily living listed at 130 CMR 404.405(C) performed while in attendance at the ADH and
b. skilled services listed at 130 CMR 404.405(B)(1) through (B)(5), (B)(8) through (B)(12), or (B)(15) required to be provided while in attendance at the ADH in a manner consistent with the plan of care as directed by the ADH nurse.

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ADH Payment Levels *(cont.)*

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

Additional Requirements for Services Provided at the Complex Payment Level

MassHealth pays at the Complex Payment Level for services provided to members who meet the clinical eligibility criteria listed in either (1) or (2) below:

1. provision by the ADH provider of at least one skilled service from 130 CMR 404.405 (B)(1), (B)(2), (B)(3), (B)(4), (B)(5), or (B)(8) at least daily while in attendance at the ADH; or
2. provision by the ADH provider of a combination of at least three of the following, including at least one from (b) below:
   a. qualifying activities of daily living listed at 130 CMR 404.405(C) if performed daily at the ADH; and,
   b. skilled services listed at 130 CMR 404.405(B)(1), (B)(2), (B)(3), (B)(4), (B)(5), (B)(8), (B)(9), (B)(10), (B)(11), (B)(12) or (B)(15) provided while in attendance at the ADH in a manner consistent with the plan of care as directed by the ADH nurse.

MassHealth Website

This bulletin is available on the MassHealth website at www.mass.gov/masshealth-provider-bulletins. To sign up to receive email alerts when MassHealth issues new bulletins and transmittal letters, send a blank email to join-masshealth-provider-pubs@listserv.state.ma.us. No text in the body or subject line is needed.

Questions

The MassHealth LTSS Provider Service Center is open, 8:00 A.M. to 6:00 P.M. EST, Monday through Friday, excluding holidays. LTSS providers should direct their questions about this bulletin or other MassHealth LTSS provider questions to the LTSS TPA as follows.

Method	Contact Information for MassHealth LTSS Provider Service Center
Phone	Toll-free (844) 368-5184
Email	support@masshealthltss.com
Portal	www.MassHealthLTSS.com
Mail	MassHealth LTSS PO Box 159108 Boston, MA 02215
Fax	(888) 832-3006
LTSS Provider Portal	Trainings, general Information, and future enhancements are available at www.MassHealthLTSS.com.