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

MASSHEALTH
TRANSMITTAL LETTER AFC-11
January 2007

TO: Adult Foster Care Providers Participating in MassHealth

FROM: Beth Waldman, Medicaid Director BW

RE: *Adult Foster Care Manual* (New Program Regulations and Revised Service Codes and Descriptions)

MassHealth is pleased to announce the development and implementation of regulations governing adult foster care (AFC) programs. These regulations (130 CMR 408.000) are published as Subchapter 4 of the *Adult Foster Care Manual.*

Implementation of New Regulations

Previously, approved AFC programs provided services to MassHealth members in accordance with established guidelines. The regulations codify the current requirements necessary to provide AFC to MassHealth members. MassHealth consulted with AFC providers and clinicians, and reviewed other states' regulations to develop these regulations. These regulations incorporate aspects of the former AFC guidelines and information provided in Transmittal Letter AFC-10, dated November 2006. A summary of key points is provided below.

- The regulations incorporate new standards that are consistent with other MassHealth-covered community-based services. Some of the new standards include the scope of adult foster care, clinical criteria for MassHealth payment, provider responsibilities, preadmission and admission procedures, discharge procedures, personnel and caregiver qualifications and responsibilities, qualified-setting requirements, and emergency services and plans.

- The regulations formalize the requirements for the provision of adult foster care to MassHealth members at two levels: Level I and Level II. These levels are based on the members' clinical needs. The new regulations also explain the criteria for both levels of AFC and the scope of services that AFC programs must provide.

- The regulations introduce an additional payment rate for providing intake and assessment services to members applying for enrollment into AFC. This intake and assessment rate is a one-time payment to providers for performing preadmission activities necessary to enroll a potential AFC member into AFC.

- The regulations broaden the definition of a caregiver as described in the guidelines. Transmittal Letter AFC-10 amended the guidelines by allowing certain family members to be paid as AFC caregivers for members receiving Level II AFC services. The regulations now allow certain family members to be paid as AFC caregivers for members receiving either Level I or Level II services.

Effective February 1, 2007, AFC providers should discard their AFC guidelines, and begin referring to the AFC regulations transmitted by this letter.

Changes to Subchapter 6 (Service Codes and Descriptions)

AFC providers requesting payment for AFC, including intake and assessment services, must bill with the appropriate service codes and modifiers listed in Subchapter 6 of the *Adult Foster Care Manual*. Effective February 1, 2007, intake and assessment services must be billed with Service Code T1028.

These regulations are effective February 1, 2007.

Questions

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 Foster Care Manual

Pages iv, vi, vii, 4-1 through 4-24, 6-1, and 6-2

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

Adult Foster Care Manual

Page vi — transmitted by Transmittal Letter AFC-5

Pages 6-1 and 6-2 — transmitted by Transmittal Letter AFC-10

4. Program Regulations

The regulations and instructions governing provider participation in MassHealth are published in the Provider Manual Series. MassHealth publishes a separate manual for each provider type.

Manuals in the series contain administrative regulations, billing regulations, program regulations, service codes, administrative and billing instructions, and general information. MassHealth regulations are incorporated into the Code of Massachusetts Regulations (CMR), a collection of regulations promulgated by state agencies within the Commonwealth and by the Secretary of State. MassHealth regulations are assigned Title 130 of the Code. The regulations governing provider participation in MassHealth are assigned Chapters 400 through 499 within Title 130. Pages that contain regulatory material have a CMR chapter number in the banner beneath the subchapter number and title.

Administrative regulations and billing regulations apply to all providers and are contained in 130 CMR Chapter 450.000. These regulations are reproduced as Subchapters 1, 2, and 3 in this and all other manuals.

Program regulations cover matters that apply specifically to the type of provider for which the manual was prepared. For adult foster care, those matters are covered in 130 CMR Chapter 408.000, reproduced as Subchapter 4 in the *Adult Foster Care Manual*.

Revisions and additions to the manual are made as needed by means of transmittal letters, which furnish instructions for making changes by hand ("pen-and-ink" revisions), and by substituting, adding, or removing pages. Some transmittal letters will be directed to all providers; others will be addressed to providers in specific provider types. In this way, a provider will receive all those transmittal letters that affect its manual, but no others.

The Provider Manual Series is intended for the convenience of providers. Neither this nor any other manual can or should contain every federal and state law and regulation that might affect a provider's participation in MassHealth. The provider manuals represent instead MassHealth’s effort to give each provider a single convenient source for the essential information providers need in their routine interaction with MassHealth and its members.

408.401: Introduction

130 CMR 408.000 contains regulations governing adult foster care services under MassHealth. All adult foster care providers participating in MassHealth must comply with 130 CMR 408.000 and 450.000.

408.402: Definitions

The following terms used in 130 CMR 408.000 have the meanings given in 130 CMR 408.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 408.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 408.000 and 450.000.

Adult Foster Care (AFC) – services ordered by a physician delivered to a member in a qualified setting as described in 130 CMR 408.435 by a multidisciplinary team and qualified AFC caregiver, that includes assistance with ADLs, IADLs, other personal care as needed, nursing services and oversight, and AFC care management.

Activities of Daily Living (ADLs) – fundamental personal-care tasks that are performed as part of an individual's routine of self-care. ADLs include, but are not limited to, eating, toileting, dressing, bathing, transferring, and ambulation.

Adult Foster Care Caregiver – a person who is selected, supervised, and paid by the AFC provider for the provision of direct care in accordance with 130 CMR 408.415(A).

Adult Foster Care Plan of Care – an individualized, written description of activities developed to furnish care that meets the individual's medical, physical, emotional, and social needs, based on clinical and psychosocial assessments. The AFC plan of care is prepared by the AFC provider's registered nurse with input from the AFC care manager, member, and AFC caregiver.

Adult Foster Care Provider – an organization that meets the requirements of 130 CMR 408.000 and that contracts with MassHealth as the provider of AFC.

Alternative Placement – a short-term placement of up to 14 days per calendar year during which a member receives AFC from an alternative care provider when the AFC caregiver is temporarily unavailable or unable to provide care.

Clinical Assessments – evaluations by qualified professionals that determine a member's level of need and serve as the basis for development of the AFC plan of care. Clinical assessments include, but are not limited to, Minimum Data Set – Home Care (MDS-HC) or Comprehensive Data Set (CDS), and any other nursing, fall risk, nutritional, and skin assessments.

Family Member – a spouse, parent of a minor member, including adoptive parent, or any legally responsible relative of the member.

Instrumental Activities of Daily Living (IADLs) – activities related to independent living that are incidental to the care of the member and that include, but are not limited to, household-management tasks, laundry, shopping, housekeeping, meal preparation and cleanup, transportation (accompanying the member to medical providers and other appointments), care and maintenance of wheelchairs and adaptive devices, medication management and any paperwork required for receiving prescribed medications within the AFC setting, or any other medical need determined by the AFC provider as being instrumental to the health care and general well-being of the member.

Intake and Assessment Services – services provided to a member who has been referred to an AFC program for AFC services. These services include, but are not limited to, assessment of the need for AFC services; reviewing and approving AFC caregiver applicants; matching the member with the most appropriate AFC caregiver; instruction in the rules, policies, and procedures of the AFC program; evaluation of the qualified setting, including conducting on-site interviews in the qualified setting; scheduling meetings with the member and potential AFC caregiver; instruction in the member's rights and responsibilities when using AFC services; instruction and initial training of AFC caregivers; and setting up the member's move-in date with the AFC caregiver.

Medical Leave of Absence (MLOA) – a short-term absence of up to a total of 40 days per calendar year during which a member does not receive AFC from the AFC caregiver because the member is temporarily admitted to a hospital or nursing facility.

Multidisciplinary Professional Team – a team comprising, at a minimum, a registered nurse and care manager who work for the AFC provider.

Nonmedical Leave of Absence (NMLOA) – a short-term absence of up to a total of 15 days per calendar year during which a member does not receive AFC from the AFC caregiver because the member is away from the AFC-qualified setting for nonmedical reasons.

Significant Change – a major change in the member's health status that:
(1) is not self-limiting (temporary) but permanent;
(2) impacts more than one area of the member's health status; and
(3) requires a multidisciplinary review or revision of the AFC plan of care.

408.403: Eligible Members

(A) (1) MassHealth Members. The MassHealth agency pays for AFC only when provided to eligible members 16 years of age or older, subject to the restrictions and limitations described in MassHealth regulations. 130 CMR 450.105 specifically states, 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.

408.404: Provider Eligibility

(A) An organization seeking to participate in MassHealth as a provider of AFC must:

(1) maintain a business office in Massachusetts and be duly authorized to conduct a business in Massachusetts that delivers health and human services to elderly or disabled adult populations;

(2) accept MassHealth payments as payment in full for all AFC services;

(3) establish, maintain, and comply with written policies and procedures, including but not limited to:

(a) recruitment, selection, training, management, and employment of appropriate and qualified personnel to meet the AFC personnel qualifications and responsibilities set forth in 130 CMR 408.433;

(b) the evaluation of AFC caregivers and qualified settings in accordance with 130 CMR 408.434 and 130 CMR 408.435;

(c) matching and placement criteria for members and AFC caregivers;

(d) the admission and clinical assessment of each member and the coordination of the AFC plan of care with the primary-care physician and others involved in the care of the member;

(e) transferring a member to a different AFC caregiver or to a different residential setting in which AFC or other needed personal care is available; and

(f) discharging and ensuring continuity of necessary care for a member;

(4) submit a written description of AFC offered by the AFC provider and its care objectives;

(5) meet all provider participation requirements described in 130 CMR 408.000 and 450.000; and

(6) agree to pay AFC caregivers on a timely basis for services provided at applicable compensation levels.

(B) The MassHealth agency requires documentation from applicants seeking to become AFC providers. All required application documentation must be submitted and approved in order to participate as an AFC provider in MassHealth. All required MassHealth application documentation will be specified by the MassHealth agency.

(C) The MassHealth agency may conduct periodic inspections of AFC providers to ensure compliance with all provider participation requirements described in 130 CMR 408.000 and 450.000. An AFC provider must cooperate with any inspection and furnish any requested records.

(130 CMR 408.405 through 408.414 Reserved)

408.415: Scope of Adult Foster Care Services

(A) Direct Care. The AFC provider must ensure the delivery of direct care to members in a qualified setting as described in 130 CMR 408.415 by a qualified AFC caregiver, as described in 130 CMR 408.434, who lives in the residence and who is selected, supervised, and paid by the AFC provider. AFC must be ordered by a physician and delivered by an AFC caregiver under the supervision of the multidisciplinary professional team in accordance with a written plan of care. AFC includes 24-hour supervision, assistance with ADLs and IADLs as defined in 130 CMR 408.402, and other personal care as needed.

(B) Nursing Services and Oversight. The AFC provider must provide nursing coverage by a registered nurse in compliance with 130 CMR 408.433(B)(2). Nursing services must be individualized to meet the needs of each member and must include all of the following activities:

(1) completing a nursing assessment;
(2) coordinating all other applicable clinical assessments;
(3) developing the member's AFC plan of care;
(4) conducting on-site visits with each member at the qualified setting:
  (a) for Level I, bimonthly (alternating with the bimonthly visit by the care manager);
  (b) for Level II, monthly, or more often as the member's condition warrants;
(5) completing a nursing progress note for each on-site visit or encounter and upon significant change;
(6) monitoring each member's health status and documenting those findings in the member's medical record for each on-site visit or encounter, or more often as the member's condition warrants;
(7) educating the member about hygiene and health concerns;
(8) reporting changes in the member's condition to the member's physician;
(9) coordinating the implementation of physician's orders with the member, AFC caregiver, and AFC provider personnel; and
(10) evaluating, supporting, and training the AFC caregiver.

(C) Care Management. The AFC provider is responsible for planning, coordinating, and monitoring the member's AFC. Care management includes:

(1) conducting an initial psychosocial assessment and evaluation of a member's appropriateness for AFC, with ongoing monitoring as needed;
(2) evaluating, supporting, and training the AFC caregiver;
(3) ensuring implementation of the AFC plan of care;
(4) conducting on-site visits with each member at the qualified setting:
  (a) for Level I, bimonthly (alternating with the bimonthly visit by the registered nurse);
  (b) for Level II, monthly;
(5) completing a care-management progress note corresponding with each on-site visit or encounter and upon significant change;
(6) conducting regular, periodic evaluations and assessments, at least annually, to ensure that each qualified setting where AFC is provided meets the requirements of 130 CMR 408.435;

(7) making referrals to appropriate service providers if a member requires health or social services other than AFC;
(8) providing timely assistance and responding to urgent or emergency needs of the member; and
(9) developing an emergency backup and personal care contingency plan for each member, that includes an alternative care plan for the member if the AFC caregiver is temporarily unavailable or unable to provide care.

408.416: Clinical Authorization for MassHealth Payment

(A) The AFC provider must request clinical authorization from the MassHealth agency as a prerequisite to payment for AFC. In determining clinical authorization, the MassHealth agency will apply the criteria set forth in 130 CMR 408.417. 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 financial eligibility or use of other potential sources of payment as described in 130 CMR 503.007 and 517.008.

(B) An AFC provider must obtain clinical authorization before the first date of service upon original admission, transfer from one AFC provider to another, or readmission if there has been a six-month gap in the delivery of AFC services.

(C) The AFC provider must submit requests for authorization of payment for AFC 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. This must include a designated screening tool that must be completed and signed by a registered nurse. In addition, the AFC provider must include a statement documenting its assessment that the AFC provider can safely and appropriately care for the member in a qualified setting that meets the requirements of 130 CMR 408.435.

408.417: Clinical Criteria for MassHealth Payment

To obtain clinical authorization for MassHealth payment of AFC, all of the following clinical criteria must be met:

(A) A physician must have written an order for AFC.

(B) The member must have a medical or mental condition that requires daily physical assistance or cueing and supervision during the task in order for the member to complete successfully at least one of the following activities:
(1) bathing (full-body bath or shower);
(2) dressing, including street clothes and undergarments, but not solely help with shoes, socks, buttons, snaps, or zippers;
(3) toileting, if the member is incontinent (bladder or bowel) or requires scheduled assistance or routine catheter or colostomy care;

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

408.418: Notice of Approval or Denial of Clinical Authorization Request

(A) Notice of Approval. When the MassHealth agency approves a request for clinical authorization using the criteria outlined in 130 CMR 408.417, it sends written notice to the member and the AFC provider.

(B) Notice of Denial and Right of Appeal.
(1) If the request for clinical authorization of AFC is denied, the MassHealth agency notifies both the member and the AFC provider. The denial notice states the reason for the denial and contains information about the member's right to appeal and the appeal procedure.
(2) A member may appeal a denial by requesting a fair hearing from the MassHealth agency. The request for a fair hearing must be made in accordance with the requirements described in 130 CMR 610.015(B). The MassHealth agency's Board of Hearings will conduct the hearing in accordance with 130 CMR 610.000.

408.419: Conditions for Payment

(A) The MassHealth agency pays an AFC provider for AFC in accordance with the applicable payment methodology and rate schedule established by the Division of Health Care Finance and Policy or by the MassHealth agency. Rates of payment for AFC do not cover or include any payment for room and board.

(B) Payment for services is subject to the conditions, exclusions, and limitations set forth in 130 CMR 408.000 and 450.000.

(C) The MassHealth agency pays an AFC provider for AFC only if
(1) the AFC is medically necessary;
(2) the member meets the clinical criteria for MassHealth payment; and
(3) the AFC provider has obtained clinical authorization for MassHealth payment in accordance with the requirements set forth in 130 CMR 408.416 and 408.417.

(D) The MassHealth agency pays for the following two levels of AFC services.

(1) Level I. The MassHealth agency pays for AFC services at Level I for members who meet the clinical eligibility requirements described in 130 CMR 408.417.

(2) Level II. In addition to Level I AFC services, the MassHealth agency pays for AFC at Level II if a member requires

(a) physical assistance with three of the activities described in 130 CMR 408.417(B)(1) through (6); or

(b) physical assistance with two of the activities described in 130 CMR 408.417(B)(1) through (6) and management of behaviors that require caregiver intervention as described below:

(i) wandering: moving with no rational purpose, seemingly oblivious to needs or safety;

(ii) verbally abusive behavioral symptoms: threatening, screaming, or cursing at others;

(iii) physically abusive behavioral symptoms: hitting, shoving, or scratching;

(iv) 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, or causing general disruption; or

(v) resisting care.

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

(F) Once a member has been determined to meet the minimum standard for coverage of AFC, the provider may submit claims for either Level I or Level II.

(1) The determination of what service level is paid for must be done on admission, annually, and when there is a significant change in the member's clinical status. The AFC provider must use the assessment form designated by the MassHealth agency to document the need for Level I or Level II.

(2) The AFC provider must assess the member's clinical status annually and when there is a significant change in the member's clinical status. The AFC provider must bill the MassHealth agency at the Level I rate until the determination of service level indicates that the member's condition requires Level II.

(3) The AFC provider must maintain documentation in the member's medical record that reflects the member's service level.

(G) MassHealth payment to AFC providers begins on the later of:

(1) the effective date of the clinical authorization from the MassHealth agency; or

(2) the first date on which AFC is provided to the member.

(H) The MassHealth agency pays an intake and assessment rate for services provided to members who have been referred for AFC services. This rate is payable only once per member per provider as a preadmission service payment. Intake and assessment services are outlined in 130 CMR 408.431(A).

(I) MassHealth payment to an AFC provider ends on the date on which a member no longer meets the clinical criteria described in 130 CMR 408.417 or is no longer receiving AFC services.

(J) The MassHealth agency pays an AFC provider for days that an eligible member receives AFC. An AFC provider may not bill for non-service days and the MassHealth agency does not pay for any period during which an eligible member does not receive AFC, with the exception of a medical leave of absence, a nonmedical leave of absence, and alternative placement days.

(K) The MassHealth agency pays for a maximum of 40 days each calendar year for medical leave of absence and up to 15 days each calendar year for nonmedical leave of absence. Any unused leave-of-absence days follow the member when transferring from one AFC provider to another AFC provider.

(L) An AFC provider may bill for up to 14 short-term alternative-placement days per member per calendar year. Any unused alternative-placement days follow the member when transferring from one AFC provider to another AFC provider.

(130 CMR 408.420 through 408.429 Reserved)

408.430: Adult Foster Care Provider Responsibilities

In addition to meeting all of the qualifications set forth in 130 CMR 408.000 and 450.000, the AFC provider must meet all of the following requirements.

(A) Policies and Procedures Manual. Each AFC provider must develop, maintain, review annually, and update a comprehensive policies and procedures manual governing the delivery of services. Each manual at a minimum must contain written policies and procedures on the following:

(1) administrative policies and procedures, including but not limited to:
- (a) human resource and personnel policies and procedures;
- (b) personnel requirements;
- (c) staff training;
- (d) fire and safety;
- (e) member rights;
- (f) nondiscrimination;
- (g) incident and accident reporting;
- (h) outreach and marketing of the AFC;
- (i) alternative-care arrangements for members when the AFC caregiver is temporarily absent or temporarily unable to provide care;
- (j) staff, AFC caregiver, and member grievances;
- (k) cultural competency;
- (l) quality assurance and improvement;
- (m) caregiver training;
- (n) emergency services and plans;
- (o) notifying the fire department and police in emergencies;
- (p) relocating members in an emergency; and
- (q) procedures to be followed if a member is missing or lost; and

(2) clinical policies and procedures, including, but not limited to:
- (a) confidentiality;
- (b) 24-hour emergency coverage, including medical and other emergencies;
- (c) documentation of visits and progress notes;
- (d) medication management;
- (e) universal precautions;
- (f) communicable disease;
- (g) recognizing and reporting elder or member abuse;
- (h) AFC provider staff and AFC caregiver evaluation and monitoring; and
- (i) member and caregiver counseling.

(B) Clinical Assessments. The AFC provider's multidisciplinary team must complete an MDS-HC or CDS and all other applicable clinical assessments on all members. The MDS-HC or CDS must be completed prior to admission. Other applicable clinical assessments must be completed

(1) upon significant change; and

(2) annually on the anniversary date of the member's admission.

(C) AFC Plan of Care. The plan of care must contain measurable goals and objectives and reflect the clinical assessment of needs, current care and treatment, problem identification with appropriate follow-up, and implementation with interventions and evaluation.

(1) The AFC provider's multidisciplinary professional team must develop an AFC plan of care for the member within 30 days of admission. The plan of care must be signed by the registered nurse, and must include

(a) a treatment plan describing how the member's service needs are going to be met 24 hours a day, seven days a week, that is based on the member's physician's summary, physical examination, nursing assessments, and all other applicable clinical assessments;

(b) an assessment, completed by the multidisciplinary team, of the member's ability to manage safely in the qualified setting for a maximum of three hours a day without the presence of a qualified caregiver; and

(c) documentation of any other health services or supportive services the member is receiving from the MassHealth agency or other agencies or organizations (for example, visiting nurse services, therapy services, DMR services, DMH services, or counseling services).

(2) The plan of care must include

(a) the AFC caregiver's log of care provided;

(b) the nursing progress notes;

(c) the care manager's progress notes;

(d) the physician's summary and approval to participate in AFC;

(e) the member's physical examination; and

(f) the member's discharge plan.

(3) The AFC provider's registered nurse must send a copy of the updated plan of care and a copy of the member's semiannual health-status report to the member's physician for review and approval.

(D) Recordkeeping. The AFC provider must maintain records in compliance with the record retention requirements set forth in 130 CMR 450.205. All records, including but not limited to the following, must be accessible and made available on site for inspection by the MassHealth agency:

(1) administrative records, including

(a) payroll and personnel records;

(b) financial records;

(c) member utilization;

(d) staffing levels;

(e) complaints and grievances;

(f) qualified setting file;

(g) AFC caregiver file; and

(h) contracts for subcontracted services;

(2) member records, which must contain at a minimum all of the following:

(a) initial referral and admission information, including

(i) the member information sheet;

(ii) the clinical authorization for payment by the MassHealth agency or its agent; and

(iii) clinical assessments;

(b) medical information, including
(i) a copy of the most recent physical examination (within the past 12 months);
(ii) the physician's authorization and summary;
(iii) the member's semiannual health-status report;
(iv) medical history;
(v) tuberculosis screening documentation;
(vi) a list of any known allergies;
(vii) information about the member's dietary requirements;
(viii) a list of current medications;
(ix) clinical assessments; and
(x) if designated by the member, advance directives and the name of the health-care proxy;

(c) progress notes, including
(i) nursing notes;
(ii) care manager notes; and
(iii) caregiver service documentation (log of care received);

(d) correspondence from family, therapists, physicians, or others about the care of the member in the program;
(e) the discharge plan;
(f) legal documentation, for example, signed authorizations for release of information;
(g) the AFC plan of care;
(h) incident and accident reports; and
(i) the member's post-discharge status and condition.

(E) Reporting.
(1) The AFC provider must immediately notify the MassHealth agency of any of the following incidents and follow up in writing within three business days:
(a) the death of a member;
(b) a fire or other natural or unnatural disaster in either the qualified setting or the AFC administrative office;
(c) a life-threatening accident or incident;
(d) a serious communicable disease contracted by AFC staff, an AFC caregiver or a member; and
(e) an allegation of abuse or neglect.

(2) The AFC provider must submit all of the following information in the format and time frames required by the MassHealth agency:
(a) clinical and statistical information;
(b) member incidents or accidents;
(c) cost and expense information; and
(d) member satisfaction survey results and a description of how the findings will be addressed.

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

(G) Quality Improvement Plan. Each AFC provider must conduct a biennial survey of members, caregivers, and staff and develop a quality improvement plan that addresses issues and concerns raised by the survey.

408.431: Preadmission and Admission Procedures

(A) Preadmission Procedures. Before admitting a member, the AFC provider must perform all of the following intake and assessment services. Intake and assessment services are provided to members who have been referred to an AFC provider but who have not yet been authorized for payment by the MassHealth agency for AFC. The AFC provider must

(1) conduct a preadmission meeting with the member, and if applicable or requested, the member's family, other informal caregivers, and any other health or social service provider involved in the member's care. The AFC provider must use the meeting to obtain information about the member's overall health characteristics, psychosocial condition, nutritional habits, financial and health insurance information, housing situation, formal and informal supports in place, and ethnic and cultural background. The AFC provider must also use this meeting to inform the member and the member's family about the scope of AFC services to be provided and any other relevant information;
(2) identify appropriate potential AFC caregivers and qualified settings;
(3) schedule meetings with the member and potential AFC caregiver;
(4) match the member with the most appropriate potential AFC caregiver;
(5) provide information on the member's rights and responsibilities when using AFC services;
(6) provide instruction and initial training of AFC caregivers;
(7) schedule the member's move-in date with the AFC caregiver; and
(8) submit a request for authorization of MassHealth payment in accordance with the requirements set forth in 130 CMR 408.416;

(B) Admission Procedures. Upon admission, the AFC provider must perform the following activities.

(1) Complete and submit a written notification to the member and, if appropriate, the member's legal guardian. The notice must at a minimum specify the following:
(a) the services offered to the member by the AFC provider;
(b) the member's AFC plan of care;
(c) the respective responsibilities of the member and the member's family, the AFC provider, and the AFC caregiver;
(d) emergency procedures; and
(e) reasons for discharge from the AFC provider.
(2) Create a member record. By the first day of AFC services, the AFC provider must obtain all the necessary documentation from the member's physician and other service providers. The documentation must include
(a) the physician's authorization for AFC;
(b) the member's medical history;
(c) results of a physician's visit within the past three months;

(d) results of a physical examination given within the past 12 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;
(e) a list of current medications, treatments, and other services provided;
(f) a statement of special dietary requirements;
(g) a statement indicating any contraindications or limitations to the individual's participation; and
(h) recommendations for other services, when applicable.

(3) Conduct on-site visits according to the member's AFC level.
(a) For Level I, the visit must be conducted on the day of admission by the registered nurse or care manager.
(b) For Level II, the visit must be conducted by the AFC provider's registered nurse on the day of admission and weekly for the first 30 days.

408.432: Discharge Procedures

(A) A member may be discharged upon the member's request, by the AFC provider, or when the member ceases to benefit from AFC, including the following circumstances:
(1) the member no longer meets the clinical criteria for MassHealth payment for AFC;
(2) the member demonstrates behavioral or other problems that may endanger himself or herself, the AFC caregiver, or AFC provider staff; or
(3) the member's needs cannot be met by the AFC provider.

(B) For all discharges, the AFC provider must:
(1) develop a discharge plan. The discharge plan must:
(a) include the date and reason for discharge;
(b) identify any referrals by the AFC provider to other appropriate service providers for any health or social services required by the member;
(c) ensure continuity of needed care by the member;
(d) be dated and signed by the registered nurse and the AFC care manager; and
(e) require at least one follow-up telephone call within 30 business days after discharge to determine the member's post-discharge status and condition;
(2) arrange for the member to be discharged to a more appropriate setting;
(3) coordinate the discharge with the member, member's family or legal guardian, and staff of the program or agency to which the member is to be transferred; and
(4) not discharge the member until appropriate services are available.

408.433: Adult Foster Care Personnel Qualifications and Responsibilities

(A) General Personnel Requirements. The AFC provider must:

(1) check the candidate's references and job history and ensure that the candidate meets all of the required experience, education, and qualifications before hiring;

(2) conduct a Criminal Offender Records Information (CORI) check and determine whether any offender records may disqualify the individual for employment;

(3) ensure that each AFC staff person has satisfactorily completed a pre-employment physical examination and received a tuberculosis screening within the previous 12 months;

(4) ensure that all staff receive tuberculosis screening every two years;

(5) ensure that all staff are appropriately trained and managed;

(6) have available at all times a sufficient number of educated, experienced, trained, and competent personnel to provide AFC to elderly or disabled adults;

(7) evaluate staff annually using standardized evaluation measures; and

(8) maintain a record of each performance evaluation in a separate personnel file for each staff member.

(B) Multidisciplinary Professional Team. Each AFC provider must have a multidisciplinary professional team to meet the nursing, oversight, and care-management needs of members. The multidisciplinary professional team must include a registered nurse and an AFC care manager, either of which may assume the role of program director. The multidisciplinary professional team staff must provide a minimum of 3.5 hours of service per member per week. For employees or independent contractors, the AFC provider must maintain a job description that includes the title, reporting authority, qualifications, and responsibilities.

(1) Program Director. The AFC provider must employ a program director who is a health-care professional.

(a) Qualifications. The program director must have a bachelor’s degree and a minimum of five years of professional health-care experience working with elderly or disabled adults. A master’s degree in a relevant health-care discipline may be substituted for two of the required five years of work experience. At least one of those years must have been spent in an administrative role.

(b) Responsibilities. The responsibilities of the program director include

(i) development and implementation of the AFC provider's policies and procedures as set forth in 130 CMR 408.430(A);

(ii) direction and supervision of all aspects of the AFC program;

(iii) oversight of the hiring, training, supervision, firing, and evaluation, of all AFC employees and independent contractors;

(iv) payment of all AFC caregivers for their services;

(v) the fiscal administration of the AFC program including billing, budget preparation, and required program statistical and financial reports; and

(vi) ensuring that the AFC provider meets all of the requirements in 130 CMR 408.000 and 450.000.

(2) Registered Nurse. The AFC provider must employ or independently contract with a registered nurse. The registered nurse may function as the program director.

(a) Qualifications. The registered nurse must be fully licensed by the Massachusetts Board of Registration in Nursing. The registered nurse must have at least two years' recent experience in the direct care of the elderly or disabled adults.

(b) Responsibilities. The responsibilities of the registered nurse include:

(i) completing and signing the designated screening tool as required under 130 CMR 408.416(C) for MassHealth payment;

(ii) completing the MDS-HC or CDS and other nursing assessments and coordinating all other applicable clinical assessments;

(iii) developing and reviewing on an ongoing basis each member's AFC plan of care;

(iv) selecting, training, evaluating, and supervising AFC caregivers in conjunction with the care manager;

(v) reviewing the physician summary;

(vi) monitoring the health status of all members to ensure that all needed AFC is properly delivered;

(vii) reporting changes in the health status of any member to the member's physician;

(viii) periodically reviewing AFC caregiver logs;

(ix) conducting on-site visits with each member at the qualified setting bimonthly (alternating with the bimonthly visit by the care manager) for Level I, and monthly or more often as the member's condition warrants for Level II;

(x) completing a nursing progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;

(xi) submitting a semiannual health-status report to the member's primary care physician;

(xii) planning for and implementing discharges from the AFC program;

(xiii) conducting an orientation for each AFC caregiver before the AFC caregiver begins personal care; and

(xiv) providing ongoing training to AFC caregivers on health and aging.

(3) AFC Care Manager. The AFC provider must employ a care manager to provide psychosocial and counseling assistance for the AFC program. The AFC care manager may function as the program director.

(a) Qualifications. The care manager must have

(i) a bachelor's degree, a social worker license from the Massachusetts Board of Registration in Social Work, and at least two years' recent experience working with elderly or disabled adults; or

(ii) a bachelor's degree and two years' clinical experience in the care of elderly or disabled persons.

(b) Responsibilities. The responsibilities of the care manager include
(i) conducting the initial and ongoing assessments of the AFC qualified setting;
(ii) obtaining a social history and conducting a psychosocial assessment and evaluation;
(iii) selecting, training, evaluating, and supervising AFC caregivers in conjunction with the registered nurse;
(iv) participating in the development, implementation, and ongoing review of the AFC plan of care;
(v) conducting on-site visits with each member at the qualified setting bimonthly (alternating with the bimonthly visit by the registered nurse) for Level I, and monthly for Level II;
(vi) completing a care-management progress note corresponding with each on-site visit or encounter and upon significant change;
(vii) periodically reviewing AFC caregiver logs;
(viii) assisting with obtaining information and accessing other health-care and community services;
(ix) reviewing and documenting the fire and safety procedures for the qualified setting;
(x) participating in discharge planning and implementation; and
(xi) reviewing at least annually the suitability of the qualified setting.

(D) AFC Personnel Training Requirements.
(1) AFC providers must provide initial and periodic training to all staff who are responsible for the care of a member. Records of completed training must be kept on file and updated regularly by AFC providers.
(2) AFC providers must hold an orientation for new staff within one month of hire. This orientation must include the following topics:
(a) delivery of AFC services by the AFC provider;
(b) written policies and procedures of the AFC provider;
(c) the requirements of 130 CMR 408.000;
(d) the roles and responsibilities of AFC provider staff;
(e) behavioral interventions, behavior acceptance, and accommodations;
(f) the completion of a caregiver log;
(g) cardiopulmonary resuscitation (CPR) and first aid;
(h) infection control and safety practices;
(i) information about local health, fire, safety, and building codes;
(j) privacy and confidentiality;
(k) multidisciplinary team approach;
(l) medication management;
(m) communication skills;
(n) advance directives;
(o) abuse identification and reporting;
(p) good body mechanics;
(q) cultural sensitivity;
(r) universal precautions; and
(s) emergency procedures, including the AFC provider's fire, safety, and disaster plans.

408.434: Adult Foster Care Caregiver Qualifications and Responsibilities

(A) General Requirements. The AFC provider must
(1) uniformly administer an evaluation of all prospective AFC caregivers to ensure that the individuals meet all of the necessary qualifications defined in 130 CMR 408.434(B);
(2) conduct a Criminal Offender Records Information (CORI) check and determine whether any offender records may disqualify the individual from performing as an AFC caregiver;
(3) ensure that each AFC caregiver has satisfactorily completed a physical examination, received a tuberculosis screening within the prior 12 months, and thereafter receives tuberculosis screening every two years while employed with the AFC provider;
(4) employ or independently contract with an AFC caregiver;
(5) ensure that the AFC caregiver is not serving more than a total of three persons, no more than two of whom require Level II AFC services, in the qualified setting regardless of service provided or payer source; and
(6) ensure that all AFC caregivers are appropriately trained and managed.

(B) Qualifications. Each AFC caregiver must
(1) be a responsible person who is at least 18 years of age, with the ability to make mature and accurate judgments and with no mental, physical, or other impairments that would interfere with the adequate performance of the duties and responsibilities of an AFC caregiver;
(2) not abuse alcohol or drugs;
(3) be able to devote appropriate time necessary to provide needed personal care to the member to ensure the member's safety and well-being at all times;
(4) not be a family member, as defined in 130 CMR 408.402; and
(5) meet all other requirements established by the AFC provider for an AFC caregiver.

(C) Responsibilities. The responsibilities of the AFC caregiver include
(1) supervision and assistance with ADLs, IADLs, and any other personal care of a member that is necessary for the member's health and well-being;
(2) monitoring and reporting any nonurgent or nonemergency changes in the member's medical condition to the member's AFC provider. In cases of emergency, report directly to the most appropriate provider and follow up with the AFC provider;
(3) maintenance of the qualified setting consistent with the requirements of 130 CMR 408.435;
(4) completing a caregiver log;
(5) sending the completed caregiver log at the end of each month to the program's registered nurse where it is maintained as part of the member's file;
(6) providing ongoing supervision of health-related activities, such as:
(a) issuing reminders to the member about prescribed medications;
(b) timely refilling of the member's prescriptions;
(c) assisting with or arranging for member transportation to medical and other appointments;
(d) assisting the member to comply with health-care instructions from health-care providers; and
(e) promptly arranging for needed medical care;

(7) notifying the AFC provider of the need for alternative care of the member; and
(8) immediately notifying the AFC provider when any of the following events occur:
(a) death of a member;
(b) a medical emergency or any significant change in a member's health or level of functioning;
(c) a fire, accident, injury, or contraction of a serious communicable disease by the member or AFC caregiver;
(d) any planned or unexpected departure from the residence by a member or AFC caregiver; and
(e) all other member or caregiver incidents or accidents.

(D) AFC Caregiver Training Requirements.
(1) AFC providers must provide AFC caregivers a minimum of eight hours of in-service training sessions per year.
(2) Records of completed training must be kept on file and updated regularly by AFC providers. The initial orientation training sessions must include the following topics:
(a) delivery of ADLs, IADLs, and any other personal care;
(b) delivery of AFC by the AFC provider;
(c) written policies and procedures of the AFC provider;
(d) the requirements of 130 CMR 408.000;
(e) the roles and responsibilities of AFC provider staff and AFC caregivers;
(f) behavioral interventions, behavior acceptance, and accommodations;
(g) cardiopulmonary resuscitation (CPR) and first aid;
(h) infection control and safety practices;
(i) privacy and confidentiality;
(j) communication skills;
(k) advance directive policies;
(l) elder and disabled persons abuse identification and reporting;
(m) good body mechanics;
(n) cultural sensitivity;
(o) universal precautions; and
(p) emergency procedures, including the AFC provider's fire, safety, and disaster plans.
(3) The ongoing annual training curriculum must include, at a minimum, eight hours of training that complements or reinforces the topics listed above.

408.435: Adult Foster Care Qualified Setting Requirements

Any residence where AFC is provided must be qualified by the AFC provider and meet the setting requirements of 130 CMR 408.435(A) through (D).

(A) The setting must be

(1) a private residence located in Massachusetts, occupied by the AFC caregiver, and not subject to state licensure or certification as a hospital, nursing facility, rest home, group home, intermediate care facility for the mentally retarded, or assisted living residence;

(2) accessible to meet the specific needs of its residents, including the specific needs of any physically disabled member. The provider may consult the Architectural Barriers Board Guidelines;

(3) compliant with local health, fire, safety, occupancy, and state building codes for dwelling units in accordance with 780 CMR 36.02;

(4) equipped with appropriate safety equipment, including, at a minimum, an easily accessible Class ABC fire extinguisher and an emergency first-aid kit on the premises;

(5) adequately heated and clean;

(6) in good repair, with the exterior of the residence showing adequate maintenance in regard to paint, stairs, railings, windows, screens, storm windows, and grounds; and

(7) occupied by no more than three people, no more than two of whom require Level II AFC services, regardless of type and payment source.

(B) The qualified setting must show evidence of regular household maintenance. All interior floors, ceilings, walls, and furnishings must be free of vermin, clean, in good repair, and adequately maintained, including, but not limited to, the following.

(1) Kitchen Area. The refrigerator and stove must be clean. Storage areas must be clean, tidy, and adequate in size. Food must be safe both with respect to where and how it is purchased and to storage, cooking, and dish and utensil sanitation. There must be prompt disposal of trash. There must be a functioning fire extinguisher within easy reach in case of fires.

(2) Bathroom. The showers, bathtubs, toilets, and sinks must be clean and in safe working order. There must be adequate hot water daily for bathing and washing. There must be an adequate supply of clean towels and personal-care supplies. The bathroom must be accessible without disturbing the private space of another occupant. Handrails must be installed as needed.

(3) Member's Bedroom.

(a) The bedroom must have a door to ensure privacy. The bed may not be a cot. The box spring, mattress, and pillows must be in good condition and may not be stained. The mattress and pillows must have covers. Bed linens must be changed weekly or more often if necessary. The room must also contain a bureau, closet or wardrobe with hangers, chair, bedside table and lamp, a mirror, and nonskid floor covering. There must be at least one window.

(b) The member must have his or her own bedroom or share the bedroom with

(i) only one other adult of the same sex; or

(ii) the member's spouse or significant other.

(4) Ventilation. Windows must be screened in the warmer months. Storm windows must be used in the colder months. The living areas must be free of drafts.
(5) Lighting. Lighting must be adequate and switches must be easily accessible. Wiring may not be exposed anywhere in the home. Extension cords, if used, must not be a safety hazard.
(6) Stairs. Stairs that are located inside or outside the home must have a railing.
(7) Heat. The home must be adequately heated.

(C) The qualified setting must have the following safety and fire protections.
(1) Hallways used by members must have night-lights.
(2) There must be a written, predetermined fire evacuation plan for exiting the home in an emergency. The evacuation plan must be reviewed every other month with the member.
(3) The member must have an unobstructed fire escape route out of the home.
(4) Fire and carbon monoxide detectors must be installed and operable in the home. When activated, the alarms must be audible in sleeping areas.
(5) Periodic fire drills must be conducted during which the member must be instructed in following the available escape routes.

(D) The qualified setting must provide meals in accordance with the following requirements.
(1) There must be a daily meal plan that will provide the member's daily nutritional needs according to the recommended daily allowance established by the American Dietary Association. The meal plan must outline how the member's meals are being provided on a regular basis.
(2) Meals must be served at regular intervals and may be provided outside the qualified setting.
(3) The AFC caregiver must be tolerant of the member's ethnic or religious preferences in food.
(4) The AFC caregiver must be aware of the member's dietary restrictions.
(5) Alternative meal choices and snacks must be stored and made available to the member on a regular basis.
(6) The member must receive a minimum of three meals and two snacks a day unless otherwise approved by the registered nurse.

408.436: Emergency Services and Plans

The AFC provider must establish written plans for medical and other emergencies. Emergency plans must include, at a minimum, the following:

(A) an easily accessible file for each member listing the member's name, telephone number of the member's physician, special medical needs, including treatments and medications, and emergency phone numbers for notification of the family or legal guardian;

(B) a written Continuity of Operations Plan (COOP) that follows the guidelines from the Department of Public Health; and

(C) a written disaster plan for evacuating the qualified setting in the event of a fire, flood, or other natural or unnatural disaster.

408.437: Noncovered Days

The MassHealth agency does not pay an AFC provider when

(A) the member is receiving any other personal care services, including, but not limited to, personal care services under 130 CMR 422.000 and home care services under the Executive Office of Elder Affairs regulation 651 CMR 3.03(5);

(B) the member is a resident or inpatient of a hospital, nursing facility (with the exception of MLOA or alternative placement days), rest home, group home, intermediate care facility for the mentally retarded, assisted living residence, or any other residential facility subject to state licensure or certification; or

(C) the AFC provider has not received clinical authorization from MassHealth.

408.438: Withdrawal by an Adult Foster Care Provider from MassHealth

An AFC provider that intends to withdraw from MassHealth must satisfy all of the following obligations.

(A) MassHealth Agency Notification.
(1) An AFC provider electing to withdraw from participation in MassHealth must give written notice of its intention to withdraw to the MassHealth agency. The AFC provider must send the withdrawal notice by certified or registered mail (return receipt requested) to the MassHealth Adult Foster Care Unit. The notice must be received by the MassHealth agency no less than 90 days before the effective date of withdrawal.
(2) If such withdrawal results from a situation beyond the control of the AFC provider, such as fire or natural or unnatural disaster, the AFC provider must notify the MassHealth agency immediately by phone and follow up in writing within three calendar days. The burden of proof to demonstrate an emergency is on the AFC provider. The AFC provider must notify the MassHealth agency in writing as members are placed in other programs, including the name of the new program and the members' start dates in the new program.

(B) Notification to Member and Family.
(1) The AFC provider must notify all members, guardians, family, and other funding sources in writing of the intended closing date no less than 90 days from the intended closing date and specify the assistance to be provided each member in identifying alternative services.
(2) On the same date on which the AFC provider sends a withdrawal notice to the MassHealth agency, the program must give notice, in hand, to all its members and their authorized representatives, including those members who have been transferred to hospitals, or who are on medical or nonmedical leave of absence. The notice must advise that any member who is eligible for MassHealth on the effective date of the withdrawal must relocate to an AFC provider participating in MassHealth to ensure continuation of MassHealth payment of services and must be determined eligible to continue to receive the services.
(3) The notice must also state that the AFC provider will work promptly and diligently to arrange for the relocation of members to MassHealth-participating AFC providers or, if appropriate, to alternative community-service providers.

(C) Admission and Relocation Requirements.

(1) An AFC provider must not admit any new MassHealth members after the date on which the withdrawal notice was sent to the MassHealth agency.

(2) An AFC provider that withdraws from participation in MassHealth must continue to provide services to members until other services for the members have been arranged.

(3) The AFC provider must work promptly and diligently to arrange for the relocation of members to MassHealth-participating providers. For relocation requirements, see 130 CMR 408.432.

REGULATORY AUTHORITY

130 CMR 408.000: M.G.L. c. 118E, §§ 7 and 12.

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601 Service Codes and Descriptions

Service Code	Modifier	Service Description
S5140		Foster care, adult; per diem (Adult foster care personal care and administration; per diem, Level I)
S5140	TG	Foster care, adult; per diem (Adult foster care personal care and administration; per diem, Level II)
S5140	TF	Foster care, adult; per diem (Adult foster care short-term alternate placement; per diem for caregiver)
T1028		Assessment of home, physical, and family environment, to determine suitability to meet patient's medical needs (Adult foster care intake and assessment services rate; one-time payment per member per provider)

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