4. Program Regulations

130 CMR 408.000: *Adult Foster Care*

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408.401: Introduction

130 CMR 408.000 governs adult foster care services and group adult foster care services provided under MassHealth. All adult foster care providers and group adult foster care providers participating in MassHealth must comply with 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*. Adult foster care services are governed by 130 CMR 408.402 through 408.439. Group adult foster care services are governed by 130 CMR 408.502 through 408.527.

408.402: Definitions

The following terms used in 130 CMR 408.403 through 408.438 have the meanings given in 130 CMR 408.402, unless the context clearly requires a different meaning. Payment for 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: *Administrative and Billing Regulations*.

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

Adult Foster Care (AFC). A service ordered by a primary care provider delivered to a member in a qualified setting as described in 130 CMR 408.435 by a multidisciplinary team (MDT) and qualified AFC caregiver, that includes assistance with ADLs and IADLs, nursing oversight, and AFC care management, as described in 130 CMR 408.415(C).

AFC Alternative Caregiver Days. A short-term period during which a member receives AFC in a qualified setting from an alternative caregiver when the AFC caregiver is temporarily unavailable or unable to provide care.

AFC Caregiver. A person who lives with the AFC member and paid by the AFC provider for the provision of direct care in accordance with 130 CMR 408.415 (A).

AFC Community Support Specialist. A public health worker qualified in accordance with 130 CMR 408.433(D)(1) who applies their unique understanding of the experience, language, or culture of the populations they serve in order to carry out their responsibilities in AFC-qualified settings.

AFC Intake and Assessment Services. Preadmission services provided to a member seeking admission to an AFC program for AFC as described in 130 CMR 408.431(A)(2).

AFC Level I Service Payment. A rate established by the MassHealth agency for members who meet the requirements of 130 CMR 408.419(D)(1).

AFC Level II Service Payment. A rate established by the MassHealth agency for members who meet the requirements of 130 CMR 408.419(D)(2).

Alternative Caregiver. A person who meets all of the qualifications of an AFC caregiver and provides AFC to the member in a qualified setting in the absence of the AFC caregiver.

Assisted Living Residence (ALR). Any entity that meets the requirements for certification pursuant to M.G.L. c. 19D, and 651 CMR 12.00: *Certification Procedures and Standards for Assisted Living Residences*.

Clinical Assessment. The screening process of cataloging a member's need for AFC using a tool designated by the MassHealth agency and that forms the basis for prior authorization.

Clinical Evaluations. Nursing, fall risk, nutritional, skin, and other clinical or psychosocial evaluations conducted by the MDT that serve as the basis for the development of the AFC plan of care.

Executive Office of Health and Human Services (EOHHS). The Executive Office of Health and Human Services established under M.G.L. c. 6A.

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

Hospital. A facility that is licensed or operated as a hospital by the Massachusetts Department of Public Health (DPH) or the Massachusetts Department of Mental Health (DMH) that provides diagnosis and treatment on an inpatient or outpatient basis for patients who have any of a variety of medical conditions.

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 qualified 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.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). A facility, or distinct part of a facility, that provides intermediate care facility services as defined under 42 CFR § 440.150, and that meets federal conditions of participation, and is licensed by the state primarily for the diagnosis, treatment, or rehabilitation for individuals with intellectual disabilities; and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health or rehabilitative services to help individuals function at their greatest ability.

MassHealth. The medical assistance and benefit programs administered by EOHHS pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

Medical Leave of Absence (MLOA). A short-term absence from an AFC-qualified setting, during which a member does not receive AFC services because the member is temporarily admitted to a hospital, nursing facility, or other medical setting.

Member. A person determined by the MassHealth agency to be eligible for MassHealth.

Multidisciplinary Professional Team (MDT). A team employed or contracted by the provider, including, but not limited to, a program director, a registered nurse, or a licensed practical nurse; and a care manager; and which may also include an AFC community support specialist, who works in conjunction with the AFC caregiver.

Nonmedical Leave of Absence (NMLOA). A short-term absence from an AFC-qualified setting, during which a member does not receive AFC services for nonmedical reasons.

Nursing Facility. An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured people, people with disabilities, or sick persons, or on a regular basis, health-related care and services to individuals who, because of their mental or physical condition require care and services that meet the requirements of Sections 1919(a), through (d) of the Social Security Act, and is licensed under and certified by the Massachusetts Department of Public Health.

Plan of Care. A person-centered, written plan based on clinical and psychosocial evaluations, describing activities to meet a member's medical, physical, emotional, and social needs and goals for AFC.

Provider. An organization that meets the requirements of 130 CMR 408.404 and contracts with MassHealth as the provider for AFC.

Primary Care Provider (PCP). A physician or a physician assistant or nurse practitioner who operates under the supervision of a physician.

Primary Care Provider (PCP) Summary Form. The form that a PCP uses to order AFC.

Qualified Setting. A location for the provision of AFC that meets all of the standards described in 130 CMR 408.435.

Resident Care Facility. A facility or distinct units licensed as a level IV by the DPH under 105 CMR 150.000: *Licensing of Long-term Care Facilities* that are not certified to participate in Medicare or Medicaid and that provides a protective living environment and minimum basic care.

Significant Change. A major change in the member's status that
(1) is permanent;
(2) impacts more than one area of the member's health status; and
(3) requires a multidisciplinary review or revision of the care plan. A significant change is presumed when a member authorized to receive AFC services does not receive AFC services for 90 days or more, or when the provider is seeking a change in service amount or payment level.

408.403: Eligible Members

(A) MassHealth Members. MassHealth-eligible members 16 years of age or older, subject to the restrictions and limitations described in 130 CMR 450.105: *Coverage Types* that specifies, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.
(B) 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: *Emergency Aid to the Elderly, Disabled and Children Program*.

(C) MassHealth Member Eligibility and Coverage Type. For information on verifying MassHealth member eligibility and coverage type, *see* 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

408.404: Provider Eligibility

(A) An organization seeking to participate in MassHealth as an AFC provider must
(1) enter into a contract with the MassHealth agency;
(2) maintain a business office in Massachusetts and be duly authorized to conduct a business in Massachusetts that delivers health and human services to elders or people with disabilities. Such business offices must:
(a) be available to members during regular, posted business hours;
(b) be physically accessible to members with disabilities;
(c) have clear access and space for storing of business records;
(d) have a sign visible from outside the facility identifying the business name and hours that the business office is open;
(e) have a publicly listed business name, address, and local toll-free telephone number that is answered by customer service staff during business hours and that has Telecommunication Device for the Deaf/Teletype (TTY/TDD) transmission and reception capability; provided, that during business hours, this number cannot be a pager, answering service, voice message system, or cell phone; and
(f) maintain a 24-hour voice message system;
(3) accept MassHealth payments as payment in full for all AFC;
(4) establish, maintain, and comply with written policies and procedures to comply with 130 CMR 408.000;
(5) agree to periodic inspections, by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 408.000;

(6) agree to comply with all the provisions of 130 CMR 408.000, 450.000*: Administrative and Billing Regulations*, and all other applicable MassHealth rules and regulations.
(7) participate in any AFC provider orientation required by EOHHS;
(8) meet all provider participation requirements described in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*;
(9) agree to pay AFC caregivers on a timely basis for services provided at applicable compensation levels;
(10) be accredited by the National Committee for Quality Assurance (NCQA), the Council on Accreditation (COA), the Commission on Accreditation of Rehabilitation Facilities (CARF), or other nationally recognized accreditation organizations determined acceptable by the MassHealth agency. AFC providers must provide evidence of accreditation in accordance with 130 CMR 408.404(A)(10) in the form and format as required by the MassHealth agency;
(11) submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the AFC provider supported by documentation to demonstrate that the provider has adequate resources to finance the provision of services in accordance with 130 CMR 408.000 in the form and format as required by the MassHealth agency; and
(12) provide evidence in the form and format required by the MassHealth agency that the organization is actively billing for and serving at least eight individuals at the time of accreditation and re-accreditation.

(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.

(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 408.435, by a qualified AFC caregiver, as described in 130 CMR 408.434, who lives in the residence and paid by the AFC provider. AFC must be ordered by a PCP and delivered by a qualified AFC caregiver under the oversight of the registered nurse and the MDT in accordance with each member's written plan of care. Direct care includes 24-hour supervision, and daily assistance with ADLs and IADLs as defined in 130 CMR 408.402.

(B) Nursing Oversight. The AFC provider must provide nursing oversight by a registered nurse or licensed practical nurse under the supervision of a registered nurse who meets the qualifications as described in 130 CMR 408.433(C)(2)(a) and 130 CMR 408.433(E)(1), who is not related to the member, and who is licensed in Massachusetts. Nursing oversight services must be individualized to meet the needs of each member in accordance with the member's AFC plan of care and must include all of the following activities:

(1) completing or coordinating all applicable clinical assessments and clinical evaluations, provided that only a registered nurse can complete such assessments and evaluations;
(2) developing the member's interim and final AFC plan of care, with input from the member or responsible party, all members of the MDT, and other individuals designated by the member;
(3) completing a semi-annual health status report for each member;
(4) ensuring implementation of the AFC plan of care;
(5) coordinating the delivery of AFC with any other health services or supportive services the member is receiving from MassHealth or other agencies or organizations including, but not limited to, visiting nurse services, therapy services, Department of Developmental Services (DDS) services, Department of Mental Health (DMH) services, and Massachusetts Rehabilitation Commission (MRC) services;
(6) conducting on-site visits with each member at the qualified setting:
  (a) for members authorized for AFC level I service payment, the nurse must conduct on-site visits every other month, or more often as the member's condition warrants where such visits alternate with the required visits by the care manager to ensure the member receives one visit by the nurse or care manager every month, as determined by the MDT in accordance with 130 CMR 408.433(B), a community support specialist may conduct up to three non-consecutive on-site visits per 12-month period in place of the nurse; and
  (b) for AFC level II service payment, the nurse must conduct on-site visits every month, or more often as the member's condition warrants, to ensure the member receives one visit by the nurse and one visit by the care manager every month, if determined appropriate by the MDT in accordance with 130 CMR 408.433(B), a community support specialist may conduct up to six non-consecutive on-site visits per 12-month period in place of the nurse;
(7) completing a nursing progress note for each on-site visit or encounter and upon significant change;

(8) 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;
(9) educating the member about hygiene and health concerns;
(10) reporting changes in the member's condition to the member's PCP;
(11) coordinating and implementing the PCP form and approval for AFC with the member, AFC caregiver, and AFC provider personnel;
(12) developing, in conjunction with the MDT the AFC caregiver, and the member or responsible party, an emergency backup and personal care contingency plan for each member receiving AFC that includes an alternative plan for the member if the AFC caregiver is temporarily unable to provide care; and
(13) overseeing, monitoring, supporting, training, and evaluating AFC caregivers.

(C) Care Management. Care management must be provided by a qualified AFC care manager, as described in 130 CMR 408.433(C)(3)(a), who is not related to the member, and who is responsible for coordinating care and monitoring the needs of the member in conjunction with the registered nurse. Care management performed by the AFC care manager must include the following activities:
(1) conducting initial and ongoing psychosocial evaluation of a member's appropriateness for AFC;
(2) evaluating, supporting, and training AFC caregivers;
(3) assisting with the development of the member's interim and final AFC plan of care with input from the member or responsible party, all members of the MDT, and other individuals designated by the member.
(4) ensuring implementation of the AFC plan of care;
(5) conducting on-site visits with each member at the qualified setting:
(a) for AFC level I service payment, the care manager must conduct on-site visits every other month, or more often as the member's condition warrants, where such visits alternate with the required visits by the nurse to ensure the member receives one visit by the nurse or care manager every month, provided that, as determined by the MDT in accordance with 130 CMR 408.433(B), a community support specialist may conduct up to three non-consecutive on-site visits per 12-month period in place of the AFC care manager;
(b) for AFC level II service payment, the care manager must conduct on-site visits every month, or more often as the member's condition warrants, to ensure the member receives one visit by the nurse and one visit by the care manager every month. If determined appropriate by the MDT in accordance with 130 CMR 408.433(B), an AFC community support specialist may conduct up to six non-consecutive on-site visits per 12-month period in place of the care manager;
(6) assisting with coordination of AFC with any other health services or supportive services the member is receiving from MassHealth, a managed care organization, an accountable care organization or other agencies or organizations including, but not limited to, visiting nurse services, therapy services, Department of Developmental Services (DDS) services, Department of Mental Health (DMH) services, and Massachusetts Rehabilitation Commission (MRC) services;

(7) completing a care manager progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;
(8) reporting changes in the member's condition to the member's AFC nurse;
(9) assisting with making referrals to appropriate service providers if the member requires services other than those provided by the AFC provider;
(10) conducting regular, periodic evaluations, at least annually, to ensure that each qualified setting where AFC is provided meets the requirements of 130 CMR 408.435;
(11) providing timely assistance and responding to urgent or emergency needs of the member; and
(12) developing, in conjunction with the MDT, the AFC caregiver, and the member or responsible party, an emergency backup and personal care contingency plan for each member, receiving AFC that includes an alternative plan for the member if the AFC caregiver is temporarily unable to provide care.

(D) AFC Community Support Specialist On-site Visits. An AFC community support specialist who is qualified as described in 130 CMR 408.433(D)(1), who is not related to the member, and who has the responsibilities described in 130 CMR 408.433(D)(2) may conduct on-site visits of the member at the qualified setting in place of the nurse or care manager if determined appropriate by the MDT in accordance with 130 CMR 408.433(B).

408.416: Clinical Eligibility Criteria for AFC

A member must meet the following clinical eligibility criteria for receipt of AFC.

(A) AFC must be ordered by the member's PCP.

(B) The member has a medical or mental condition that requires daily hands-on (physical) assistance or cueing and supervision throughout the entire activity in order for the member to successfully complete at least one of the following activities:
(1) Bathing: a full-body bath or shower or a sponge (partial) bath that 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 (including denture care and brushing of teeth), shaving, and, when applicable, applying make-up;
(2) Dressing: upper and lower body, including street clothes and undergarments, but not solely help with shoes, socks, buttons, snaps, or zippers;
(3) Toileting: member is incontinent (bladder or bowel) or requires assistance or routine catheter or colostomy care;
(4) Transferring: member must be assisted or lifted to another position;
(5) Mobility: (ambulation) - member must be physically steadied, assisted, or guided during ambulation indoors and outdoors, 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 consuming a portion or all of the meal.

408.417: Clinical Assessment and Prior Authorization

(A) Clinical Assessment. As part of the prior authorization process, members seeking AFC must undergo a clinical assessment to assess the member's clinical status and need for AFC. Completed clinical assessment documentation must be submitted to MassHealth, or its designee, in the form and format requested by the MassHealth agency. A new clinical assessment is required annually and upon significant change.

(B) Prior Authorization.

(1) As a prerequisite for payment of AFC, the AFC provider must obtain prior authorization from the MassHealth agency or its designee before the first date of service delivery and annually thereafter, and upon significant change.

(2) Prior authorization determines the medical necessity for AFC as described under 130 CMR 408.416 and in accordance with 130 CMR 450.204: *Medical Necessity*.

(3) Prior authorization may specify the service level for payment for the service.

(4) Prior authorization does not establish or waive any other prerequisites for payment such as the member's financial eligibility described in 130 CMR 503.007: *Potential Sources of Health Care* and 130 CMR 517.008: *Potential Sources of Health Care*.

(5) When submitting a request for prior authorization for payment of AFC to the MassHealth agency, or its designee, the AFC provider must submit requests in the form and format as required by the MassHealth agency. The AFC provider must include all required information including, but not limited to, documentation of the completed clinical assessment conducted by the MassHealth agency or its designee; other nursing, medical or psychosocial evaluations or assessments; and any other documentation that the MassHealth agency, or its designee, requests in order to complete the review and determination of prior authorization.

(6) In making its prior authorization determination, the MassHealth agency or its designee, may require additional assessments of the member or require other necessary information in support of the request for prior authorization.

(C) Notice of Determination of Prior Authorization.

(1) Notice of Approval. If the MassHealth agency or its designee approves a request for prior authorization, it will send written notice to the member and the AFC provider.

(2) Notice of Denial or Service Modification. If the MassHealth agency or its designee denies, or approves with a service modification, request for prior authorization of AFC, the MassHealth agency or its designee will notify both the member and the AFC provider. The notice will state the reason for the denial or service modification and contain information about the member's right to appeal and the appeal procedure.

(3) Right of Appeal. A member may appeal a service denial or modification by requesting a fair hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(D) Review Requirement. The MassHealth agency, or its designee, may at any time review prior authorization of MassHealth members including, but not limited to, instances in which there has been a significant change in the member's status as defined in 130 CMR 408.402.

408.418: Quality Management

AFC providers must participate in any quality management and program integrity processes established by the MassHealth agency, including making any necessary data available and access to visit the provider's place of business upon request by the MassHealth agency or its designee.

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 EOHHS. Rates of payment for AFC do not cover or include any amount for room and board.

(B) Payment for AFC is subject to the conditions, exclusions, and limitations set forth in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) The MassHealth agency pays an AFC provider for AFC only if
(1) the person receiving AFC is eligible under 130 CMR 408.403;
(2) the member meets the clinical eligibility criteria for AFC in accordance with 130 CMR 408.416;
(3) the AFC provider has obtained prior authorization for AFC in accordance with 130 CMR 408.417.
(4) the member resides in an AFC-qualified setting in accordance with 130 CMR 408.435;
(5) the AFC provider bills at the payment level authorized by the MassHealth agency or its designee; and
(6) the AFC provider is not billing for days that are non-covered days under 130 CMR 408.437.

(D) AFC Payments are made as follows.
(1) AFC Level I Service Payment. The MassHealth agency will pay the level I service payment rate if a member requires hands-on (physical) assistance with one or two of the activities described in 130 CMR 408.416 or requires cueing and supervision throughout one or more of the activities listed in 130 CMR 408.416 in order for the member to complete the activity.
(2) AFC Level II Service Payment. The MassHealth agency will pay the level II service payment rate for members who require
(a) hands-on (physical) assistance with at least three of the activities described in 130 CMR 408.416; or
(b) hands-on (physical) assistance with at least two of the activities described in 130 CMR 408.416 and management of behaviors that require frequent caregiver intervention as described in 130 CMR 408.419(D)(2)(b)1. through 5.
1. wandering: moving with no rational purpose, seemingly oblivious to needs or safety;
2. verbally abusive behavioral symptoms: threatening, screaming, or cursing at others;
3. physically abusive behavioral symptoms: hitting, shoving, or scratching;

4. 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
5. resisting care.

(3) Intake and Assessment Services. The MassHealth agency will pay the intake and assessment rate for preadmission intake and assessment services as outlined in 130 CMR 408.431(A). In order to bill for the intake and assessment rate, an AFC provider must complete the tasks described in 130 CMR 408.431(A).

(E) If a member changes from one AFC provider to another AFC provider, a new assessment is required and the new AFC provider must obtain prior authorization. The previous AFC provider must continue to provide AFC to the member while the new AFC provider is obtaining prior authorization and until the member is admitted and receiving services from the new AFC provider. The previous AFC provider must discharge the member from its AFC program before the new AFC provider may bill the MassHealth agency for AFC. The MassHealth agency will pay only one AFC provider per day for the provision of AFC to a member.

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

(G) MassHealth payment to AFC providers begins on the later of
(1) the effective date of the prior authorization from the MassHealth agency; or
(2) the first date on which AFC is provided to the member.

(H) MassHealth payment to an AFC provider ends on the date on which a member no longer meets the clinical criteria for AFC described in 130 CMR 408.416, is no longer receiving AFC, or no longer has a prior authorization in effect, whichever comes first.

(I) 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 or nonmedical leave of absence. The MassHealth agency does not pay an AFC provider for non-covered days, which includes days when the AFC caregiver or setting has become unqualified for any reason, or a member has exhausted alternative caregiver days, MLOA days, or NMLOA days.

(J) The MassHealth agency pays for a maximum of 40 days per member per calendar year for MLOA and up to 15 days per member per calendar year for NMLOA. Any unused leave-of-absence days follow the member when changing from one AFC provider to another AFC provider. MLOA and NMLOA days cannot be used interchangeably.

(K) An AFC provider may bill for up to 14 alternative-caregiver days per member per calendar year. Any unused alternative caregiver days follow the member when changing 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 130 CMR 450.000: *Administrative and Billing Regulations*, the AFC provider must meet all of the following requirements.

(A) Policies and Procedures Manual. Each AFC provider must develop, maintain, annually review, and update a comprehensive policies and procedures manual governing the delivery of AFC services. Each manual at a minimum must contain a mission statement; the goals and objectives of the program; an organizational chart describing the lines of authority and communication needed to manage the AFC program, including the lines of authority for delegation of responsibility down to the member care level; job descriptions that include titles, reporting authority, qualifications, and responsibilities; and a description of the governing body. Additionally, each policy and procedure manual must contain the following:

(1) administrative policies and procedures including, but not limited to
  (a) human resource and personnel;
  (b) staff and staffing requirements;
  (c) backup staff in the event coverage is required due to illness, vacation, or other reasons;
  (d) staff education and training;
  (e) AFC provider staff evaluation and monitoring;
  (f) emergencies, including fire, safety and disasters, including notifying the fire department and police in emergencies and relocating members during an emergency;
  (g) MassHealth basics and member rights;
  (h) human rights and nondiscrimination;
  (i) incident and accident reporting;
  (j) alternative caregiver and/or arrangements for members when the AFC caregiver is temporarily absent or temporarily unable to provide care;
  (k) staff, AFC caregiver, and member grievances;
  (l) cultural competency;
  (m) quality assurance and improvement;
  (n) caregiver training;
  (o) emergency services and plans;
  (p) first aid and cardiopulmonary resuscitation requirements;
  (q) Health Insurance Portability and Accountability Act (HIPAA);
  (r) coordination of AFC with other services the member is receiving; and
  (s) procedures to be followed if a member is missing or lost; and
(2) clinical policies and procedures, including, but not limited to:
  (a) clinical evaluations;
  (b) privacy and confidentiality;
  (c) 24-hour emergency coverage, including medical and other emergencies;
  (d) documentation of visits and progress notes;
  (e) medication management;
  (f) universal precautions;
  (g) infection control and communicable disease;

(h) recognizing and reporting abuse (physical, sexual, emotional, psychological) neglect, self-neglect and financial exploitation;
(i) discharge criteria; and
(j) member and caregiver counseling.

(B) Clinical Assessment and Clinical Evaluations. If required by MassHealth, the AFC provider's MDT must perform a clinical assessment by completing a clinical assessment screening tool designated by the MassHealth agency as well as all any other applicable clinical evaluations for each member
(1) before admission to AFC;
(2) upon significant change; and
(3) annually on the anniversary date of the member's admission to AFC.

(C) AFC Plan of Care. The plan of care must be based upon clinical evaluations and contain the following elements: prioritized goals and objectives that consider and document the needs, goals and preferences of the member; the resources to be utilized; and a plan for continuity of care. The goals and actions of the plan of care must be measurable and reflect the member's desired outcomes for AFC and address medical, social, and other services needed and chosen by the member. The plan of care must reflect the member's needs, current care and treatment; problem identification with appropriate follow-up, and implementation with interventions and evaluation. The plan of care must be in language that is understandable to the member and to the individuals important in supporting the member.
(1) Within five working days of a member's admission to AFC, the AFC provider's MDT, the member, and others as designated by the member must design an interim AFC plan of care. The interim plan must be signed by the registered nurse and include, at a minimum, an outline of a temporary schedule of care provided that will be used until the final AFC plan of care is completed.
(2) Within 30 calendar days of a member's admission to AFC, the AFC provider's MDT, the member or responsible party, the AFC caregiver, and others designated by the member must develop the final AFC plan of care. The final plan of care must be signed by the member, the registered nurse, and the care manager, and must include:
(a) a treatment plan describing how, and by whom, the member's service needs will be met 24 hours per day, seven days per week, that is based on the member's PCP's summary, physical examination, and all applicable clinical evaluations;
(b) an evaluation, completed by the MDT, 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;
(c) a current and updated list and contact information for
1. an alternative caregiver, if identified; and
2. the primary contact person who is able to address the member's needs and is available if an unforeseen event occurs that prevents the member's AFC caregiver from providing services; and
(d) documentation of any other health services or supportive services the member is receiving from the MassHealth agency or other agencies or organizations (for example, adult day health, visiting nurse services, therapy services, services provided by DDS, DMH, and MRC, or counseling services).

(3) The plan of care must be based upon
(a) the member's strengths, preferences, and member identified goals and desired outcomes for AFC;
(b) clinical evaluation;
(c) the AFC caregiver's care log;
(d) the nursing progress notes;
(e) the care manager's progress notes;
(f) the AFC community support specialist's progress notes;
(g) the PCP Summary Form and approval to participate in AFC;
(h) documentation of the member's PCP annual visit and the member's physical examination; and
(i) the member's discharge and transition plan.

(4) For members who meet the requirements for receiving AFC level I service payment, the AFC provider must annually review the plan of care and send a copy of the member's health-status report to the member's PCP.

(5) For members who meet the requirements for level II service payment, the AFC provider must semi-annually review the plan of care and send a copy of the member's health status report to the member's PCP.

(6) Review of the plan of care under 130 CMR 408.430(C)(4) or (5) will be conducted by the MDT with participation from the member or responsible party, the AFC caregiver, and others as designated by the member. If a plan of care is modified, the AFC provider must send a copy of the plan of care to the member's PCP.

(7) The member, health care proxy, or surrogate identified by a member with decisional capacity must be afforded the opportunity to attend all plan-of-care meetings.

(8) The AFC provider must establish emergency policies and procedures in writing and include them with the member's plan of care including, at a minimum, an emergency file (such as an emergency fact sheet) on the member that must contain
(a) the name and telephone number of the member's PCP;
(b) the member's diagnosis;
(c) any special treatments or medications the member may need;
(d) insurance information;
(e) emergency contact information for notification of the family or legal guardian;
(f) procedures to be followed in the event a member is missing or lost; and
(g) procedures for handling medical emergencies.

(D) Recordkeeping. The AFC provider must maintain records in compliance with the record retention requirements set forth in 130 CMR 450.205: *Recordkeeping and Disclosure*. 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 staff records, including evidence of completed staff orientation and training;
(b) financial records;
(c) member utilization;
(d) staffing levels;
(e) complaints and grievances;

(f) documentation related to the qualified setting;
(g) documentation related to the AFC caregiver and alternative caregivers;
(h) contracts for subcontracted services;
(i) documentation of the preadmission procedure described in 130 CMR 408.431(A);
(j) contracts for independent contractor services, including a description of how the AFC provider will supervise the independent contractors and their services; and
(k) maintain job descriptions that include titles, reporting authority, qualifications, and responsibilities;

(2) member records, which must contain at a minimum all of the following:
(a) initial preadmission and admission information, including
1. the member information sheet;
2. the prior authorization by the MassHealth agency or its designee; and
3. clinical evaluations;
(b) medical information, including
1. a copy of the most recent physical examination (within the past 12 months);
2. the PCP's authorization and summary;
3. the member's semi-annual health-status reports and documentation that the health-status reports were sent to the PCP;
4. the member's medical history;
5. the member's tuberculosis screening documentation;
6. the member's a list of any known allergies;
7. information about the member's dietary requirements;
8. a list of the member's current medications;
9. if designated by the member, advance directives and the name of the healthcare proxy; and
10. the ADL needs as outlined in 408.416(B);
(c) progress notes, including
1. nursing notes;
2. care manager notes;
3. AFC community support specialist notes; and
4. caregiver service documentation (log of care received);
(d) correspondence from family, therapists, PCP, other service providers, or others, including a managed care organization or an accountable care organization, about the care of the member in the AFC program;
(e) the AFC plan of care, including any documentation forming the basis of the plan of care;
(f) the discharge plan;
(g) legal documentation, for example, signed authorizations for release of information;
(h) critical incident reports in a form and format designated by the MassHealth agency;
(i) the member's post-discharge status;
(j) documentation of the AFC caregiver's daily schedule; and
(k) documentation of the care required to be provided by the MDT; and

(3) records 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.

(E) Reporting.

(1) Incident Reporting. 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;

(e) any allegation of abuse or neglect of or by the member; and

(f) a member missing from a qualified setting.

(2) Program Reporting. The AFC provider must submit all of the following information in the format and time frames as requested by the MassHealth agency:

(a) clinical and statistical information;

(b) cost and expense information;

(c) member satisfaction survey results, including the survey developed by the provider, and a description of how the findings will be addressed.

(d) change in AFC provider contact information; and

(e) any additional information requested by the MassHealth agency or its designee related to the provider's provision of AFC services.

(f) data necessary to measure the quality of the services delivered by the provider as required by MassHealth.

(F) 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. The provider must maintain the survey and quality improvement plan;

(G) AFC Caregiver Compensation. Each AFC provider must agree to pay AFC caregivers on a timely basis for services provided at applicable compensation levels for which a minimum amount may be established by the MassHealth agency by bulletin or other written issuance. Any such bulletin or written issuance will be concurrent with the rates established pursuant to M.G.L. c. 118E, § 13D, and 101 CMR 351.00: *Rates for Certain Adult Foster Care Services*.

408.431: Preadmission and Admission Procedures

(A) Preadmission Procedures and Activities.

(1) Preadmission Procedures. Before admitting a member in AFC, the AFC provider must perform all of the activities in 130 CMR 408.431(A)(2). Intake and assessment services are provided to members seeking admission to AFC but who may have not yet received prior authorization by the MassHealth agency or its designee, for AFC. The AFC provider must 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 nurse must determine that the AFC provider is able to meet all of the ADL and IADL needs of the member prior to admitting the member to AFC, as well as 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 to be provided and any other relevant information;

(2) Preadmission Activities. Prior to admitting the member, the AFC provider must perform the following intake and assessment services:

(a) conduct clinical evaluations of the need for AFC;

(b) review and approve AFC caregiver applicants;

(c) instruct members on the rules, policies, and procedures of the AFC program;

(d) identify appropriate potential AFC caregivers and qualified settings, including conducting on-site interviews in the qualified setting;

(e) schedule meetings with the member or responsible party and potential AFC caregiver;

(f) match the member with the most appropriate potential AFC caregiver;

(g) provide information on the member's rights and responsibilities when receiving AFC services;

(h) provide instruction and initial training of AFC caregivers; and

(i) schedule the member's move-in date with the AFC caregiver in circumstances in which the member is moving into the AFC caregiver's home.

(B) Admission Activities. Upon the AFC provider's receipt of the MassHealth agency's initial prior authorization authorizing the member to receive services and, by the end of the fifth day of service, the AFC provider must perform the following activities:

(1) Complete and submit a written notification to the member and, if applicable, the member's legal guardian. The notice must at a minimum specify the following:

(a) that the member has been admitted to AFC;

(b) the member's interim AFC plan of care, as outlined in 130 CMR 408.430(C)(1);

(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, the AFC provider must obtain all the necessary documentation from the member's PCP and other service providers on or before the first date of service. The documentation must include

(a) the PCP Summary Form and order for AFC that documents that the member has been examined in the past 12 months and that the MassHealth member's condition requires support with activities of daily living that is provided by the AFC provider;

(b) the member's medical history;

(c) results of a PCP visit within the past three months; however if the PCP has completed a physical examination in the past 12 months and there has been no change in the members medical status, and the PCP has deemed a second physical is not medically necessary, the PCP may document and sign such a statement on the PCP Summary Form;

(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;

(h) recommendations for other services, if applicable; and

(i) a list of known allergies, if any.

(3) Conduct on-site visits according to the member's AFC service payment level.

(a) For members receiving AFC level I service payment, the initial visit must be conducted on the first day of AFC and may be conducted by the registered nurse, licensed practical nurse, or care manager.

(b) For members receiving AFC level II service payment, the initial visit must be conducted on the first day of AFC and must be conducted by the AFC provider's registered nurse or licensed practical nurse. For the first month of service, weekly visits must be made by the registered nurse or licensed practical nurse.

(4) Provide the member by day 30 a written copy of the member's completed AFC plan of care.

408.432: Discharge Procedures

(A) A member must be discharged by the AFC provider upon the member's request, or if the member ceases to benefit from AFC, including the following circumstances:

(1) the member no longer meets the clinical eligibility criteria for AFC;

(2) the member demonstrates behavioral or other problems that may endanger the member, the AFC caregiver, or AFC provider staff;

(3) the member's clinical needs are beyond the scope of AFC;

(4) the member's needs cannot be met by the AFC provider;

(5) the member does not reside in an AFC-qualified setting;

(6) the member selects another service that is duplicative of AFC; or

(7) the member transitions to another AFC provider.

(B) For all discharges, the AFC provider must
(1) develop a discharge and transition plan that 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 care by the member, including during transitions of care as specified in the AFC plan of care;
(d) be dated and signed by the AFC registered nurse, the AFC care manager, and the member; 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) provide assistance to the member in identifying and locating another provider;
(3) arrange for the member to be discharged and transitioned to the provider identified in 130 CMR 408.432(B)(2);
(4) coordinate the discharge and transition 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
(5) maintain current level of services until the member is admitted with a new provider.

408.433: Adult Foster Care Staff Qualifications and Responsibilities

All staff directly employed by the AFC provider, as well as any contract staff, *per diem* staff, backup staff, or anyone providing AFC on behalf of the AFC provider to members must meet the following requirements.

(A) General Staff Requirements.
(1) Prior to hiring or contracting with any staff the AFC provider must:
(a) check the candidate's references and job history and ensure that the candidate meets all of the required experience, education, and qualifications;
(b) conduct a Criminal Offender Records Information (CORI) check and determine whether any offender records may disqualify the individual for employment;
(c) conduct a Sex Offender Registry Information (SORI) check;
(d) conduct Office of Inspector General (OIG) check;
(e) conduct licenses and certification checks and validate that the candidate has obtained all necessary licenses and certifications and that all licenses and certifications are current;
(f) ensure that each AFC staff person is not related to or legally responsible for the member receiving AFC; and
(g) ensure that each AFC registered nurse, licensed practical nurse, care manager, and AFC community support specialist has received a tuberculosis screening within the previous 12 months.
(2) On an ongoing basis, the AFC provider must
(a) ensure that all registered nurses, licensed practical nurses, care managers, and AFC community support specialists receive tuberculosis screenings in accordance with current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Massachusetts Department of Public Health;

(b) ensure that all staff are appropriately trained and managed, which must include, but not be limited to, training in recognition and reporting of abuse of elders and persons with disabilities and provider services;
(c) have available at all times a sufficient number of educated, experienced, trained, and competent personnel to provide AFC to elders or adults with disabilities;
(d) evaluate staff annually using standardized evaluation measures;
(e) maintain a record of each performance evaluation in a separate personnel file for each staff member; and
(f) include in each staff member's personnel file any staff incident or accident reports.

(B) Multidisciplinary Professional Team. Each AFC provider must have an MDT, which works in conjunction with the AFC caregiver, to meet the nursing, oversight, and care-management needs of members. The MDT must include a program director, a registered nurse or a licensed practical nurse, and an AFC care manager, and may include an AFC community support specialist. The registered nurse or the AFC care manager may assume the role of program director. For each employee and independent contractor, the AFC provider must maintain a job description that includes the title, reporting authority, qualifications, and responsibilities. The MDT must meet to discuss AFC services provided to a member upon significant change of the member or more often as the member's condition warrants, but not less frequently than every six months. The MDT may determine when AFC community support specialist visits are appropriate in place of a registered nurse, licensed practical nurse, or AFC care manager visit based on member needs and as specified in 130 CMR 408.415(B)(6), 408.415(C)(5), and 408.415(D).

(C) The Multidisciplinary Professional Team Staff Qualifications and Responsibilities
(1) Program Director. The AFC provider must employ a program director who is a healthcare professional.
(a) Qualifications. The program director must have a bachelor's degree and a minimum of five years of recent professional healthcare experience working with elders or adults. A master's degree in a relevant healthcare 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
1. development and implementation of the AFC provider's policies and procedures in 130 CMR 408.430(A);
2. direction and supervision of all aspects of the AFC program;
3. oversight of the hiring, training, supervision, firing, and evaluation, of all AFC employees and independent contractors;
4. payment of a stipend to all AFC caregivers for their services, and in accordance with any minimum amount established by the MassHealth agency pursuant to 130 CMR 408.404(A)(9);
5. the fiscal administration of the AFC program, including billing, budget preparation, and required program statistical and financial reports; and
6. ensuring that the AFC provider meets all of the requirements in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(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 of recent experience in the direct care of elders or adults with disabilities.

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

1. completing and coordinating all applicable clinical assessments and clinical evaluations;
2. developing and reviewing on an ongoing basis each member's AFC plan of care;
3. provide oversight to AFC caregivers in conjunction with the care manager;
4. reviewing the PCP Summary Form;
5. monitoring the health status of all members to ensure that all needed AFC is properly delivered;
6. reporting changes in the health status of any member to the member's PCP;
7. reviewing AFC caregiver logs at a minimum of every 30 days;
8. conducting on-site visits with each member at the qualified setting in accordance with 130 CMR 408.415(B)(6);
9. completing a nursing progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;
10. submitting semiannual health-status reports to the member's PCP;
11. planning for and implementing discharges and transition from the AFC program;
12. conducting an orientation for each AFC caregiver before the AFC caregiver begins personal care; and
13. providing ongoing training to AFC caregivers on health and aging.

(3) Care Manager. The AFC provider must employ or independently contract with a care manager. The AFC care manager may function as the program director.

(a) Qualifications. The care manager must have

1. a bachelor's degree, a social worker license from the Massachusetts Board of Registration in Social Work, and at least two years of recent experience working with elders or adults with disabilities; or
2. a bachelor's degree and two years of clinical experience in the care of elders or people with disabilities.

(b) Responsibilities. The responsibilities of the care manager include

1. conducting the initial and ongoing evaluations of the AFC qualified setting;
2. obtaining a social history and conducting a psychosocial evaluation;
3. provide oversight to AFC caregivers in conjunction with the registered nurse;
4. participating in the development, implementation, and ongoing review of the AFC plan of care;
5. conducting on-site visits with each member at the qualified setting in accordance with 130 CMR 408.415(C)(5);
6. completing a care-management progress note corresponding with each on-site visit or encounter and upon significant change;
7. reviewing AFC caregiver logs at a minimum of every 30 days;
8. assisting with obtaining information and accessing other healthcare and community services;

9. reviewing and documenting the fire and safety procedures for the qualified setting;
10. participating in discharge and transition planning and implementation; and
11. reviewing, as needed and at least annually the suitability of the qualified setting.

(4) Staff Qualification Substitution. For any staff member on the MDT that does not meet the qualifications as stated in 130 CMR 408.433, the AFC provider must receive a written approval from the MassHealth agency for substitution of the qualification prior to hiring.

(D) AFC Community Support Specialist. The AFC provider may employ or independently contract with community support specialists.

(1) Qualifications. A community support specialist must have at least one year of experience working with elders or adults with disabilities.

(2) Responsibilities. The responsibilities of a community support specialist include

(a) conducting on-site visits with the member at the qualified setting in accordance with 130 CMR 408.415(B)(6),408.415(C)(5) and 408.415(D);

(b) participating in the development, implementation, and ongoing review of the AFC plan of care;

(c) completing a community support specialist progress note corresponding with each on-site visit and encounter with members; and

(d) providing to the member and caregiver culturally appropriate health education, information, support, and counseling.

(E) Licensed Practical Nurse. The AFC provider may employ or independently contract with a licensed practical nurse.

(1) Qualifications. The licensed practical nurse must be licensed by the Massachusetts Board of Registration in Nursing and in good standing with the Board.

(2) Responsibilities. Under the direction and supervision of the AFC provider RN, licensed practical nurses may:

(a) complete and coordinate all applicable clinical assessments and clinical evaluations;
(b) develop and review on an ongoing basis each member's AFC plan of care;
(c) provide oversight to AFC caregivers in conjunction with the care manager;
(d) review the PCP Summary Form;
(e) monitor the health status of all members to ensure that all needed AFC is properly delivered;
(f) report changes in the health status of any member to the member's PCP;
(g) review AFC caregiver logs at a minimum of every 30 days;
(h) conduct on-site visits with each member at the qualified setting in accordance with 130 CMR 408.415(B)(6);
(i) complete a progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;
(j) submit semiannual health-status reports to the member's PCP;
(k) plan for and implementing discharges and transition from the AFC program;
(l) conduct an orientation for each AFC caregiver before the AFC caregiver begins personal care; and
(m) provide ongoing training to AFC caregivers on health and aging.

(F) AFC Staff Training Requirements.

(1) The AFC provider must provide initial and periodic training to all staff members who are responsible for the care of a member. Records of completed training must be kept on file and updated regularly by the AFC provider.

(2) The AFC provider must hold an orientation for new staff within one month of hire. This orientation must include the following topics:

(a) delivery of AFC by the AFC provider;
(b) AFC provider written policies and procedures;
(c) the requirements of 130 CMR 408.000;
(d) AFC provider staff roles and responsibilities;
(e) caring for people with disabilities, elders, individuals with Alzheimer's disease and related disorders, behavioral health issues and cognitive impairments including behavioral interventions, behavior acceptance, and accommodations;
(f) observation, reporting, and documentation of the member's status and the care provided, including AFC caregiver log entries;
(g) basic first aid, cardiopulmonary resuscitation (CPR) and emergency procedures including the Heimlich maneuver;
(h) universal precautions and infection control practices;
(i) information about local health, fire, safety, and building codes;
(j) privacy and confidentiality;
(k) multidisciplinary team approach;
(l) medication management;
(m) communication and interpersonal skills;
(n) advance directives;
(o) prevention of and reporting of, abuse, neglect, mistreatment/and misappropriation/financial exploitation;
(p) completing and filing critical incident reports;
(q) techniques of providing safe personal care assistance: good body mechanics;
(r) human rights, nondiscrimination and cultural sensitivity;
(s) recognizing the physical, emotional and developmental needs of the individuals in their care and working in a manner that respects them, their privacy and their property;
(t) recognizing, responding to and reporting change in condition, emergencies and knowledge of emergency procedures, including the AFC provider's fire, safety, and disaster plans; and
(u) relevant provisions of the Health Insurance Portability and Accountability Act of 1996.

(G) AFC Backup Staff Coverage. The AFC provider must ensure the availability of professional and direct care backup staff if coverage is required due to illness, vacation, or other reasons. All staff providing backup coverage must possess an equal or greater level of licensure and certification required for each position, and must meet all other requirements of regular staff members.

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) conduct a Sex Offender Registry Information (SORI) check;
(4) conduct Office of Inspector General (OIG) check;
(5) ensure that each AFC caregiver has received a tuberculosis screening within the prior 12 months, and thereafter every two years in accordance with current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Massachusetts Department of Public Health;
(6) ensure that the AFC caregiver is not serving more than a total of three persons, no more than two of whom are authorized for AFC level II service payment, in the qualified setting regardless of service provided or payer source;
(7) ensure that all AFC caregivers are appropriately trained and managed; and
(8) ensure that the AFC caregiver is in the qualified setting to provide the appropriate amount of necessary care to meet the member's needs.

(B) Qualifications. Each AFC caregiver must
(1) be a responsible person who is at least 18 years old, 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 suffer from alcohol or substance use disorder;
(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;
(5) not serve in another role within a member's MDT (e.g., cannot be a member's AFC care manager and also the member's AFC caregiver); and
(6) meet all other requirements established by the AFC provider for an AFC caregiver.

(C) Responsibilities. The AFC caregiver must
(1) supervise and assist with ADLs and IADLs of a member that is necessary for the member's health and well-being;
(2) monitor and report any nonurgent or nonemergency changes in the member's medical condition to the member's AFC provider. In cases of emergency, the AFC caregiver must report directly to the most appropriate provider and follow up with the AFC provider;
(3) maintain of the qualified setting consistent with the requirements of 130 CMR 408.435;
(4) complete a caregiver log;
(5) send 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) provide ongoing supervision to the member 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 healthcare instructions from healthcare providers; and
(e) promptly arranging for medical care that the member needs;
(7) notify the AFC provider of the need for alternative care of the member; and
(8) immediately notify 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 per year on topics that complement or reinforce the topics listed in 130 CMR 408.434(D)(2) with at least one hour of training on recognizing, responding to, communicating, and reporting changes in condition, critical incidences, emergencies, and knowledge of emergency procedures, including the AFC provider's fire, safety, and disaster plans. Records of completed training must be kept on file and updated regularly by AFC providers.
(2) The initial orientation training sessions must include the following topics:
(a) techniques of providing safe delivery of ADLs and IADLs and good body mechanics;
(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) caring for people with disabilities, elders, individuals with Alzheimer's disease and related disorders, behavioral health issues and cognitive impairments, including behavioral interventions, behavior acceptance, and accommodations;
(g) observation, reporting and documentation of the member's status and the care provided including AFC caregiver log entries;
(h) basic first aid, cardiopulmonary resuscitation (CPR), and emergency procedures, including the Heimlich maneuver;
(i) universal precautions and infection control and practices;
(j) information about local health, fire, safety, and building codes;
(k) privacy and confidentiality;

(l) communication and interpersonal skills;
(m) advance directives;
(n) prevention of, and reporting of, abuse, neglect, mistreatment and misappropriation/financial exploitation;
(o) completing and filing critical incident reports;
(p) human rights, nondiscrimination and cultural sensitivity;
(q) recognizing the physical, emotional, and developmental needs of the individuals in their care and working in a manner that respects them, their privacy and their property;
(r) recognizing, responding to, communicating, and reporting change in condition, critical incidences, emergencies, and knowledge of emergency procedures, including the AFC provider's fire, safety, and disaster plans; and
(s) relevant provisions of the Health Insurance Portability and Accountability Act of 1996.

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) The qualified 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, resident care facility, group home, ICF/IID Disability, or ALR;
(2) accessible to meet the specific needs of its residents, including the specific needs of any member with physical disabilities. The provider may consult the Architectural Access Board guidelines;
(3) compliant with local health, fire, safety, occupancy, and state building codes for dwelling units in accordance with 780 CMR 1.00: *Board of Building Regulations and Standards*;
(4) equipped with appropriate safety equipment including, at a minimum, an easily accessible Class ABC fire extinguisher, smoke and carbon monoxide detectors, and a 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 persons receiving services from the AFC caregiver, no more than two of whom are authorized for AFC level II service payment, regardless of services provided or payer 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 and in good working order. 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 must not be a cot. The box spring, mattress, and pillows must be in good condition. 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 the member's own bedroom or share the bedroom with

1. only one other adult of the same sex; or
2. the member's spouse or significant other.

(c) The member must be given a choice of roommates, if asked to share their bedroom.

(d) The member must be allowed the freedom to furnish or decorate their bedroom within the allowances of their living arrangement.

(4) Ventilation. The home must be properly ventilated and allow for appropriate temperature conditions in all seasons.

(5) Lighting. Lighting must be adequate and switches must be easily accessible. Wiring must 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 be free of clutter and include a railing or other appropriate equipment to support the needs of the member.

(C) The qualified setting must have the following safety and emergency protections.

(1) Hallways used by members must have adequate lighting to ensure safety.

(2) There must be a written, predetermined emergency evacuation plan for exiting the home. The emergency evacuation plan must be reviewed every other month with the member.

(3) The member must have an unobstructed emergency evacuation 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, or reasonably alert the member of the emergency.

(5) Emergency procedures including fire drills must be conducted semi-annually. Documentation of emergency evacuation drills must be maintained in the member's record.

(D) The qualified setting must provide meals and snacks 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 and snacks 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 honor the member's ethnic or religious preferences in food.

(4) The AFC caregiver must provide meals and snacks in accordance with the member's dietary restrictions and preferences.
(5) Alternative meal choices and snacks must be stored and made available to the member on a regular basis.
(6) The member must be allowed to access food at any time and be offered and receive at least breakfast, lunch, and dinner, and snacks each 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 emergency plan 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 as specified in 408.430(C)(8), and contact information for an alternative caregiver, if identified, and a primary contact person who is able to address the member's needs and available if an unforeseen event occurs that prevents the member's AFC caregiver from providing services;

(B) a written plan for emergency staff coverage;

(C) a written plan for emergency care and service in the event a member is displaced for any reason;

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

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

408.437: Non-covered 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: *Personal Care Attendant Services*;

(B) the member receives home health aide services provided by a home health agency under 130 CMR 403.000: *Home Health Agency*;

(C) the member is a resident or inpatient of a hospital, nursing facility (with the exception of MLOA days), resident care facility, ICF/IID, ALR, or any other residential facility subject to state licensure or certification;

(D) the AFC provider has not received prior authorization from the MassHealth agency; or

(E) the provider is seeking payment for alternative caregiver days in excess of 14 days within a calendar year, or payment for NMLOA days in excess of 15 days within a calendar year, or payment for MLOA days in excess of 40 days within a calendar year.

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 Notification.

(1) An AFC provider electing to withdraw from participation in MassHealth must send written notice to the MassHealth agency, or its designee, of the provider's intention to withdraw from the AFC program. The AFC provider must send the withdrawal notice by certified or registered mail (return receipt requested) to the MassHealth agency or its designee, no fewer than 90 days before the effective date of withdrawal.

(2) In the instance of alleged emergency withdrawal, the AFC provider must contact the MassHealth agency or its designee, within one business day of the emergency withdrawal and follow up in writing within three business days, informing the MassHealth agency or its designee of the reasoning for such emergency withdrawal, and must
provide proof in documentation or other form as the MassHealth agency may require. The AFC provider must also notify all members and the MassHealth agency about the status of all members and any plans for relocation under 130 CMR 408.432.

(3) The AFC provider must forward a list of all members currently receiving AFC. The AFC provider must notify the MassHealth agency in writing as members are placed in other programs or begin to receive alternative services, including the name of the new program or service and the members' start date in the new program or service.

(B) Notification to Member and Authorized Representatives.

(1) The AFC provider must notify all members, authorized representatives of members, and other funding sources in writing of the intended closing date no fewer than 90 days from the intended closing date and specify the assistance to be provided to 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 provider must give notice, in hand, to all members to whom it is providing AFC services and the member's 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 another AFC provider participating in MassHealth to ensure continuation of MassHealth payment of services and must be determined eligible to continue to receive the services. A copy of this notice must be forwarded to the MassHealth agency. 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 Provider Enrollment Center. Members of the AFC program, for whom prior authorization was sought prior to the withdrawal notice being sent, who are then authorized for AFC after the notice of withdrawal are not considered newly admitted members.

(2) An AFC provider that withdraws from participation in MassHealth must assist members to whom it has been providing AFC services to identify and locate another AFC provider, and must continue to provide its current level of AFC services until all members receiving services from the AFC provider have been admitted with a new AFC provider or another qualified MassHealth provider.

(3) An AFC provider seeking to withdraw from the MassHealth program will work promptly and diligently to arrange for the relocation of members to MassHealth-participating AFC or other qualified MassHealth providers. For relocation requirements, *see* 130 CMR 408.432.

(130 CMR 408.439 through 408.501 Reserved)

408.502: Definitions

The following terms used in 130 CMR 408.503 through 408.527 have the meanings given in 130 CMR 408.502, unless the context clearly requires a different meaning. Payment for 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 130 CMR 450.000: *Administrative and Billing Regulations*.

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

Assisted Living Residence (ALR). Any entity that meets the requirements for certification pursuant to M.G.L. c. 19D and 651 CMR 12.00: *Certification Procedures and Standards for Assisted Living Residences*.

Clinical Assessment. The screening process of cataloging a member's need for GAFC using a tool designated by the MassHealth agency and that forms the basis for prior authorization.

Clinical Evaluations. Nursing, fall risk, nutritional, skin, and other clinical or psychosocial evaluations conducted by the MDT that serve as the basis for the development of the GAFC plan of care.

Electronic Visit Verification (EVV). The method or system designated or approved by EOHHS to electronically verify service delivery in the form and format as required by EOHHS.

Executive Office of Health and Human Services (EOHHS). The Executive Office of Health and Human Services established under M.G.L. c. 6A.

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

Group Adult Foster Care (GAFC). A service ordered by a PCP delivered to a member in a member's home by a MDT and a qualified GAFC direct care aide, that includes assistance with ADLs and IADLs, nursing oversight and care management, as described under 130 CMR 408.505.

GAFC Direct Care Aide. A person who is employed or contracted by a GAFC provider and meets the qualifications and responsibilities provided in 130 CMR 408.524(C).

Hospital. A facility that is licensed or operated as a hospital by the Massachusetts Department of Public Health (DPH) or the Massachusetts Department of Mental Health (DMH) that provides diagnosis and treatment on an inpatient or outpatient basis for patients who have any of a variety of medical conditions.

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 member's residence, or any other medical need determined by the provider as being instrumental to the health care and general well-being of the member.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). A facility, or distinct part of a facility, that provides intermediate care facility services as defined under 42 CFR § 440.150, and that meets federal conditions of participation, and is licensed by the state primarily for the diagnosis, treatment, or rehabilitation for individuals with intellectual disabilities; and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health or rehabilitative services to help individuals function at their greatest ability.

MassHealth. The medical assistance and benefit programs administered by EOHHS pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

Member. A person determined by the MassHealth agency to be eligible for MassHealth.

Multidisciplinary Professional Team (MDT). A team employed or contracted by the provider including, but not limited to, a program director, a registered nurse or a licensed practical nurse, and a care manager.

Nursing Facility. An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured people, people with disabilities, or sick persons, or on a regular basis, health-related care and services to individuals who, because of their mental or physical condition require care and services that meet the requirements of Sections 1919(a), through (d) of the Social Security Act, and is licensed under and certified by the Massachusetts Department of Public Health.

Plan of Care. A person-centered, written plan based on clinical and psychosocial evaluations, describing activities to meet a member's medical, physical, emotional, and social needs and goals for GAFC.

Provider. An organization that meets the requirements of 130 CMR 408.504 and contracts with MassHealth as the provider for GAFC.

Primary Care Provider (PCP). A physician or a physician assistant or nurse practitioner who operates under the supervision of a physician.

Primary Care Provider (PCP) Summary Form. The form that a PCP uses to order GAFC.

Significant Change. A major change in the member's status that
(1) is permanent;
(2) impacts more than one area of the member's health status; and
(3) requires a multidisciplinary review or revision of the care plan. A significant change is presumed when a member authorized to receive services does not receive services for 90 days or more, or when the provider is seeking a change in service amount or payment level.

408.503: GAFC Eligible Members

(A) MassHealth Members. MassHealth eligible members 22 years of age or older may receive GAFC, subject to the restrictions and limitations described in 130 CMR 450.105: *Coverage Types* that specifies, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(B) 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: *Emergency Aid to the Elderly, Disabled and Children Program*.

(C) Reference. For information on verifying MassHealth member eligibility and coverage type, *see* 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

408.504: GAFC Provider Eligibility

(A) An organization seeking to participate in MassHealth as a GAFC provider must:
(1) enter into a contract with the MassHealth agency;
(2) maintain a business office in Massachusetts and be duly authorized to conduct a business in Massachusetts that delivers health and human services to elders or people with disabilities. Such business offices must:
(a) be available to members during regular, posted business hours;
(b) be physically accessible to members with disabilities;
(c) have clear access and space for storing of business records;
(d) have a sign visible from outside the facility identifying the business name and hours that the business office is open;
(e) have a publicly listed business name, address and local toll-free telephone number that is answered by a customer service staff during business hours and that has Telecommunication Device for the Deaf/Teletype (TTY/TDD) transmission and reception capability provided, that during business hours, this number cannot be a pager, answering service, voice message system, or cell phone; and
(f) maintain a 24-hour voice message system;
(3) accept MassHealth payments as payment in full for all GAFC services;
(4) establish, maintain, and comply with written policies and procedures to comply with 130 CMR 408.000;

(5) agree to periodic inspections, by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 408.000;
(6) agree to comply with all the provisions of 130 CMR 408.000, 130 CMR 450.000: *Administrative and Billing Regulations*, and all other applicable MassHealth rules and regulations;
(7) participate in any GAFC provider orientation required by EOHHS;
(8) meet all provider participation requirements described in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*; and
(9) be certified as an assisted living residence pursuant to 651 CMR 12.00: *Certification Procedures and Standards for Assisted Living Residences* and provide GAFC only to members who reside at such residence or be accredited by the National Committee for Quality Assurance (NCQA), the Council on Accreditation (COA), the Commission on Accreditation of Rehabilitation Facilities (CARF), or other nationally recognized accreditation organizations determined acceptable by the MassHealth agency. GAFC providers must provide evidence of such certification or accreditation in accordance with 130 CMR 408.504(A)(9) in the form and format as required by the MassHealth agency;
(10) submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the GAFC provider supported by documentation to demonstrate that the provider has adequate resources to finance the provision of services in accordance with 130 CMR 408.504(A)(10) in the form and format as required by the MassHealth agency; and
(11) provide evidence in the form and format required by the MassHealth agency that the organization is actively billing for and serving at least eight (8) individuals at the time of accreditation and re-accreditation.

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

408.505: Scope of Group Adult Foster Care Services

(A) Direct Care. Direct care includes daily assistance with ADLs and IADLs as defined in 130 CMR 408.502. The GAFC provider must ensure the delivery of direct care to members by a qualified GAFC direct care aide, as described in 130 CMR 408.524(C), who is supervised by the GAFC provider. GAFC must be ordered by a PCP and delivered by a qualified GAFC direct care aide under the supervision of the registered nurse and the MDT in accordance with each member's written plan of care. Direct care includes daily assistance with ADLs and IADLs as defined in 130 CMR 408.502.

(B) Nursing Oversight. The GAFC provider must provide nursing oversight by a registered nurse or licensed practical nurse under the supervision of a registered nurse who meets the qualifications as described in 130 CMR 408.524(B)(2)(a) and 130 CMR 408.524(D)(1), who is not related to the member, and who is licensed in Massachusetts. Nursing oversight services must be individualized to meet the needs of each member in accordance with the member's GAFC plan of care and must include all of the following activities:
(1) completing or coordinating all applicable clinical assessments and clinical evaluations, provided that a licensed practical nurse may complete clinical assessments and evaluations only under the supervision of a registered nurse;

(2) developing the member's interim and final GAFC plan of care with input from the member or responsible party, all members of the MDT, and other individuals designated by the member;
(3) completing a semi-annual health status report for each member;
(4) ensuring implementation of the GAFC plan of care;
(5) coordinating the delivery of GAFC with any other health services or supportive services the member is receiving from MassHealth or other agencies or organizations including, but not limited to, visiting nurse services, therapy services, Department of Developmental Services (DDS), Department of Mental Health (DMH) services, Executive Office of Elder Affairs, and Massachusetts Rehabilitation Commission (MRC) services;
(6) conducting on-site visits with each member at the member's home every other month or more often as the member's condition warrants, where such visits alternate with the required visits by the care manager to ensure the member receives one visit by the nurse or care manager every month;
(7) completing a nursing progress note for each on-site visit or encounter and upon significant change;
(8) 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;
(9) educating the member about hygiene and health concerns;
(10) reporting changes in the member's condition to the member's PCP;
(11) coordinating and implementing the PCP form and approval for GAFC with the member and GAFC provider personnel;
(12) developing, in conjunction with the MDT, the GAFC direct care aide, and the member or responsible party, an emergency backup and personal care contingency plan for each member receiving GAFC that includes an alternative plan for the member if the GAFC provider is temporarily unable to provide care; and
(13) overseeing, monitoring, supporting, training, and evaluating GAFC direct care aides.

(C) Care Management. Care management must be provided by a qualified GAFC care manager, as described in 130 CMR 408.524(B)(3)(a), who is not related to the member, and who is responsible for coordinating care and monitoring the needs of the member in conjunction with the registered nurse. Care management performed by the GAFC care manager must include the following activities:
(1) conducting initial and ongoing psychosocial evaluation of a member's appropriateness for GAFC;
(2) evaluating, supporting, and training GAFC direct care aides;
(3) assisting with the development of the member's interim and final GAFC plan of care with input from the member or responsible party, all members of the MDT, and other individuals designated by the member.
(4) ensuring implementation of the GAFC plan of care;
(5) conducting on-site visits with each member at the member's home every other month, or more often as the member's condition warrants, where such visits alternate with the required visits by the nurse or care manager to ensure the member receives one visit by the care manager or nurse every month;

(6) assisting with coordination of GAFC with any other health services or supportive services the member is receiving from MassHealth, a managed care organization, an accountable care organization or other agencies or organizations including, but not limited to, visiting nurse services, therapy services, Department of Developmental Services (DDS), Department of Mental Health (DMH) services, and Massachusetts Rehabilitation Commission (MRC) services;
(7) completing a care manager progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;
(8) reporting changes in the member's condition to the member's GAFC nurse;
(9) assisting with making referrals to appropriate service providers if the member requires services other than those provided by the GAFC provider;
(10) providing timely assistance and responding to urgent or emergency needs of the member; and
(11) developing, in conjunction with the MDT, the GAFC direct care aide, and the member or responsible party, an emergency backup and personal care contingency plan for each member receiving GAFC that includes an alternative plan for the member if the GAFC provider is temporarily unable to provide care.

408.506: GAFC Clinical Eligibility Criteria

A member must meet the following clinical eligibility criteria for receipt of GAFC:

(A) GAFC has been ordered by the member's PCP; and

(B) The member has a medical or mental condition that requires daily assistance with at least one of the ADLs described at 130 CMR 408.506(C). Such assistance must be either:
(1) hands-on (physical) assistance, or
(2) cueing and supervision throughout the entire ADL.

(C) The following activities constitute ADLs applicable to GAFC eligibility:
(1) bathing: a full-body bath or shower or a sponge (partial) bath which must 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 (including denture care and brushing of teeth), shaving, and, when applicable, applying make-up;
(2) dressing: upper and lower body, including street clothes and undergarments, but not solely help with shoes, socks, buttons, snaps, or zippers;
(3) toileting: member is incontinent (bladder or bowel) or requires assistance or routine catheter or colostomy care;
(4) transferring: member must be assisted or lifted to another position;
(5) mobility (ambulation): member must be physically steadied, assisted, or guided during ambulation indoors and outdoors, 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 consuming a portion or all of the meal.

408.507: GAFC Clinical Assessment and Prior Authorization

(A) Clinical Assessment. As part of the prior authorization process, members seeking GAFC must undergo a clinical assessment to assess the member's clinical status and need for GAFC. Completed clinical assessment documentation must be submitted to the MassHealth agency, or its designee, in the form and format requested by the MassHealth agency. A new clinical assessment is required annually and upon significant change. The MassHealth agency reserves the right to conduct the clinical assessment.

(B) Prior Authorization.

(1) As a prerequisite for payment of GAFC, the GAFC provider must obtain prior authorization from the MassHealth agency or its designee before the first date of service delivery and annually thereafter, and upon significant change.

(2) Prior authorization determines the medical necessity for GAFC as described under 130 CMR 408.507 and in accordance with 130 CMR 450.204: *Medical Necessity*.

(3) Prior authorization may specify the service amount for payment for the service.

(4) prior authorization does not establish or waive any other prerequisites for payment such as the member's financial eligibility described in 130 CMR 503.007: *Potential Sources of Health Care* and 130 CMR 517.008: *Potential Sources of Health Care*.

(5) When submitting a request for prior authorization for payment of GAFC to the MassHealth agency, or its designee, the GAFC provider must submit requests in the form and format required by the MassHealth agency. The GAFC provider must include all required information including, but not limited to, documentation of the completed clinical assessment conducted by the MassHealth agency or its designee; other nursing, medical or psychosocial evaluations or assessments; and any other documentation that the MassHealth agency, or its designee, requests in order to complete the review and determination of prior authorization.

(6) In making its prior authorization determination, the MassHealth agency or its designee, may require additional assessments of the member or require other necessary information in support of the request for prior authorization.

(C) Notice of Determination of Prior Authorization.

(1) Notice of Approval. If the MassHealth agency or its designee approves a request for prior authorization, it will send written notice to the member and the GAFC provider.

(2) Notice of Denial or Service Modification. If the MassHealth agency or its designee denies, or approves with a service modification, a request for prior authorization of GAFC, the MassHealth agency or its designee will notify both the member and the GAFC provider. The notice will state the reason for the denial or service modification and contain information about the member's right to appeal and the appeal procedure.

(3) Right of Appeal. A member may appeal a service denial or modification by requesting a fair hearing in accordance with 130 CMR 610.000: *MassHealth Fair Hearing Rules*.

(D) Review Requirement. The MassHealth agency, or its designee, may at any time, review prior authorization of MassHealth members including, but not limited to, instances in which there has been a significant change in the member's status as defined in 130 CMR 408.502.

408.508: GAFC Quality Management

Providers must participate in any quality management and program integrity processes established by the MassHealth agency, including making any necessary data available and access to visit the provider's place of business upon request by the MassHealth agency or its designee.

408.509: GAFC Conditions for Payment

(A) The MassHealth agency pays a GAFC provider for GAFC in accordance with the applicable payment methodology and rate schedule established by the EOHHS. Rates of payment for GAFC do not cover or include any amount for room and board.

(B) Payment for GAFC is subject to the conditions, exclusions, and limitations set forth in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) The MassHealth agency pays a GAFC provider for GAFC only if
(1) the member receiving GAFC is eligible under 130 CMR 408.503;
(2) the member meets the clinical eligibility criteria for GAFC in accordance with 130 CMR 408.506;
(3) the GAFC provider has obtained prior authorization for GAFC in accordance with 130 CMR 408.507;
(4) the GAFC provider bills for GAFC provided by direct care aides with the use of electronic visit verification (EVV) in the form and format as required by EOHHS; and
(5) the GAFC provider is not billing for days that are non-covered days under 130 CMR 408.526.

(D) If a member changes from one GAFC provider to another GAFC provider, a new assessment is required and the new GAFC provider must obtain prior authorization. The previous GAFC provider must continue to provide GAFC to the member while the new GAFC provider is obtaining prior authorization and until the member is admitted and receiving services from the new GAFC provider. The previous GAFC provider must discharge the member from its GAFC program before the new GAFC provider may bill the MassHealth agency for GAFC. The MassHealth agency will pay only one GAFC provider per day for the provision of GAFC to a member.

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

(F) MassHealth payment to GAFC providers begins on the later of:
(1) the effective date of the prior authorization from the MassHealth agency; or
(2) the first date on which GAFC is provided to the member.

(G) MassHealth payment to a GAFC provider ends on the date on which a member no longer meets the clinical criteria for GAFC described in 130 CMR 408.456, is no longer receiving GAFC, or no longer has a prior authorization in effect, whichever comes first.

(H) The MassHealth agency pays a GAFC provider for days that an eligible member receives GAFC services. A GAFC 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 GAFC.

(130 CMR 408.510 through 408.520 Reserved)

408.521: GAFC Provider Responsibilities

In addition to meeting all of the qualifications set forth in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*, the GAFC provider must meet all of the following requirements.

(A) Policies and Procedures Manual. Each GAFC provider must develop, maintain, annually review, and update a comprehensive policies and procedures manual governing the delivery of GAFC services. Each manual at a minimum must contain a mission statement; the goals and objectives of the program; an organizational chart describing the lines of authority and communication needed to manage the GAFC program, including the lines of authority for delegation of responsibility down to the member care level; job descriptions that include titles, reporting authority, qualifications and responsibilities; and a description of the governing body. Additionally, each policy and procedure manual must contain the following:

(1) administrative policies and procedures including, but not limited to:
   (a) human resource and personnel;
   (b) staff and staffing requirements;
   (c) backup staff in the event coverage is required due to illness, vacation, or other reasons;
   (d) staff education and training;
   (e) GAFC provider staff evaluation and monitoring;
   (f) emergencies, including fire, safety and disasters, including notifying the fire department and police in emergencies, relocating members during an emergency, and coordinating alternative GAFC providers when a member is relocated;
   (g) MassHealth basics and member rights;
   (h) human rights and nondiscrimination;
   (i) incident and accident reporting;
   (j) staff and member grievances;
   (k) cultural competency;
   (l) quality assurance and improvement;
   (m) direct care aide training;
   (n) emergency services and plans;
   (o) first aid and cardiopulmonary resuscitation requirements;
   (p) Health Insurance Portability and Accountability Act (HIPAA);
   (q) coordination of GAFC with other services the member is receiving; and
   (r) procedures to be followed if a member is missing or lost; and

(2) clinical policies and procedures including, but not limited to:
   (a) clinical evaluations;
   (b) privacy and confidentiality;
   (c) 24-hour emergency coverage, including medical and other emergencies;
   (d) documentation of visits and progress notes;
   (e) medication management;
   (f) universal precautions;
   (g) infection control and communicable disease;

(h) recognizing and reporting abuse (physical, sexual, emotional, psychological) neglect, self-neglect and financial exploitation;
(i) discharge criteria; and
(j) member counseling.

(B) Clinical Assessment and Clinical Evaluations. If required by MassHealth, the GAFC provider's MDT must perform a clinical assessment by completing a clinical assessment screening tool designated by the MassHealth agency as well as all other applicable clinical evaluations for each member
(1) before admission to GAFC;
(2) upon significant change; and
(3) annually on the anniversary date of the member's admission to GAFC.

(C) GAFC Plan of Care. The plan of care must be based upon clinical evaluations and contain the following elements: prioritized goals and objectives that consider and document the needs, goals and preferences of the member; the resources to be utilized; and a plan for continuity of care. The goals and actions of the plan of care must be measurable and reflect the member's desired outcomes for GAFC and address medical, social, and other services needed and chosen by the member. The plan of care must reflect the member's needs, current care and treatment, problem identification with appropriate follow-up, and implementation with interventions and evaluation. The plan of care must be in language that is understandable to the member, and to the individuals important in supporting the member.
(1) Within five working days of a member's admission to GAFC, the GAFC provider's MDT, the member, and others as designated by the member must design an interim GAFC plan of care. The interim plan must be signed by the registered nurse and include, at a minimum, an outline of a temporary schedule of care provided that will be used until the final GAFC plan of care is completed.
(2) Within 30 calendar days of a member's admission to GAFC, the GAFC provider's MDT, the member or responsible party, and others designated by the member must develop the final GAFC plan of care. The final plan of care must be signed by the member, the registered nurse, and the care manager. The final signed plan of care must be sent to the PCP. The final plan of care must include:
(a) a treatment plan describing how, and by whom, the member's service needs will be met seven days a week that is based on the member's PCP's summary, physical examination, and all applicable clinical evaluations; and
(b) documentation of any other health services or supportive services the member is receiving from MassHealth or other agencies or organizations (for example, adult day health, visiting nurse services, therapy services, services provided by DDS, DMH, and MRC, or counseling services, including behavioral health).
(3) The plan of care must be based upon:
(a) the member's strengths, preferences, and member identified goals and desired outcomes for GAFC;
(b) clinical evaluation;
(c) the GAFC direct care aide's care log;
(d) the nursing progress notes;
(e) the care manager's progress notes;

(f) the PCP Summary Form and approval to participate in GAFC;
(g) documentation of the member's PCP annual visit and the member's physical examination; and
(h) the member's discharge and transition plan.

(4) For members who meet the requirements for GAFC service payment, the GAFC provider must annually review the plan of care and send a copy of the member's health status report to the member's PCP.

(5) Review of the plan of care will be conducted by the MDT with participation from the member or responsible party and others as designated by the member at a minimum of every six months, or more often as warranted by changes in the member's condition or other significant changes. If a plan of care is modified, the GAFC provider must send a copy of the plan of care to the member's PCP.

(6) The member, health care proxy, or surrogate identified by a member with decisional capacity must be afforded the opportunity to attend all plan of care meetings.

(7) The GAFC provider must establish emergency policy and procedures in writing and include them with the member's plan of care including, at a minimum, an emergency file (such as an emergency fact sheet) on the member that must contain:
(a) the name and telephone number of the member's PCP;
(b) the member's diagnosis;
(c) any special treatments or medications the member may need;
(d) insurance information;
(e) emergency contact information for notification of the family or legal guardian;
(f) procedures to be followed in the event a member is missing or lost; and
(g) procedures for handling medical emergencies.

(D) Recordkeeping. The GAFC provider must maintain records in compliance with the record retention requirements set forth in 130 CMR 450.205: *Recordkeeping and Disclosure*. 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 staff records, including evidence of completed staff orientation and training, members served per day, and timesheets;
(b) financial records;
(c) member utilization;
(d) staffing levels;
(e) complaints and grievances;
(f) documents related to the member's home;
(g) contracts for subcontracted services;
(h) contracts for independent contractor services, including a description of how the GAFC provider will supervise the independent contractors and their services;
(i) documentation of the preadmission procedure described in 130 CMR 408.522(A); and
(j) maintain job descriptions that include titles, reporting authority, qualifications and responsibilities.

(2) member records, which must contain at a minimum all of the following:
(a) initial admission information, including
1. the member information sheet;
2. the prior authorization by the MassHealth agency or its designee; and
3. clinical evaluations;
(b) medical information, including:
1. a copy of the most recent physical examination (within the past 12 months);
2. the PCP's authorization and summary;
3. the member's semi-annual health-status reports and documentation that the health status reports were sent to the PCP;
4. the member's medical history;
5. the member's tuberculosis screening documentation;
6. list of the member's known allergies;
7. information about the member's dietary requirements;
8. a list of the member's current medications;
9. if designated by the member, advance directives and the name of the healthcare proxy; and
10. the ADL needs as outlined in 130 CMR 408.506(B);
(c) progress notes, including;
1. nursing notes;
2. care manager notes; and
3. service documentation (log of care received);
(d) correspondence from family, therapists, PCP, other service providers, or others, including a managed care organization or an accountable care organization, about the care of the member in the GAFC program;
(e) the GAFC plan of care, including any documentation forming the basis of the plan of care, and documentation that the signed final plan of care was sent to the PCP;
(f) the discharge plan;
(g) legal documentation, for example, signed authorizations for release of information;
(h) critical incident reports in a form and format designated by the MassHealth agency;
(i) the member's post-discharge status;
(j) documentation of the direct care aide's daily schedule; and
(k) documentation of the care required to be provided by the MDT;
(3) records 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.

(E) Reporting.
(1) Incident Reporting. The GAFC 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 GAFC administrative office;
(c) a life-threatening accident or incident;
(d) a serious communicable disease contracted by GAFC staff or a member;
(e) any allegation of abuse or neglect of or by the member; and
(f) a member missing from a qualified setting.

(2) Program Reporting. The GAFC provider must submit all of the following information in the format and time frames as requested by the MassHealth agency:

(a) clinical and statistical information;

(b) cost and expense information;

(c) member satisfaction survey results, including the survey developed by the provider, and a description of how the findings will be addressed;

(d) change in GAFC provider contact information;

(e) any additional information requested by the MassHealth agency or its designee related to the provider's provision of GAFC services; and

(f) data necessary to measure the quality of the services delivered by the provider as required by the MassHealth agency.

(F) Quality Improvement Plan. Each GAFC provider must conduct a biennial survey of members and staff and develop a quality improvement plan that addresses issues and concerns raised by the survey. The provider must maintain the survey and quality improvement plan.

(G) Electronic Visit Verification (EVV). Each GAFC provider must use EVV in the form and format as required by EOHHS.

408.522: GAFC Preadmission and Admission Procedures

Before admitting a member in GAFC, the GAFC provider must perform all of the activities in 130 CMR 408.522(A)(2). Intake and assessment services are provided to members seeking admission to GAFC but who may have not yet received prior authorization by the MassHealth agency or its designee for GAFC.

(A) Preadmission Procedures and Activities

(1) Preadmission Procedures. Before admitting a member in GAFC the GAFC provider must 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 nurse must determine that the GAFC provider is able to meet the ADL and IADL needs of the member prior to admitting the member to GAFC, as well as use the meeting to obtain information about the member's overall health characteristics, psychosocial condition, nutrition habits, financial and health insurance information, housing situation, formal and informal supports in place, and ethnic and cultural background. The GAFC provider must also use this meeting to inform the member and the member's family about the scope of GAFC to be provided and any other relevant information;

(2) Preadmission Activities. Prior to admitting the member, the GAFC provider must perform the following intake and assessment services:

(a) conduct clinical evaluations of the need for GAFC;

(b) instruct members on the rules, policies, and procedures of the GAFC program; and

(c) provide information on the member's rights and responsibilities when receiving GAFC services.

(B) Admission Activities. Upon the GAFC provider's receipt of the MassHealth agency's initial prior authorization authorizing the member to receive services, and by the end of the fifth day after admission, the GAFC provider must perform all four of the following activities:

(1) Complete and submit a written notification to the member and, if applicable, the member's legal guardian. The notice must, at a minimum, specify the following:

(a) that the member has been admitted to GAFC;
(b) the member's interim GAFC plan of care as outlined in 130 CMR 408.521(C)(1);
(c) the respective responsibilities of the member and the GAFC provider;
(d) emergency procedures; and
(e) reasons for discharge from the GAFC provider.

(2) Create a member record. By the first day of GAFC services, the GAFC provider must obtain all the necessary documentation from the member's PCP and other service providers on or before the first date of service. The documentation must include:

(a) the PCP Summary Form and order for GAFC that documents that the member has been examined in the past 12 months and that the MassHealth member's condition requires support with activities of daily living that is provided by the GAFC provider. If the member has a behavior health need, the provider must obtain supporting documentation from the PCP if applicable that may include a psychiatric diagnosis and treatment plan from the member's behavioral health provider;
(b) the member's medical history;
(c) results of a PCP visit within the past three months; however if the PCP has completed a physical examination in the past 12 months and there has been no change in the members medical status, and the PCP has deemed a second physical is not medically necessary, the PCP may document and sign such a statement on the PCP Summary Form;
(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 indicating any contraindications or limitations to the individual's participation;
(g) recommendations for other services, if applicable; and
(h) a list of known allergies, if any.

(3) Conduct an on-site visit on the day of admission by the GAFC nurse.

(4) Conduct on-site visits at least weekly for the first four weeks, including the first visit on the day of admission. Such on-site visits must be conducted by the nurse and care manager on alternating weeks.

(5) Provide the member by day 30, a written copy of the member's completed GAFC plan of care.

408.523: GAFC Discharge Procedures

(A) A member must be discharged by the GAFC provider upon the member's request, or if the member ceases to benefit from GAFC, including the following circumstances:
(1) the member no longer meets the clinical eligibility criteria for GAFC;
(2) the member demonstrates behavioral or other problems that may endanger the member or GAFC provider staff;
(3) the member's clinical needs are beyond the scope of GAFC;
(4) the member's needs cannot be met by the GAFC provider;
(5) the member selects another service which is duplicative of GAFC; or
(6) the member transitions to another GAFC provider.

(B) For all discharges, the GAFC provider must:
(1) develop a discharge and transition plan, which must:
(a) include the date and reason for discharge;
(b) identify any referrals by the GAFC provider to other appropriate service providers for any health or social services required by the member;
(c) ensure continuity of care by the member, including during transitions of care, as specified in the GAFC plan of care;
(d) be dated and signed by the GAFC registered nurse, the GAFC care manager, and the member; 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) provide assistance to the member in identifying and locating another provider;
(3) arrange for the member to be discharged and transitioned to the provider identified in 130 CMR 408.523(B)(2);
(4) coordinate the discharge and transition 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
(5) maintain current services until the member is admitted with a new provider.

408.524: GAFC Staff Qualifications and Responsibilities

All staff directly employed by the GAFC provider, as well as any contract staff, *per diem* staff, backup staff, or anyone providing GAFC on behalf of the GAFC provider to members must meet the following requirements.

(A) General Staff Requirements.
(1) Prior to hiring or contracting with any staff the GAFC provider must:
(a) check the candidate's references and job history and ensure that the candidate meets all of the required experience, education, and qualifications before hiring;
(b) conduct a Criminal Offender Records Information (CORI) check and determine whether any offender records may disqualify the individual for employment;
(c) conduct a Sex Offender Registry Information (SORI) check;
(d) conduct Office of Inspector General (OIG) check;
(e) conduct licenses and certification checks and validate that the candidate has obtained all necessary licenses and certifications and that all licenses and certifications are current;

(f) ensure that each GAFC staff person is not related to or legally responsible for the member receiving GAFC; and

(g) ensure that each GAFC direct care aide, registered nurse, licensed practical nurse, and care manager has received a tuberculosis screening within the previous 12 months.

(2) On an ongoing basis, the GAFC provider must:

(a) ensure that all GAFC direct care aides, registered nurses, licensed practical nurses, and care managers receive tuberculosis screenings in accordance with current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Massachusetts Department of Public Health;

(b) ensure that all staff are appropriately trained and managed, which must include, but not be limited to, training in recognition and reporting of abuse of elders and persons with disabilities and provider services;

(c) evaluate staff annually using standardized evaluation measures;

(d) maintain a record of each performance evaluation in a separate personnel file for each staff member; and

(e) include in each staff member's personnel file any staff incident or accident reports.

(B) The Multidisciplinary Professional Team Staff Qualifications and Responsibilities.

(1) Program Director. The GAFC provider must employ a program director who is a healthcare professional.

(a) Qualifications. The program director must have a bachelor's degree and a minimum of five years of recent professional healthcare experience working with elders or adults. A master's degree in a relevant healthcare 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:

1. development and implementation of the GAFC provider's policies and procedures in 130 CMR 408.521(A);
2. direction and supervision of all aspects of the GAFC program;
3. oversight of the hiring, training, supervision, firing, and evaluation of all GAFC employees and contractors;
4. the fiscal administration of the GAFC program, including billing, budget preparation, and required program statistical and financial reports;
5. ensuring the MDT reviews GAFC direct care aide logs every six months;
6. ensuring that either the nurse or the case manager reviews the GAFC direct care aide logs every month; and
7. ensuring that the GAFC provider meets all of the requirements in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(2) Registered Nurse. The GAFC provider must employ or independently contract with a registered nurse. The registered nurse may function as the program director, provided that a nurse functioning as the program director is employed by the GAFC provider and is not an independent contractor.

(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 of recent experience in the direct care of elders or adults with disabilities.

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

1. completing and coordinating all applicable clinical assessments and clinical evaluations;
2. developing and reviewing on an ongoing basis each member's GAFC plan of care;
3. selecting, training, evaluating, and supervising GAFC direct care aides in conjunction with the care manager;
4. reviewing the PCP Summary Form;
5. monitoring the health status and treatment plans of all members to ensure that all needed GAFC is properly delivered;
6. reporting changes in the health status of any member to the member's PCP;
7. reviewing GAFC direct care aide logs at a minimum of every 30 days;
8. conducting on-site visits with each member at the qualified setting in accordance with 130 CMR 408.505(B)(6);
9. completing a nursing progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;
10. submitting semiannual health-status reports to the member's PCP;
11. planning for and implementing discharges and transition from the GAFC program;
12. conducting an orientation for each GAFC direct care aide before the GAFC direct care aide begins personal care; and
13. providing ongoing training to GAFC direct care aides on health and aging.

(3) GAFC Care Manager. The GAFC provider must employ or independently contract with a care manager. The GAFC care manager may function as the program director, provided that a care manager functioning as the program director is employed by the GAFC provider and is not an independent contractor.

(a) Qualifications. The care manager must have

1. a bachelor's degree, a social worker license from the Massachusetts Board of Registration in Social Work, and at least two years of recent experience working with elders or adults with disabilities; or
2. a bachelor's degree and two years of clinical experience in the care of elders or people with disabilities.

(b) Responsibilities. The responsibilities of the care manager include:

1. obtaining a social history and conducting a psychosocial evaluation;
2. participating in the development, implementation, and ongoing review of the GAFC plan of care;
3. conducting on-site visits with each member at the member's home in accordance with 130 CMR 408.505(C)(5);
4. completing a care-management progress note corresponding with each on-site visit or encounter and upon significant change;
5. reviewing GAFC direct care aide logs at a minimum of every 30 days
6. assisting with obtaining information and accessing other healthcare and community services;
7. reviewing and documenting the fire and safety procedures for the qualified setting;

8. participating in discharge and transition planning and implementation; and
9. conducting an initial review of the suitability of the member's home, and conducting a review at least annually, or more often as needed, the suitability of the member's home.

(4) Staff Qualification Substitution. For any staff member on the MDT who does not meet the qualifications as stated in 130 CMR 408.524, the GAFC provider must receive a written approval from the MassHealth agency for substitution of the qualification prior to hiring.

(C) Direct Care Aide. The GAFC provider must employ or contract with direct care aides.

(1) Qualifications. The direct care aide must:

(a) not be a family member as defined in 130 CMR 408.502;

(b) have one or more years of experience working with elders and people with disabilities providing assistance with ADLs and IADLs; and

(c) hold a valid certification as a home health aide; or

(d) have been determined competent either through a competency evaluation program or by the GAFC provider's registered nurse in all of the following areas:

1. techniques for providing safe personal care assistance;
2. basic understanding of body functioning and changes in body function;
3. assisting participants at various levels of functioning;
4. caring for participants admitted at the Program and participants with Alzheimer's disease and related disorders, behavioral health issues, and cognitive impairments;
5. observation, reporting, and documentation of the members status and the care provided;
6. recognizing the physical, emotional, and developmental needs of the individuals in their care and working in a manner that respects them, their privacy, and their property;
7. preventing and reporting abuse, neglect, mistreatment and misappropriation;
8. communication and interpersonal skills;
9. safety and emergency procedures, including the Heimlich Maneuver;
10. maintenance of a clean, safe, and healthy environment; and
11. recognizing, responding to, and reporting emergencies and knowledge of emergency procedures.

(2) Responsibilities. The responsibilities of the GAFC direct care aide include:

(a) provision of hands-on or cueing and supervision with ADLs and IADLs, of a member in accordance with the individual's GAFC plan of care and that is necessary for the member's health and well-being including, but not limited to, identifying when a crisis intervention is necessary;

(b) monitoring and reporting any nonurgent or nonemergency changes in the member's medical condition to the nurse or care manager. In cases of emergency, report directly to the most appropriate provider and follow-up with a member of the MDT;

(c) providing ongoing supervision of health-related activities, such as:

1. Issuing reminders to the member about prescribed medications; and
2. Timely refilling of the member's prescriptions.

(d) completing a direct care aide log for each visit;

(e) sending the completed direct care aide log at the end of each month to the nurse where it is maintained as part of the member's file;
(f) notifying the GAFC provider of the need for alternative care of the member;
(g) immediately notifying the GAFC provider when any of the following events occur:
1. death of a member;
2. a medical emergency or any significant change in a member's health or level of functioning;
3. a fire, accident, injury, or contraction of a serious communicable disease by the member or GAFC direct care aide;
4. any planned or unexpected departure from the member's home by the member; and
5. all other member or caregiver incidents or accidents.
(h) use electronic visit verification (EVV) in the form and format as required by the MassHealth agency.

(D) Licensed Practical Nurse. The GAFC provider may employ or independently contract with a licensed practical nurse.
(1) Qualifications. The licensed practical nurse must be licensed by the Massachusetts Board of Registration in Nursing and in good standing with the Board.
(2) Responsibilities. Under the direction and supervision of the GAFC provider RN, licensed practical nurses may:
(a) complete and coordinate all applicable clinical assessments and clinical evaluations;
(b) develop and review on an ongoing basis each member's GAFC plan of care;
(c) review the PCP Summary Form;
(d) monitor the health status of all members to ensure that all needed GAFC is properly delivered;
(e) report changes in the health status of any member to the member's PCP;
(f) review GAFC direct care aide logs at a minimum of every 30 days;
(g) conduct on-site visits with each member at the qualified setting in accordance with 130 CMR 408.505(B)(6);
(h) complete a progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;
(i) submit semiannual health-status reports to the member's PCP;
(j) plan for and implementing discharges and transition from the AFC program;
(k) conduct an orientation for each GAFC Direct Care Aide before the GAFC Direct Care Aide begins personal care; and
(l) provide ongoing training to GAFC Direct Care Aides on health and aging.

(E) GAFC Staff Training Requirements.
(1) GAFC providers must provide initial and periodic training to all staff members who are responsible for the care of a member. Records of completed training must be kept on file and updated regularly by the GAFC provider.

(2) The GAFC provider must hold an orientation for new staff within one month of hire. This orientation must include the following topics:

(a) techniques of providing safe delivery of ADLs, IADLs, and good body mechanics;
(b) delivery of GAFC by the GAFC provider;
(c) written policies and procedures of the GAFC provider;
(d) the requirements of 130 CMR 408.000;
(e) GAFC provider staff roles and responsibilities;
(f) caring for people with disabilities, elders, individuals with Alzheimer's disease and related disorders, behavioral health issues and cognitive impairments including behavioral interventions, behavior acceptance, and accommodations;
(g) observation, reporting and documentation of the member's status and the care provided, including GAFC direct care aide log entries;
(h) basic first aid, cardiopulmonary resuscitation (CPR), and emergency procedures, including the Heimlich Maneuver;
(i) universal precautions and infection control practices;
(j) information about local health, fire, safety, and building codes;
(k) privacy and confidentiality;
(l) multidisciplinary team approach;
(m) medication management;
(n) communication and interpersonal skills;
(o) advance directives;
(p) prevention of, and reporting of, abuse, neglect, mistreatment and misappropriation/financial exploitation;
(q) completing and filing critical incident reports;
(r) human rights, nondiscrimination and cultural sensitivity;
(s) recognizing the physical, emotional and developmental needs of the individuals in their care and working in a manner that respects them, their privacy and their property;
(t) recognizing, responding to, and reporting change in condition, emergencies and knowledge of emergency procedures, including the GAFC provider's fire, safety, and disaster plans; and
(u) relevant provisions of the Health Insurance Portability and Accountability Act of 1996.

(F) GAFC Backup Staff Coverage. The GAFC provider must ensure the availability of professional and direct care backup staff if coverage is required due to illness, vacation, or other reasons. All staff providing backup coverage must possess an equal or greater level of licensure and certification required for each position, and must meet all requirements of staff members.

408.525: GAFC Emergency Services and Plans

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

(A) a written disaster plan for notifying the MassHealth agency of relocation of the member and ensuring the continuity of GAFC service delivery in the event of a fire, flood, or other natural or unnatural disaster, an easily accessible emergency plan 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 as specified in 130 CMR 408.521(C)(6) for notification of the family or legal guardian, if identified, and a primary contact person who is able to address the member's needs and available if an unforeseen event occurs that prevents the member's GAFC provider from providing services;

(B) a written plan for emergency staff coverage;

(C) a written plan for emergency care and service in the event a member is displaced for any reason; and

(D) a written Continuity of Operations Plan that follows the guidelines from the Department of Public Health.

408.526: GAFC Non-covered Days

The MassHealth agency does not pay a GAFC 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: *Personal Care Attendant Services*;

(B) the member receives home health aide services provided by a home health agency under 130 CMR 403.000: *Home Health Agency*;

(C) the member is a resident or inpatient of a hospital, nursing facility, ICF/IID, or other provider-operated residential facility subject to state licensure such as group homes licensed by the Department of Developmental Services (DDS) or the Department of Mental Health (DMH), or other facility that provides the member's medically necessary personal care; or

(D) the GAFC provider has not received prior authorization from the MassHealth agency.

408.527: Withdrawal by a GAFC Provider from MassHealth

A GAFC provider that intends to withdraw from MassHealth must satisfy all of the following obligations:

(A) MassHealth Notification.

(1) A GAFC provider electing to withdraw from participation in MassHealth must send written notice to the MassHealth agency or its designee, of the provider's intention to withdraw from the GAFC program. The GAFC provider must send the withdrawal notice by certified or registered mail (return receipt requested) to the MassHealth agency or its designee, no fewer than 90 days before the effective date of withdrawal.

(2) In the instance of alleged emergency withdrawal, the GAFC provider must contact the MassHealth agency, or its designee, within one business day of the emergency withdrawal and follow-up, in writing, within three business days informing the MassHealth agency, or its designee, of the reasoning for such emergency withdrawal, and must provide proof in documentation or other form as the MassHealth agency may require. The GAFC provider must also notify all members and the MassHealth agency about the status of all members and any plans for relocation under 130 CMR 408.523.

(3) The GAFC provider must forward a list of all members currently receiving GAFC. The GAFC provider must notify the MassHealth agency in writing as members are placed in other programs or begin to receive alternative services, including the name of the new program or service and the members' start date in the new program or service.

(B) Notification to Member and Authorized Representatives.

(1) The GAFC provider must notify all members, authorized representatives of members and other funding sources in writing of the intended closing date no fewer than 90 days from the intended closing date, and specify the assistance to be provided to each member in identifying alternative services.

(2) On the same date on which the GAFC provider sends a withdrawal notice to the MassHealth agency, the provider must give notice, in hand, to all members to whom it is providing GAFC services and the member's 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 another GAFC provider participating in MassHealth to ensure continuation of MassHealth payment of services and must be determined eligible to continue to receive the services. A copy of this notice must be forwarded to the MassHealth agency. The notice must also state that the GAFC provider will work promptly and diligently to arrange for the relocation of members to MassHealth-participating GAFC providers or, if appropriate, to alternative community-service providers.

(C) Admission and Relocation Requirements.

(1) A GAFC provider must not admit any new MassHealth members after the date on which the withdrawal notice was sent to MassHealth. Members of the GAFC program, for whom prior authorization was sought prior to the withdrawal notice being sent, who are then authorized for GAFC after the notice of withdrawal are not considered newly admitted members.

(2) A GAFC provider that withdraws from participation in MassHealth must assist members to whom it has been providing GAFC services to identify and locate another GAFC provider, and must continue to provide its current level of GAFC services until all members receiving services from the GAFC provider have been admitted with a new GAFC provider or another qualified MassHealth provider.

(3) A GAFC provider seeking to withdraw from the MassHealth program will work promptly and diligently to arrange for the relocation of members to MassHealth participating GAFC or other qualified MassHealth providers. For relocation requirements, see 130 CMR 408.523.

REGULATORY AUTHORITY

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