




MassHealth
Adult Foster Care Bulletin 13
January 2018

TO: Adult Foster Care Providers Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary for MassHealth 

RE: **Frequently Asked Questions About Adult Foster Care Services**

Introduction

MassHealth amended 130 CMR 408.000: *Adult Foster Care* (AFC), effective May 5, 2017, to revise and clarify certain AFC program requirements. As part of the outreach efforts to support these amendments, MassHealth staff conducted a series of training sessions throughout the Commonwealth to educate providers about the revisions to the updated AFC program requirements. This bulletin provides additional guidance about certain regulatory requirements of the AFC program, based on the feedback that we received during the training sessions.

Frequently Asked Questions About Adult Foster Care Services

Clinical Eligibility

Q: Does the AFC caregiver have to be in the room throughout an entire task or activity?

A: MassHealth recognizes and respects members' right to privacy. There may be tasks where the member would like as much privacy as possible. For example, the caregiver may assist the member to the bathroom and transfer to the toilet, and then provide the member privacy to use the toilet, then go back in to assist with cleanup and transfer while maintaining supervision throughout the entire task/activity.

Q: Does the member need assistance with personal hygiene for bathing to be a qualifying Activity for Daily Living (ADL) for AFC?

A: No. It is not required that a member need assistance with personal hygiene in addition to assistance with a full or partial bath for bathing to be a qualifying ADL for AFC. The regulation at 130 CMR 408.416(B)(1) permits flexibility to qualify a member for AFC based on the need for assistance with bathing but not personal hygiene.

Q: To qualify a member for AFC that requires assistance with dressing, must the member need assistance with both upper and lower body dressing, or is a need for assistance with upper or lower body dressing, but not both, sufficient?

A: To qualify a member for AFC based on a need for assistance with dressing, the member must require assistance with **both** upper and lower body dressing in accordance with 130 CMR 408.416(B)(2). A member who requires assistance with upper or lower body dressing, but not both, does not meet the requirements for dressing to be a qualifying ADL for AFC.

(continued on next page)

Frequently Asked Questions About Adult Foster Care Services (*cont.*)

Q: If a member requires “cueing and supervision” for upper dressing but requires “hands-on” for lower dressing, or the reverse, does dressing qualify as cueing and supervision or hands-on?

A: If the member requires hands-on assistance for upper or lower dressing, but not both, and also requires cueing and supervision for the other, the member would be determined to need “hands-on” assistance with dressing, and dressing would be considered a qualifying ADL for AFC in accordance with 130 CMR 408.416(B)(2).

Q: Must a member require assistance with mobility both indoors and outdoors for mobility to be a qualifying ADL for AFC?

A: Yes, a need for assistance with a particular ADL should be present in all applicable environments. Therefore, a member must require mobility assistance both indoors and outdoors for mobility to be considered a qualifying ADL need for purposes of AFC in accordance with 130 CMR 408.416(B)(5).

Conditions for Payment

Q: What does “frequent caregiver intervention” mean when used to qualify a member for Level II service payment?

A: Caregiver intervention is “frequent” as used in the regulation at 130 CMR 408.419(D)(2)(b) when the member needs consistent or ongoing intervention to manage the identified behavior. Management of behaviors may include a need for a caregiver to proactively deter behaviors. The behaviors requiring frequent caregiver intervention must be defined in the plan of care.

Q: Is the administration of medication by the caregiver considered management of behaviors under the AFC program?

A: No. Medication management is not considered a behavioral intervention as described at 130 CMR 408.419(D)(2)(b) for the purposes of the AFC program.

Staff Qualifications

Q: Will MassHealth consider a Community Health Worker (CHW) applicant that has one year’s experience working with elders or adults with disabilities, or a combination of the two, as having satisfied the CHW work experience requirement under 130 CMR 408.422(D)(1)?

A: Yes. MassHealth will consider a Community Health Worker (CHW) that has at least one year of experience working with either elders or adults with disabilities, or a combination of the two, as having met the CHW qualification requirement at 130 CMR 408.422(D)(1).

Q: Will Community Health Workers need to be certified through the Department of Public Health’s Board of Certification once that certification mechanism is available?

A: No. In accordance with 130 CMR 408.433(D)(1), CHWs must have at least one year of experience working with elders or adults with disabilities—there is no requirement for CHWs to be certified by the Department of Public Health.

Q: What is the primary function of the Community Health Worker (CHW) in the AFC program?

(continued on next page)

Frequently Asked Questions About Adult Foster Care Services (cont.)

A: The primary function of the CHW is to provide the member and caregiver culturally appropriate health education, information, support, and counseling in accordance with 130 CMR 408.433(D)(2). In performing this function, the CHW applies a unique understanding of the experience, language, or culture of the populations the worker serves to carry out these responsibilities.

Home Visit Requirements

Q: If a Community Health Worker (CHW) covers for a registered nurse (RN) for one visit, can the CHW cover the care manager (CM) for the next visit?

A: No. A CHW cannot make consecutive visits. At least one RN or CM visit must take place between CHW visits. Visits must occur at the frequency specified and be provided by the RN, CM, and CHW as specified in the regulation at 130 CMR 408.415(B)(6) for members at Level I service payment, and 130 CMR 408.415(C)(5) for members at Level II service payment.

Q: Can a Community Health Worker (CHW) conduct initial visits for new members at a Level I or Level II service payment?

A: No. A CHW cannot conduct initial visits. The initial visit conducted on the first day of AFC for members at a Level I service payment must be performed by the registered nurse or the care manager pursuant to 130 CMR 408.431(B)(3)(a). The initial visit conducted on the first day and weekly visits conducted within the first month of AFC for members at a Level II service payment must be performed by the registered nurse pursuant to 130 CMR 408.431(B)(3)(b). The Multidisciplinary Team can determine if a CHW is appropriate for the member to make on-site visits thereafter.

Clinical Assessment

Q: What is the expectation of MassHealth about the responsibility of the AFC provider to a member who does not receive AFC for more than 90 days if the provider continues to maintain an active open case because the member intends to return to the AFC qualified setting and resume AFC?

A: Where a member authorized to receive AFC does not receive AFC for 90 days or more, a significant change in the member's status is presumed pursuant to the definition of "significant change" at 130 CMR 408.402. If the member returns to the AFC qualified setting after 90 days of not receiving AFC, the AFC provider must perform a new clinical assessment and obtain a new clinical authorization to continue providing AFC in accordance with 130 CMR 408.417, which requires a new assessment and authorization when there is a significant change in the member's status.

Prior Authorization

Q: When the clinical authorization process updates to the new prior authorization (PA) process, must providers submit new minimum data set (MDS) assessments for all members at the same time?

(continued on next page)

Frequently Asked Questions About Adult Foster Care Services (*cont.*)

A: MassHealth will continue to engage with providers and stakeholders to develop an appropriate implementation approach for the new PA process that will minimize disruption for those involved. MassHealth will provide further guidance regarding the new PA process, including a streamlined approach to transfer existing approval and referral responsibilities from Coastline to Optum.

Quality Management

Q: Who will be developing the quality metrics and when does the measurement period begin?

A: MassHealth continues to collaborate with stakeholder groups to determine appropriate quality metrics for the AFC program. MassHealth will offer further guidance once these metrics are defined and a feasible measurement period is determined.

Provider Responsibilities

Q: What is the caregiver stipend requirement?

A: In accordance with 130 CMR 408.434(A)(4), AFC providers in operation on January 1, 2017, are required to pay AFC caregivers on average, no less than the average amount paid to AFC caregivers as reported in the AFC provider's 2016 cost report.

Q: Is there a MassHealth form for caregiver logs?

A: No. There is no standard MassHealth caregiver log form. Providers must comply with the requirements provided at 130 CMR 408.434(C)(4) and (5) to ensure that caregivers complete a caregiver log and send the caregiver log at the end of the month to the registered nurse to be maintained in the member's file.

Plan of Care

Q: Is a PCP signature required on health status reports?

A: A PCP signature is not required on health status reports, but AFC providers should document that the health status reports were sent to the member's PCP. In accordance with 130 CMR 408.430(C)(4) and (5), the AFC provider must review the plan of care and send a copy of the member's health status report to the member's PCP annually for members with a Level I service payment and semi-annually for members with a Level II service payment.

Q: When should health status reports be sent to PCPs for each level of service payment?

A: In accordance with 130 CMR 408.415(B)(3), health status reports should be completed by RNs on all members semiannually. In accordance with 130 CMR 408.430(C)(4) and (5), health status reports must be sent to the member's PCP annually for members with a Level I service payment and semiannually for members with a Level II service payment.

Q: Do providers need to complete both an interim plan of care within five days and a final plan of care within 30 days if the plan of care is finalized within five days?

A: Yes. In accordance with 130 CMR 408.430(C)(1) and (2), both an interim and final plan of care must be developed, but if the interim plan of care sufficiently meets the needs of the

(continued on next page)

Frequently Asked Questions About Adult Foster Care Services (*cont.*)

member and has been reviewed for this sufficiency, it can be used as the final plan of care. The interim and final plans of care do not need to contain substantive differences, but the final plan of care must contain an updated date reviewed and must be signed by the member, the registered nurse, and the care manager.

Q: What if the member cannot sign a plan of care?

A: A responsible party, such as a legal guardian, is permitted to sign the plan of care on behalf of the member when being signed in accordance with 130 CMR 408.430(C)(2).

Preadmission and Admission

Q: Must members have an annual physical to satisfy the requirement for the member's PCP annual visit, or could an annual wellness exam or complete medical exam replace an annual physical?

A: In accordance with 130 CMR 408.430(C)(3)(h), the plan of care must be based on the "member's PCP annual visit and the member's physical examination." Common terms used to describe an annual visit include "checkup," "physical," "well-visit," and similar terms. These types of periodic visits during which the member's PCP performs a physical examination would be an appropriate PCP annual visit to satisfy the AFC program requirements.

Discharge Procedures

Q: If a member receiving AFC is determined to no longer meet the clinical eligibility criteria for receipt of AFC, may the AFC provider continue to bill for its provision of AFC to the member pending completion of the member's discharge from the AFC program?

A: No. Once an AFC provider has determined that a member no longer meets the clinical eligibility criteria for receipt of AFC, the continued provision of AFC to the member no longer meet the conditions of payment requirements under 130 CMR 408.419(C)(2), which provides that MassHealth makes payments for AFC only if "the member meets clinical eligibility criteria for AFC in accordance with 130 CMR 408.416." Members who no longer meet the clinical eligibility criteria for receipt of AFC must be discharged from the AFC program in accordance with the requirements at 130 CMR 408.432, including ensuring continuity of care for the member during the transition of care. For members who no longer meet the clinical eligibility requirements for AFC but are clients of other state agencies, such as the Department of Mental Health (DMH), the Massachusetts Rehabilitation Commission (MRC), or the Department of Developmental Services (DDS), please refer the members to the appropriate agency so that the agency can assess the member for services provided through that agency. For members over age 60 who no longer meet the clinical eligibility requirements for AFC, please refer those members to their local Aging Service Access Point (ASAP) so that the ASAPs may assess the members for Executive Office of Elder Affairs Home Care program services.

Staff Training

Q: Do AFC provider staff need to be certified in cardiopulmonary resuscitation (CPR)?

(continued on next page)

Frequently Asked Questions About Adult Foster Care Services (cont.)

A: No. The regulation at 130 CMR 408.433(E)(2)(g) requires that new AFC provider staff orientation must include training in basic first aid, CPR, and emergency procedures including the Heimlich maneuver, but does not require full certification.

Caregiver Training

Q: Does MassHealth have any particular requirements regarding the methods by which providers train caregivers?

A: AFC providers must conduct trainings that meet the requirements of 130 CMR 408.434(D), but MassHealth allows for flexibility regarding the delivery and method of training. In addition to actually providing training, the provider must properly document the training provided, including records of complete trainings, in accordance with 130 CMR 408.434(D).

Non-covered Days

Q: The regulations indicate that a medical leave of absence (MLOA) day can be billed when a member has been “admitted” to a hospital, but current practice is to bill MLOA days when a member is out of the qualified setting and in the hospital emergency department for more than 24 hours or on observation status (i.e., not admitted). Is it still permissible to bill for MLOA days when a member is in the hospital but not formally “admitted”?

A: Yes. If a member is out of the AFC qualified setting for more than 24 hours because they are in a hospital setting, including in an emergency room or on observational status, the AFC provider can bill for MLOA days for those days that the member is in the hospital setting for a maximum of 40 days per calendar year in accordance with 130 CMR 408.419(J).

Q: If the member is out of the country for temporary travel, can the AFC provider bill for those days the member is away as non-medical leave of absence (NMLOA) days?

A: Yes, the AFC provider can bill NMLOA days as defined at 130 CMR 408.402 and in accordance with 130 CMR 408.419(J) if the member is out of the country for temporary travel.

Q: Can an AFC provider bill MLOA days for a member while the member is in a skilled nursing facility (SNF) for short term rehabilitation?

A: Yes, an AFC provider can bill MLOA days as defined at 130 CMR 408.402 and in accordance with 130 CMR 408.419(J) while the member is in a SNF for short term rehabilitation. Pursuant to 130 CMR 408.437(C), MassHealth does not pay an AFC provider when the member is a resident or inpatient of a hospital, nursing facility, rest home, ICF/ID, ALR, or any other residential facility subject to state licensure or certification, with the exception of applicable and appropriate MLOA days.

Q: Can an AFC provider bill MLOA days when both the primary and alternative caregivers are unavailable to provide care to the member and the member is placed in the SNF for respite purposes?

A: No, the AFC provider cannot bill MLOA days in this instance. The AFC provider can, however, bill up to 15 NMLOA days per year as defined in 130 CMR 408.402 and in accordance with 130

(continued on next page)

Frequently Asked Questions About Adult Foster Care Services (cont.)

CMR 408.419(J) and 408.437(E). NMLOA is a short-term absence from an AFC qualified setting during which a member does not receive AFC for nonmedical reasons.

Q: Can an AFC provider bill for days in which an AFC member is receiving home health agency services?

A: AFC services are not payable on days in which a member receives home health aide services. See 130 CMR 408.437(B). This prohibition does not apply, however, to skilled nursing or therapy services provided by a home health agency.

Q: Can a member who is in the AFC program elect hospice services?

A: Yes, a member who is receiving AFC services may elect hospice. If the member elects hospice, the AFC provider must coordinate its delivery of AFC services with the services provided through hospice in accordance with 130 CMR 408.415(B)(5) and 408.415(C)(6) and document hospice services provided to the member in the plan of care pursuant to 130 CMR 408.430(C)(2)(d).

Q: Can a member be in the AFC program and also receive supports through the Department of Development Services (DDS)?

A: Services that are not duplicative of AFC may be provided to members in AFC by other agencies or organizations, including DDS. The AFC provider must coordinate its delivery of AFC with these other services in accordance with 130 CMR 408.415(B)(5) and 408.415(C)(6) and document these others services in the plan of care pursuant to 130 CMR 408.430(C)(2)(d).

Q: Can a member be left alone for more than three hours a day in which the AFC bills for AFC services?

A: No. A member receiving AFC services cannot be left alone for more than three hours for a day for which the provider bills for AFC services. In accordance with 130 CMR 408.430(C)(2)(b), the AFC provider must note in the plan of care that a member can manage safely alone in the AFC qualified setting up to but not exceeding three hours per day.

Q: Can someone other than the qualified AFC caregiver provide support to the member in the AFC qualified setting?

A: Yes. Additional supports (provided, for example, by a family member or friend) are permitted, provided that the person providing the additional supports is able to meet the member's needs and provided that the additional supports as well as the person providing the additional supports are documented in the plan of care in accordance with 130 CMR 408.430(C).

Questions

The MassHealth LTSS Provider Service Center is open 8 a.m. to 6 p.m. ET, 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.

(continued on next page)

Questions (*cont.*)

Contact Information for MassHealth LTSS Provider Service Center

Phone	Toll-free 1-844-368-5184
Email	support@masshealthtss.com
Portal	www.MassHealthLTSS.com
Mail	MassHealth LTSS P.O. Box 159108 Boston, MA 02215
Fax	1-888-832-3006
LTSS Provider Portal	Trainings, general information, and future enhancements will be available at www.MassHealthLTSS.com .