Section

3.01: Scope and Purpose

The purpose of the Home Care Program is to assist elders in the Commonwealth of Massachusetts to secure and maintain maximum independence in their home environment. These regulations set forth the functions and responsibilities of the Executive Office of Elder Affairs and providers of Home Care Program Services under agreement with or using funds provided by the Commonwealth. The Home Care Program is funded with state monies subject to appropriation by the Massachusetts Legislature.

3.02: Definitions. When used in 651 CMR 3.00, unless the context otherwise requires, the following terms shall have the following meanings:

Abuse. Consistent with the Elder Protective Services regulations, 651 CMR 5.00, an act or omission, including emotional abuse, financial exploitation, neglect, physical abuse, sexual abuse, and/or self-neglect.

Activities of Daily Living (ADLs) – Tasks, including the ability to bathe, dress/undress, eat, toilet, transfer in and out of bed or chair, move while in bed, and ambulate inside the home, which are used to measure the Functional Impairment Level (FIL) of an Applicant or Consumer.

ASAPs – Aging Services Access Points as authorized in M.G.L. c. 19A, § 4B and defined in 651 CMR 14.01.

Applicant – An individual who has applied for Home Care Program services.

Assisted Living Residence – An entity certified by Elder Affairs under 651 CMR 12.00 which provides room, board, and personal care services to residents.

Caregiver – A person, regardless of place of residence, who is 18 years of age or older and provides assistance with Activities of Daily Living and/or Instrumental Activities of Daily Living, supervision, or social and emotional support as required by a Consumer on a daily basis without pay.

Comprehensive Service Plan – A plan of care that delineates all services and funding sources to be provided to a Consumer that is developed in conjunction with the Consumer and/or the Consumer's Designated Representative.

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Moved down [1]: Legislative and Administrative Authority. The legislative and administrative authorizations for 651 CMR 3.00 are as follows:¶
M.G.L c. 19A, § 4 providing that the Executive Office of Elder Affairs "shall be the principal agency of the Commonwealth to mobilize the human, physical, and financial resources available to plan, develop, and implement innovative programs to insure the dignity and independence of Elders, including the planning, development, and implementation of a Home Care Program for the elderly in the communities of the Commonwealth".¶
M.G.L. c. 19A, § 6. The general authority and responsibility of Elder Affairs to promulgate regulations for the conduct of the business of the agency.¶

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Deleted: At Risk - Elders who are experiencing substance abuse, mental health problems or cultural or linguistic barriers to care.¶
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Certified Home Health Agency - An agency certified by the Department of Public Health that has met the Medicaid and Medicare Conditions of Participation.¶

Deleted: Client - An individual who is eligible for and receiving Home Care Program Services.¶
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Client Record - One record maintained by the ASAP for a Client which contains all required documentation in compliance with Elder Affairs' …

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Congregate Housing – A joint program between Elder Affairs and the Department of Housing and Community Development that offers a shared living environment and integrates housing and support services.

Consumer – An adult who is enrolled in a Home Care program.

Consumer Record – An aggregate file of all documentation associated with a Consumer maintained by an ASAP in compliance with Documentation Standards. Documents requiring signature or that are otherwise unable to be recorded electronically shall be stored in a hard copy file for each Consumer.

Copayment - A monthly dollar amount billed to a Consumer for Home Care Program Services based on the Consumer's income.

Designated Representative – A person who is either: (1) affirmatively identified and designated by the Consumer to share personal health information and provide assistance in making decisions related to the provision of Home Care Services, provided that the Consumer is competent; or, (2) a person serving as a durable power of attorney or as a guardian appointed by a court on behalf of a Consumer, regardless of the Consumer's competency.

Division of Medical Assistance (DMA) – A government agency within the Executive Office of Health and Human Services that is responsible for the administration of the Title XIX (Medicaid) Program known as MassHealth.

Documentation Standards – Standards issued by Elder Affairs regarding the procedures for gathering and maintaining Consumer information.

Elder Affairs – The Executive Office of Elder Affairs.

Family – An Applicant or Consumer and his or her spouse.

Frail Elder Home and Community Based Waiver – A waiver of federal requirements granted to the Commonwealth, by the U.S. Department of Health and Human Services under 42 U.S.C. §1396n(d), that allows DMA to pay for home and community-based services for MassHealth members who meet MassHealth criteria for Nursing Facility services but continue to reside in the community and agree to receive a waiver service.

Functional Impairment Level (FIL) – The degree of functional impairment experienced by an Applicant or Consumer as evidenced by an inability to complete Activities of Daily Living and Instrumental Activities of Daily Living.

Home Care Program Services – services provided to a Consumer, including but not limited to the following:

(a) Adult Day Health (ADH) – health care and supervision, restorative services, and socialization for elders who require skilled nursing or therapy, or assistance with Activities of Daily Living, nutrition, and personal care;

(b) Alzheimer's Day Program – specialized day program services provided to address the

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needs of people with Alzheimer's Disease or related disorders;

(c) Alzheimer's/Dementia Coaching – education and support to Consumers and their families who are experiencing the effects of Alzheimer's Disease or a dementia-related disorder;

(d) Chore – services to maintain the home in a clean, sanitary and safe manner, including but not limited to minor home repairs, general maintenance, and heavy household chores such as washing floors, windows, and walls, and moving heavy items of furniture to provide safe access and egress;

(e) Companion – non-medical services, such as socialization, meal preparation, laundry, shopping, and light housekeeping tasks that are incidental to the care and supervision of the Consumer;

(f) Emergency Shelter – temporary shelter not to exceed 14 calendar days in a six month period provided to an elder (and his or her household) who is without a home due to eviction, fire, flood, other natural disaster, Abuse, neglect, substance use disorder, economic incapacity, or unsafe/substandard housing conditions, including lack of fuel and/or utilities;

(g) Environmental Accessibility Adaptations – physical adaptations to the private residence of the Consumer required by the Consumer's Comprehensive Service Plan;

(h) Grocery Shopping/Delivery Services – ordering groceries, shopping for groceries, delivering groceries, and assisting with storage of groceries as needed;

(i) Home Based Wandering Response System – a device that transmits signals 24 hours per day/seven days per week using technology such as GPS or radio frequency to provide location assistance in the event the Consumer wanders;

(j) Home-delivered Meals – meals provided to Consumers to maintain optimal nutrition and health status;

(k) Home Delivery of Pre-packaged Medications – delivery of medications, including but not limited to pre-filled blister packs and pre-filled syringes by a pharmacy to a Consumer's residence;

(l) Home Health Services – services defined in MassHealth regulations at 130 CMR 403.000 which include Skilled Nursing; Physical, Occupational, and Speech Therapy; and Home Health Aide;

(m) Homemaker Services – services to assist a client with Instrumental Activities of Daily Living provided in accordance with homemaker standards issued by Elder Affairs;

(n) Laundry – pick up, washing, drying, folding, wrapping, and/or returning of laundry;

(o) Medication Dispensing System – provision of an automated medication dispenser that allows a Consumer to achieve adherence to medication requirements by receiving pill form medications at appropriate intervals through audible and/or visual cueing;

(p) Nutritional Assessment – a comprehensive nutritional assessment conducted by a qualified nutritionist;

(q) Personal Care – hands-on assistance, prompting or cueing, and supervision to assist a Consumer to perform Activities of Daily Living provided in accordance with the Personal Care Guidelines issued by Elder Affairs;

(r) Personal Emergency Response System (PERS) – provision of an electronic device which can be used to alert trained third-party staff of an emergency 24 hours per day/seven days per week;

(s) Respite Care Services – the provision of one or more other Home Care Program Services, additionally including but not limited to short term placements in Adult Foster Care, Skilled Nursing Facilities, or Rest Homes, to temporarily relieve a

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Caregiver in emergencies, or in planned circumstances, to relieve the Caregiver of the daily stresses and demands of caring for a Consumer.

(t) Supportive Day Program – services provided in a group setting, including assessments and care planning, health-related services, social services, therapeutic activities, and nutrition;

(u) Supportive Home Care Aide Services – personal care and/or homemaking, emotional support, socialization, and escort services to Consumers with Alzheimer's Disease, a dementia-related disorder, or emotional and/or behavioral problems;

(v) Transitional Assistance – non-recurring expenses associated with the transition of individuals who are moving from an institutional or other provider-operated living arrangement to a living arrangement in a private residence in which the person is directly responsible for his or her own living expenses;

(w) Transportation – The provision of transportation to enable a Consumer to gain access to community services, activities and resources;

(x) Vision Rehabilitation – a service intended to evaluate the needs of persons who are visually impaired and instruct the visually impaired in the use of compensatory skills and aids that will support safe, productive, and independent living; and,

(y) Wanderer Locator Service – payment for registration in a national database established to help track and locate those with dementia-related disorders who are at-risk of wandering and becoming lost.

Information and Referral Services – Activities related to the maintenance and dissemination of current information regarding the services available to elders and individuals with disabilities. Such activities include assessments of the type of assistance needed, referral to appropriate services, and follow-up to determine whether the referrals accomplished the desired objectives. Information and Referral services may be conducted by mail, by telephone, electronically, or in person.

Instrumental Activities of Daily Living (IADLs) – Basic tasks, including the ability to prepare meals, do housework, do laundry, go shopping, manage medication, ambulate outside the home, use transportation, manage money, and use the telephone, which are used to measure the Functional Impairment Level (FIL) of an Applicant or Consumer.

Interdisciplinary Case Management – A person-centered approach to assessment, service acquisition, reassessment, and monitoring of services provided to Consumers to help them live independently and remain in the community. The approach includes working cooperatively, coordinating Comprehensive Service Plans and maintaining ongoing communication with the elder, family members, informal and formal supports, as necessary. Interdisciplinary Care Management is provided by registered nurses and case managers working in consultation with physicians, nurses and therapists from home health agencies, hospice providers, nutritionists, housing managers, mental health professionals, and other home and health care professionals and complies with the Interdisciplinary Case Management Standards issued by Elder Affairs.

Long Term Care (LTC) Assessment – The process to determine eligibility for Home Care Program Services through the use of the comprehensive data set (CDS) assessment tool issued by Elder Affairs and used by the ASAPs.

MassHealth – The Medical assistance program known as MassHealth administered by the

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Executive Office of Health and Human Services pursuant to M.G.L. c. 118E and Title XIX of the Social Security Act.

MassHealth Member – An individual who has been determined eligible to receive benefits under MassHealth.

Medicaid – The federal designation for eligibility and benefits administered under MassHealth.

Medication Management – Services provided to a Consumer to help ensure adherence with medication requirements, including cueing and providing access to medications.

Notice of Action – A procedural notification created in accordance with 801 CMR 1.00: Standard Adjudicatory Rules of Practice and Procedure, and the Supplemental Rules to 801 CMR 1.00, 651 CMR 1.00 *et seq*.

Nursing Facility – A facility that is licensed to provide skilled nursing care to residents in accordance with the requirements of 130 CMR 456.000, *et seq*.

Peer Review – A process by which ASAPs convene in groups to review Consumer Records for the purpose of providing feedback to one another regarding how cases were handled and ensure more consistent operations among providers. The Peer Review process must be implemented according to Peer Review Program Instructions issued by Elder Affairs.

Program Instruction – A document issued by Elder Affairs that sets forth required procedures and protocols for the management of the Home Care Program.

Protective Services – Services provided by an Elder Protective Services Program in accordance with M.G.L. c. 19A, §§ 14 through 26 and 651 CMR 5.00, which are deemed necessary to prevent, eliminate or remedy the effects of Abuse to an elder.

Provider – An entity which has entered into a contract with an ASAP to provide one or more Home Care Program Services.

Service Plan – A plan of care that identifies all authorized Home Care Services.

Service Priority – A method used to prioritize Applicants to the Home Care Program which is based on an assessment of Critical Unmet Needs and Non-critical Unmet Needs.

Suspension – The temporary cessation of Home Care Program Services.

Termination – The permanent cessation of Home Care Program Services or Enrollment(s).

Uniform Intake – The intake policy and procedures established by Elder Affairs to determine eligibility for Home Care Program Services. The Uniform Intake Policy is subject to change and the eligibility of an individual under such policy is subject to appropriation of state funds.

Unmet Need(s) – The Applicant's or Consumer's identified care needs which are not being met by other sources available to the Consumer or Applicant as determined by the Long Term

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Care Assessment. Unmet Needs consist of two sub-categories:

(1) Non-critical Unmet Needs – Unmet Needs which include one or more of the following: laundry, housework, shopping other than food shopping, transportation other than transportation for medical treatment, socialization, and telephone use; or,

(2) Critical Unmet Needs – A Consumer's Unmet Needs which include one or more of the following: any Activity of Daily Living (ADL), meal preparation, grocery shopping, Medication Management, transportation for medical treatments, Respite Care Services, and Home Health Services.

Voluntary Copayment – A copayment which may be contributed should a Consumer opt to do so.

3.03: Functions and Responsibilities of the Executive Office of Elder Affairs.

(1) Elder Affairs shall be responsible for the ongoing planning, coordination, administration, monitoring, and evaluation activities necessary to implement the Home Care Program in the Commonwealth and will provide for an ongoing program of technical assistance to agencies performing home care functions in the implementation of the Home Care Program.

(2) General Functions and Responsibilities.

(a) Enter into a purchase agreement with the ASAPs which sets forth the conditions under which the ASAP will receive reimbursement from Elder Affairs for the provision of Home Care Program Services to eligible individuals;

(b) Set forth policies and procedures relative to the appropriate coordination of funding for the Home Care Program;

(c) Provide ongoing monitoring and evaluation of the operation of the Home Care Program by ASAPs;

(d) Establish reporting procedures through which Elder Affairs shall maintain current knowledge of ASAP programs and operational information in order to assist Elder Affairs to effectively carry out its legislative and administrative functions and responsibilities;

(e) Issue written policy instructions and other technical assistance information to assist ASAPs to effectively carry out their respective functions and responsibilities;

(f) Establish written policies as to the award of contracts by the ASAP in accordance with applicable Federal and State laws; and

(g) Perform other functions which relate to the proper and efficient administration of the Home Care Program in the State, including provision for training and manpower development and public information.

(h) The Secretary may issue Program Instructions to define and approve additional Home Care Program Services available to Consumers to secure and maintain maximum independence.

3.04: Eligibility and Enrollment.

ASAPs shall establish administrative procedures for carrying out the following determinations and functions:

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Administration of the Home Care Program

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(1) Eligibility. An Applicant shall be eligible for Home Care Program Services if the Applicant is an Elder who meets the following eligibility criteria: the application requirements of 651 CMR 3.04(2); the age and residency requirements set forth in 651 CMR 3.04(3); the financial eligibility requirements set forth in 651 CMR 3.04(4); and the Functional Impairment Level, determination of need and Service Priority Matrix requirements set forth in 651 CMR 3.04(5).

(a) Implications of MassHealth Frail Elder Home and Community Based Waiver Enrollment.

1. MassHealth members who meet Home Care Program eligibility criteria under 651 CMR 3.04 shall be eligible to receive Home Care Program Services provided that such services are determined to be non-duplicative with other MassHealth services.
2. MassHealth members shall be ineligible for Home Care Program Services if enrolled in an all-inclusive MassHealth program.

(2) Application for the Home Care Program.

(a) The ASAP shall afford any individual the opportunity to apply for the Home Care Program and shall inform each Applicant about the eligibility requirements and his or her rights and obligations under the program.

(b) The ASAP shall contact an Applicant within three business days after the date the referral is received to commence the intake process.

(c) Within five business days after the referral is received, the ASAP shall complete an initial LTC Assessment for the purpose of determining eligibility and assessing the needs of the Applicant in accordance with 651 CMR 3.04, §§ 1 through 5. A determination of eligibility shall be made on all applications determined to be emergency cases within one business day. For the purposes of this section, "emergency cases" shall mean any situation that may place an elder at risk of nursing home placement due to such circumstances as an imminent or unexpected return to the community from a hospital or other facility.

(d) If the Applicant is hospitalized or institutionalized, the initial assessment may be conducted prior to discharge. The Applicant's home environment and his or her ability to function in that setting will be assessed at the first home visit following discharge.

(e) If the Applicant is unable or unwilling to have an initial LTC Assessment conducted within five days from the date the referral is received, the ASAP shall make reasonable efforts to conduct the assessment within a reasonable time period and shall document the reason for the delay.

(f) An application for services shall be documented in the manner prescribed by Elder Affairs and in compliance with Documentation Standards. The Applicant or his or her Designated Representative shall sign and date an Applicant consent and disclosure form, certifying that the information is correct to the best of his or her knowledge.

(g) At the time of application, the Applicant shall be notified in writing of his/her right to appeal a decision by the ASAP in accordance with 651 CMR 3.04(6)(c).

(h) Within five business days of the initial LTC assessment, the ASAP must determine the Applicant's eligibility for Home Care Program Services; provide a written notification to the Applicant regarding eligibility; and develop and

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initiate the appropriate service(s). If circumstances preclude compliance with this requirement, they shall be documented in the Consumer Record.

(i) Appropriate Home Care Program Services shall be provided to an Applicant who is determined to be eligible pursuant to the requirements set forth in 651 CMR 3.04 in accordance with a Service Plan which is to be developed pursuant to 651 CMR 3.05.

(j) Notwithstanding the requirements for the application for and the provision of Home Care Program Services, if the ASAP determines that there is an immediate need for services, services may be implemented prior to the determination of eligibility if it is reasonable to expect the Applicant will be eligible for Home Care Program Services pursuant to the requirements of 651 CMR 3.04.

(3) Age and Residency.

(a) Age. An Applicant or Consumer must be age 60 or older, or under the age of 60 with a physician's documented diagnosis of Alzheimer's Disease, a related disorder, or other dementia must meet the eligibility criteria set forth in 651 CMR 3.04(4) and (5).

(b) Residency. An Applicant or Consumer must reside in Massachusetts. Home Care Program Services shall not be provided to individuals residing in the following settings: a hospital, clinic, or infirmary; a convalescent home, rest home, nursing facility or charitable home for the aged or other facility licensed under M.G.L. c. 111, § 71; state hospitals or facilities licensed under M.G.L. c. 19, § 7 and c. 19B, §§ 7 and 15; or Assisted Living Residences.

(4) Financial Eligibility.

(a) An Applicant must meet the appropriate financial eligibility criteria set forth in the Financial Eligibility Guidelines issued by Elder Affairs.

(b) The Financial Eligibility Guidelines based on annual gross income by Family size shall be increased to incorporate the percentage increase of the Cost of Living (COLA) announced by the U.S. Bureau of Labor Statistics and adopted by the U.S. Social Security Administration for Social Security and Supplemental Security Income (SSI) effective each January 1st. Elder Affairs may, in its discretion, not more than once per year, on the first of a month and with at least 30 days advance public notice, amend the Financial Eligibility Guidelines to change the Home Care Program voluntary suggested co-payment schedule. The Financial Eligibility Guidelines shall be made available as a public record by Elder Affairs.

(c) Information and Referral Services, Protective Services Casework (as defined in 651 CMR 5.02 for Consumers who are deemed to be suffering from Abuse in accordance with M.G.L c. 19A, §§ 14 through 26 inclusive), and Emergency Shelter are provided without regard to income.

(d) Protective Services clients in need of Home Care Program Services shall be subject to Financial Eligibility and Cost Sharing eligibility criteria for the Home Care Program. However, the ASAP may provide Home Care Program Services to these elders regardless of income and/or payment of a co-payment if the ASAP determines that discussion of financial eligibility and/or payment of fees would have an adverse effect on the provision of Protective Services.

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This determination shall be in compliance with procedures issued by Elder Affairs.

(e) Annual Gross Income. For purposes of determining financial eligibility, annual gross income means the annual rate of income received by an individual or Family from the following sources:

1. Wages or salary;
2. Net income from self-employment;
3. Social Security pensions and survivor's benefits;
4. Disability insurance income;
5. Capital gains, taxable or tax free dividends, taxable or tax free interest income, proceeds from estates or trust disbursements, and royalties;
6. Net rental income and net income from roomers and boarders (gross rental income, less expenses received from a person other than a spouse or child residing in the home);
7. Public assistance and welfare payments;
8. Pensions and annuities;
9. Unemployment compensation and worker's compensation;
10. Alimony and child support;
11. Federal Veteran's pension;
12. Railroad Retirement benefits;
13. Business income;
14. IRA distributions;
15. Lump sum payments;
16. Other income; provided that reverse mortgage loan proceeds (pursuant to M.G.L. c. 19A, § 36), and war reparations income shall not be considered income.

(f) Income from an Asset. Income from any asset jointly owned by two or more persons is presumed to be distributed in equal shares unless a different distribution of income is verified. If the Consumer or Applicant claims less than the proportional share,(s)he shall verify the amount owned with one or more of the following documents: title; purchase contract; documentation of ownership for joint bank accounts; certificate of ownership; financial institution records; other documentation that indicates ownership; or a notarized affidavit signed by all owners of the asset attesting to the distribution of ownership. When such a partial ownership is verified, the income shall be attributed to the Consumer or Applicant in proportion to the ownership interest.

(g) Verification. The Applicant's/Consumer's signed declaration that the financial information provided is true, to the best of his/her knowledge and belief shall ordinarily constitute the basis for income verification. Such declaration shall include the amount of gross monthly income, the source(s) of such income and the type of income. The Applicant's or Consumer's statements will be sufficient to establish his/her eligibility, provided that the information is complete and consistent. If the ASAP determines that the declaration appears insufficient, supportive evidence shall be requested. If the Applicant/Consumer refuses to make a full declaration, or refuses to supply evidence needed, the application for the Home Care Program shall be denied. This denial shall be subject to the right to appeal.

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(h) Determination and Redetermination of Financial Eligibility.

1. Redetermination of financial eligibility shall take place annually. If the ASAP is aware of an income change, other than cost of living allowance increases in Social Security benefits), the financial redetermination shall take place as soon as possible, or at the next scheduled home visit. An interim (between annual redeterminations) financial redetermination shall not be done solely due to a cost of living increase in Social Security benefits.
2. If the living arrangements of a Family changes for longer than three months, a redetermination must be carried out. If one spouse leaves the home for longer than three months, the spouse remaining at home shall be re-determined on the basis of a one-person Family.

(5) Functional Impairment Level Assessment and Service Priority Matrix.

(a) A Long Term Care Assessment shall be completed to determine eligibility for the Home Care Program. Such assessment shall be in accordance with forms and procedures as required by Elder Affairs. Initial assessments for Applicants shall entail at least one home visit.

(b) Functional Impairment Levels (FIL). A FIL shall be determined for each Applicant or Consumer based on his or her inability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The status of the Consumer shall be reviewed at each reassessment and the Functional Impairment Level changed if appropriate.

1. The FIL is determined by counting the number of ADL and IADL impairments based on the assessment.
2. The Functional Impairment Levels (FIL) are:

FIL 1: 4-7 ADL Impairments.
FIL 2: 2-3 ADL Impairments.
FIL 3: one ADL Impairment and any number of IADL impairments; or,
6 or more IADL Impairments.
FIL 4: no ADL impairments and 4-5 IADL Impairments.

(c) Long Term Care Assessment for Home Care Program Services. An Applicant's need for Home Care Program services shall be determined using the LTC Assessment. After determining that the Applicant or Consumer has a qualifying FIL, the ASAP shall determine the extent of need for Home Care Program Services. The assessment shall also determine a Caregiver's need for Respite Care Services. The ASAP shall determine whether an Applicant or Consumer should be expected to be maintained at home considering current problems, Unmet Needs and expected availability of other resources including formal services and informal supports. If the possible services authorized and/or arranged for are deemed inappropriate to maintain an Applicant or Consumer safely in his or her home, the ASAP may not provide purchased services, but must provide assistance in securing the appropriate needed services, following the appropriate appeals, if any, pursuant to 651 CMR 3.04(6).

(d) Service Priority. Priority of service is determined according to the FIL and Unmet Needs. The following list identifies eight service categories in order of

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<#> FIL 2: 2-3 ADL Impairments.¶
<#> FIL 3: 6-10 ADL and/or IADL Impairments.¶
<#> FIL 4: 4-5 ADL and/or IADL Impairments.¶

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<#> FIL 1: 4-7 ADL Impairments.¶
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<#> FIL 3: 6-10 ADL and/or IADL Impairments.¶
<#> FIL 4: 4-5 ADL and/or IADL Impairments.¶

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1-C: FIL 1 with one or more Critical Unmet Need(s).
2-C: FIL 2 with one or more Critical Unmet Need(s).
3-C: FIL 3 with one or more Critical Unmet Need(s).
4-C: FIL 4 with one or more Critical Unmet Need(s).
1-NC: FIL 1 with Non-Critical Unmet Needs.
2-NC: FIL 2 with Non-Critical Unmet Needs.
3-NC: FIL 3 with Non-Critical Unmet Needs.
4-NC: FIL 4 with Non-Critical Unmet Needs.

(e) To qualify for Home Care Services, an Applicant's initial FIL and Service Priority must be either 1-C, 2-C or 3-C according to the list included in 651 CMR 3.04(5)(d). A Consumer's ongoing FIL and Service Priority must be determined to be either 1-C, 2-C, 3-C or 4-C, or 1-NC, 2-NC, 3-NC, or 4-NC to remain eligible to receive Home Care Services.

(f) Consumers whose Caregivers are in need of Respite Care Services must be categorized under the appropriate FIL and be determined to have one or more Critical Unmet Needs.

(g) Exceptions to the Uniform Intake Policy. An Applicant or Consumer may qualify for an exception to the current Uniform Intake Policy when he or she meets the eligibility criteria set forth within these regulations, but is not within a Service Priority category open for Uniform Intake. To be considered for an exemption from the Uniform Intake, the Applicant or Consumer shall meet one or more of the following criteria.

1. Elders who are at risk of being unable to remain in the community due to a variety of factors, including, but not limited to substance use disorders, cognitive, emotional, or mental health problems, or cultural and/or linguistic barriers.
2. Protective Services. Elders who are receiving or are eligible to receive Protective Services as defined in 651 CMR 3.02 shall be eligible for Home Care Program Services.
3. Congregate Housing. Consumers residing in a Congregate Housing Facility.
4. Waiver Consumers. Consumers who are eligible for the Frail Elder Home and Community Based Waiver Program.

(6) Notification of Eligibility.

(a) The ASAP shall give written notice to each Applicant after a decision is made as to whether such individual is eligible for Home Care Program Services. Such notification shall include a statement of his/her suggested monthly voluntary copayment or a statement of his/her cost sharing copayment, if applicable.

(b) If the Applicant has been found ineligible for the Home Care Program, the notice of ineligibility shall contain a statement of reasons supporting the finding of ineligibility, a reference to applicable regulations, and an explanation of the Applicant's right to request an appeal pursuant to the 801 CMR 1.00: *Standard Adjudicatory Rules of Practice and Procedure* and the Supplemental Rules to 801 CMR 1.00, 651 CMR 1.00 *et seq.*

(c) Right to Appeal.

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1. An Applicant/Consumer shall be informed in writing of his or her right to request a Review of an ASAP's decision to deny an application for Home Care Program Service.
2. The Applicant or Consumer shall also be informed in writing of his or her right to Appeal a Review decision to Elder Affairs' Hearings Officer as specified in 651 CMR 1.07. The Appeal shall be conducted in accordance with 801 CMR 1.00 and 651 CMR 1.00 *et seq.*

3.05: Service Plan Development and Reassessment.

(1) Service Plan. After determining an Applicant's eligibility and need for Home Care Services pursuant to 651 CMR 3.04, a Service Plan will be developed. The Service Plan will identify the services to be provided to the Applicant or Caregiver to meet his or her identified needs and the date on which services shall commence. The ASAP shall initiate the provision of the appropriate service(s) in accordance with the time lines outlined in 651 CMR 3.04(2). Circumstances resulting in exceptions to this time requirement shall be documented in the Consumer's electronic record.

(2) Service Authorization. The ASAP shall issue a service authorization to all providers in order to initiate, change, or terminate any Home Care Program Service according to procedures mandated by Elder Affairs.

(3) Follow-up and Reassessment. The ASAP shall provide ongoing Interdisciplinary Case Management services to the Consumer to:

(a) Assess whether the services provided to the Consumer are meeting his/her needs;
(b) Ascertain whether the services are being provided by the provider in a manner acceptable to the Consumer and appropriate for his or her needs;
(c) Determine and make necessary changes in the level, amount, and/or type of services deemed appropriate by the ASAP;
(d) Reassess each Consumer's current health and functional status, need for services, service level, and service type by conducting in-home reassessments and communicating with the elder, family members, other care givers, informal supports and/or formal supports as necessary. A home visit to reassess the Consumer's needs shall be conducted according to specific Elder Affairs Program Instructions; and,
(e) Document any changes in the service pattern, including an increase, reduction, termination, or suspension of services made as a result of this ongoing reassessment process. A Long Term Care Assessment is required to be completed a minimum of every six months and more frequently as required by changes in the Consumer's circumstances, functional impairments, or service needs.

3.06: Cost Sharing.

(1) Voluntary Co-Payments.

(a) Consumers who are eligible for the Frail Elder Home and Community Based Services Waiver shall not be informed of the option to make Voluntary Co-payments for services, including without limitation, home delivered meals.
(b) Elders whose gross annual income does not exceed the amounts set forth in the Voluntary Co-payment section of the Financial Eligibility Guidelines shall be

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requested to make a Voluntary Co-payment toward the cost of Home Care Program Services provided in accordance with the schedule set forth therein.

(c) An ASAP may not deny an individual who is eligible under 651 CMR 3.04 and 651 CMR 3.06(1)(b) for Home Care Program Services because he/she will not make a Voluntary Co-payment;

(d) ASAPs shall not accept Voluntary Co-payments in excess of the cost of the Client's services;

(e) ASAPs shall maintain separate accounts for Voluntary Co-payments collected under 651 CMR 3.06(1)(b) and Co-payments collected under 651 CMR 3.06(2)(b) and (c) and shall report such collections in a manner determined by Elder Affairs.

(f) MassHealth members with any coverage type whose income is at or below 300 percent of the Supplemental Security Income Federal Benefit Rate (SSI FBR) are exempt from all co-payments, including Voluntary Co-payments;

(2) Co-Payments.

(a) Income of an Applicant or Consumer described in 651 CMR 3.06(1)(g) shall be verified by the ASAP through the MassHealth verification system. The ASAP shall record the MassHealth number as required in the Consumer's electronic record.

(b) Individuals who are not financially eligible pursuant to 651 CMR 3.06(1), whose income falls into the Home Care Services Co-payment schedule set forth in the Financial Eligibility Guidelines shall be assessed a co-payment for Home Care Program Services based on the schedule set forth therein in effect on the date of his/her initial determination or re-determination of financial eligibility as defined in 651 CMR 3.04(4)(h).

(c) If a Consumer's income is within the range noted in the Home Care Cost Sharing schedule and is in need of and eligible for Home Care Services, the following Co-payment Schedule shall be used:

1. The monthly Co-payments shall be determined according to the Home Care Cost Sharing income schedule set forth in the Financial Eligibility Guidelines in effect during his/her initial determination or re-determination of financial eligibility as defined in 651 CMR 3.04(4)(h).
2. Payment of such Copayment shall be agreed upon by the Consumers indicated on forms provided by Elder Affairs.
3. Copayments shall not be collected in excess of the cost of Home Care Services.

(d) Copayments for Home Delivered Meals for Non-Waiver Consumers.

1. Home Delivered Meals may be provided on a per meal copayment at a rate set at the same level as the suggested contribution of the Title III-C nutrition program within the area served by the ASAP, and shall not exceed the cost of the meal.
2. Copayments may be collected and retained by the Home Delivered Meals provider. Nutrition providers not subject to Title IIIC requirements shall not collect copayments.
3. Home Delivered Meals shall not be denied for failure to pay the Copayment for this service.

(e) Billing of Copayments.

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<#>Financial Eligibility and Voluntary Co-payments for Home Care Program Services. Individuals whose income falls into the categories defined in 651 CMR 3.03(3)(e)1. through 651 CMR 3.03(3)(e)3., are asked to make a Voluntary Co-payment for Home Care Program Services.¶
<#>MassHealth Members who are age 60 or older;¶
<#>Spouses, age 60 or above and residing together, of any individual referred to in 651 CMR 3.03(3)(e)1., except spouses of MassHealth Members under the Massachusetts Medical Assistance Program whose eligibility for Medical Assistance was determined under the so-called Spousal Waiver of the Home and Community Based Waiver. For purposes of financial eligibility for the Home Care Program, these spouses shall be considered to be a one-person family and the annual gross income shall be determined in accordance with 651 CMR 3.03(3)(e)3. or 651 CMR 3.03(3)(f)1.¶
<#>Elders whose gross annual income does not exceed the amounts set forth in the Voluntary Co-payment section of the Financial Eligibility Guidelines shall be requested to make a Voluntary Co-payment toward the cost of Home Care Program Services provided in accordance with the schedule set forth therein.¶ ...

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Financial Eligibility and Cost Sharing for Home Care Program Services. …ndividual ...

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1. The ASAP shall provide a monthly bill for each Consumer for the Copayment as determined in 651 CMR 3.06(2)(b) or (c). The Copayment shall be due within 30 days of the date of the bill. The ASAP shall make all reasonable efforts to collect Copayments. ASAPs may undertake action to enforce payment of said Copayment up to and including termination of services. ASAPs shall have the ability to waive or reduce Co-payments based on hardships that impact the Consumer's ability to pay.
2. If all or part of a Consumer's Copayment becomes two or more months overdue after the ASAP has made all reasonable efforts to collect the Copayment, the ASAP may send a Notice of Action to the Consumer. If the Consumer fails to pay the Copayment or to establish a payment schedule within 14 days after receipt of the Notice of Action, the ASAP may terminate services to the Consumer. An ASAP may send a Notice of Action to terminate services for reasons of non-payment to a Protective Services client receiving Home Care Services only if it complies with the procedures established in 651 CMR 3.07.
3. When an ASAP terminates Home Care Program Services due to the failure of a Consumer to pay the Copayment, such Consumer may reapply and receive Home Care Program Services provided that he/she pays all past due Copayments or agrees to a schedule of repayment of such past due amounts.
4. ASAPs shall use retained Copayments collected to provide Home Care Program Services to Consumers.
5. ASAPs shall maintain separate accounts for Voluntary Copayments collected under 651 CMR 3.06(1), and Copayments collected under 651 CMR 3.06(2)(b) and (c), and shall report such collections in a manner determined by Elder Affairs.

3.07: Suspension and Termination.

(1) An ASAP may suspend a Consumer's Home Care Program Services if the Consumer is temporarily unavailable to receive such services in his or her home for up to 90 calendar days. The ASAP may extend the Suspension of Home Care Services to a Consumer beyond such 90 day period for reasonable cause and shall document such cause in the Consumer's record. The ASAP shall reassess the Consumer's need for services when the Consumer becomes available to receive services in his or her home.

(2) If it appears during such Suspension period that the Consumer's unavailability will last longer than 90 calendar days and reasonable cause for extension of the suspension is not present, the ASAP shall forward a Notice of Action to the Consumer to terminate Home Care Program Services.

(3) If the Consumer no longer meets the eligibility criteria for the Home Care Program set forth in 651 CMR 3.04(2), (3), (4), or (5) the ASAP shall forward a Notice of Action to the Consumer to terminate Home Care Program Services.

(4) Notice of Action Requirements.

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Determination and Redetermination of Financial Eligibility.¶
Redetermination of financial eligibility shall take place annually. If the ASAP is aware of an income change (except cost of living increases in Social Security benefits), the financial redetermination shall take place as soon as possible, or at the next scheduled home visit. An interim (between annual redeterminations) financial redetermination shall not be done solely due to a cost of living increase in Social Security benefits.¶
If the living arrangements of a multi-person Family changes for longer than three months, a redetermination must be carried out. In a case of a married couple who have been determined eligible on the basis of a two-person Family, if one spouse leaves the home for longer than three months, the spouse remaining at home shall be redetermined on the basis of a one-person Family.¶
¶
Home Care Program Eligibility: Functional Impairment Level.¶
A Long Term Care Assessment shall be completed to determine eligibility for the Home Care Program. Such assessment shall be in accordance with forms and procedures as required by Elder Affairs. Initial assessments for Applicants shall entail at least one home visit.¶
Functional Impairment Levels (FIL). A FIL shall be determined for each Applicant based on his or her inability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The status of the Client shall be reviewed at each reassessment and the Functional Impairment Level changed if appropriate.¶
The Functional Impairment Levels (FIL) are:¶
FIL 1: 4-7 ADL Impairments.¶
FIL 2: 2-3 ADL Impairments.¶
FIL 3: 6-10 ADL and/or IADL Impairments.¶
FIL 4: 4-5 ADL and/or IADL Impairments.¶
The FIL is determined by counting the number of ADL and IADL impairments based on the assessment. If an Applicant or Client has two or more ADL impairments, he or she shall receive a FIL of one or two, whichever is appropriate, regardless of the number of IADL impairments. If an Applicant or Client has l …

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(a) For non-Frail Elder Waiver Consumers, the Notice of Action shall include the date on which services were suspended; the reason for the Termination; and a statement that the Consumer's Home Care Services shall be Terminated on the 15th calendar day after the Consumer receives such Notice of Action unless the Consumer takes either of the following actions prior to such date:

1. The Consumer notifies the ASAP within 14 calendar days after receiving such Notice of Action that she or he is available to receive Home Care Services in his or her home. The Consumer's need for Home Care Program Services shall be reassessed as soon as possible after the ASAP is notified that the Consumer is available to receive such services; or
2. If the Consumer requests a Review of such Termination of Home Care Services which is received by the ASAP on or before the 14th calendar day following the Consumer's receipt of such Notice of Action. If the Consumer files a timely request for Review, the ASAP shall continue the Suspension or continue the provision of Home Care Program Services during the Review and Appeal period. If the Consumer fails to timely notify the ASAP or request a Review of the Notice of Action Terminating Services as set forth in 651 CMR 3.07, the Consumer's request for reinstatement shall be treated as a new application for Services.

(b) For Frail Elder Waiver Consumers, the Notice of Action shall include the date on which a Frail Elder Waiver Consumer's services were suspended; the reason for the termination; and a statement that the Consumer's Home Care Services shall be Terminated on the 31st calendar day after the Consumer receives such Notice of Action unless the Consumer takes either of the following actions prior to such date:

1. The Consumer notifies the ASAP within 30 calendar days after receiving such Notice of Action that she or he is available to receive Home Care Services in his or her home. The Consumer's need for Home Care Program Services shall be reassessed as soon as possible after the ASAP is notified that the Consumer is available to receive such services; or
2. If the Consumer requests a Review of such Termination of Home Care Services which is received by the ASAP on or before the 30th calendar day following the Consumer's receipt of such Notice of Action. If the Consumer files a timely request for Review, the ASAP shall continue the Suspension or continue the provision of Home Care Program Services during the Review and Appeal period. If the Consumer fails to timely notify the ASAP or request a Review of the Notice of Action Terminating Services as set forth in 651 CMR 3.07, the Consumer's request for reinstatement shall be treated as a new application for Services.

(5) Right to Appeal.

(a) An Applicant/Consumer shall be informed in writing of his or her right to request a Review, where the ASAP makes a decision to deny, terminate, or reduce Home Care Program Service.

(b) An ASAP shall inform the Consumer when there has been a change in the source

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of funding of the Consumer's services but the type of and amount of such services remain unchanged. The Consumer shall not have the right to Appeal a decision by the ASAP where there is or has been a change in the source of funding of his or her services.

(c) The Applicant or Consumer shall also be informed in writing of his or her right to Appeal a Review decision to Elder Affairs' Hearings Officer as specified in 651 CMR 1.07. The Appeal shall be conducted in accordance with 801 CMR 1.00 and 651 CMR 1.00 *et seq.*

3.08: General Provisions

(1) The ASAP shall comply with regulations set forth in 651 CMR 1.00, 3.00 and 14.00, requirements set forth in the Commonwealth Terms and Conditions for Human and Social Services contracts and all written policies and procedures issued by Elder Affairs.

(2) Any contractor, sub-contractor or grantee of Elder Affairs shall comply in all respects with 801 CMR 3.00: Privacy and Confidentiality, and Elder Affairs' Privacy and Confidentiality Regulations, 651 CMR 5.20, where applicable in Protective Services cases, Supplementary Privacy and Confidentiality Policies and Procedures developed by Elder Affairs.

(3) The establishment of a Comprehensive Service Plan for an elder shall not establish an entitlement to services for any eligible person for services beyond that established by law or beyond the amounts appropriated for the services.

(4) Insofar as a waiver of a specific portion of 651 CMR 3.00 would not contradict any applicable state or federal law or regulations, a waiver may be granted by the Secretary. All requests for waivers must be made in writing to the Secretary by the President of the Board of Directors of the ASAP. The waiver request must clearly identify what section of the regulation should be waived; which conditions have made such a waiver necessary; what steps have been taken to resolve current issues and to insure future waivers will not be necessary; the consequences to the Consumers of the ASAP of not granting the waiver request; and the consequences to the ASAP of not granting the waiver request.

(5) All ASAPs and their contractors are subject to audits by Elder Affairs or its authorized agents, the Secretary of the Executive Office of Health and Human Services or his/her authorized agents, or the Commonwealth of Massachusetts or its authorized agents. Furthermore, the Governor or his/her designee, the Secretary of Administration and Finance or his/her designee, and the State Auditor or his/her designee shall have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the ASAPs which pertain to the performance of ASAP requirements. An audit may include but need not be limited to a review of an ASAP's: financial statements, accounting records, procedures, and management practices; compliance with and efficiency in carrying out the terms of the ASAP contract.

REGULATORY AUTHORITY

651 CMR 3.00: M.G.L. c. 19A, §§ 4, 6.

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<#>3.05: General Provisions¶
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