Clinical Assessment and Eligibility Program: Best Practices Guide

Version 1.02

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▶Section 1

Introduction:

The Executive Office of Elder Affairs (EOEA) and the MassHealth Office of Long Term Services and Supports (OLTSS) have established an approach to Clinical Assessment and Eligibility (CAE) which supports an interdisciplinary approach to providing the most comprehensive community service package and/or living arrangements to each member.

EOEA has contracted with Aging Service Access Points (ASAPs) to establish performance based contracts in order to ensure that all consumers receive a comprehensive clinical evaluation which ensures the most appropriate and cost effective means of meeting each members individual needs in the least restrictive setting.

The ASAP Registered Nurse (RN) and the ASAP Care Manager (CM) are part of an interdisciplinary care management team. This team ensures that each consumer and MassHealth member/applicant and their caregivers are fully informed of what community and long term options are available to them in order to achieve the most independent life style possible for their particular circumstance.

This Manual is a collaborative work of members from the OLTSS and EOEA. Please be mindful that it is up to date as of this release September 2014 and will need to be updated as new regulations and Program Instructions are developed. We hope you find it useful.

On Behalf of the OLTSS & EOEA,

Mary DeRoo, RN, BSN, MSM

Director of Home and Community Programs

Executive Office of Elder Affairs

COMMUNICATION WITH THE EXECUTIVE OFFICE OF ELDER AFFAIRS AND THE OFFICE OF LONG TERM SERVICES AND SUPPORTS

General Overview and Responsibilities:

The ASAP must maintain contact with Elder Affairs and the Office of Long Term Services and Supports and report any issues that constitute non-compliance with MassHealth or Elder Affairs regulations and instructions.

This includes but is not necessarily limited to:

- Failure of the Nursing Facility (NF) to cooperate with CAE and CSSM business processes.
- Failure of an Acute Inpatient Hospital to perform pre-admission assessments and clinical determinations.
- Refusal of any healthcare provider, except NF, to complete the necessary documentation for clinical assessment determinations.
    - NF determinations are completed onsite with a review of the clinical record and a face to face interview with the member/applicant.
- Submission of documentation that the ASAP feels is deliberately inaccurate.
- Report all circumstances in which the ASAP is unable to conduct required CAE and CSSM activities in a timely manner, including those that result from ASAP staffing issues, such as when the ASAP is:
    - Conducting assessments outside of required timeframes and other requirements contained within this manual.

▶ Section 2

General Guidelines:

ASAPs are required to perform Clinical Assessment and Eligibility (CAE) related activities for MassHealth consumers seeking approval for MassHealth payment of Community Long Term Services and Supports and Nursing Facility Services.

All CAE clinical determinations must be completed by a MA Registered Nurse (RN) employed by the ASAP.

TYPES OF SCREENINGS

Community CAE Screens:

The ASAPs conduct assessments for the following Community Long Term Care Services and Supports:

- Adult Day Health (ADH)
- Adult Foster Care (AFC); only if ASAP is a MassHealth provider of this service
- Group Adult Foster Care (GAFC); only if ASAP is a MassHealth provider of this service
- Home and Community Based Waiver(s) (HCBW) for Frail Elder (Frail Elder Waiver- FEW) (SCO/FEW)

The ASAP must conduct CAE assessments for the above programs for MassHealth members/applicants who reside within the ASAP's geographical catchment area based on the member/applicant's home address, unless the individual is residing in a nursing facility at the time of the referral.

If the MassHealth consumer is residing in a nursing facility (NF) at the time of the referral, the ASAP who covers that NF, must conduct the assessment including the onsite visit.

The ASAP must close the CSSM enrollment when the member/applicant is discharged to another ASAP's geographic area and, if requested, share that member/applicant's data with the receiving ASAP.

Nursing Facility (NF) Screens:

The ASAP conducts the following assessments for NF services:

- NF pre-admission
- Conversion Assessment
- Short Term Review (STR)
- Continuation of Stay (COS)
- Retrospective

Each ASAP is responsible to conduct clinical assessments for applicant/members residing in NFs that are located within their geographical catchment area.

REFERRAL SOURCES:

Assessment referral sources may include but are not limited to:

- Acute Inpatient Hospitals (AIH)
- Non-Acute Inpatient Hospital (NAIH)
- Psychiatric Hospitals
- Nursing Facilities (NF)
- Families or other caregivers
- Individuals
- Physicians, Nurse Practitioners, Physician's Assistants
- Certified Agencies
- Other ASAPs

AGE REQUIREMENTS:

- AFC Age 16 and over
- ADH Age 18 and over
- NF Age 22 and over
- GAFC Age 22 and over
- HCBW Age 60 and over

EXPIRATION OF CLINICAL DATA:

- Assessment Data (CDS-2 RN or CDS-2 Full) is considered current for 6 months unless there is a significant change. If the data is more than 60 days old, the ASAP RN must obtain verbal confirmation that the data is still relevant. Medical data is considered current if less than 91 days old.
- Medical documents used to confirm diagnosis must be current (no more than 60 days old). If information is more than 60 days old and less than 91 days old, the ASAP RN may use the information if s/he receives verbal confirmation of its current validity from a licensed medical professional.
    - Verbal confirmation must be documented in the record and include the name and licensure of the individual providing the information.
- MD orders, medication and treatment sheets and other like documents are current for 60 days unless there is a significant change.
- A CDS-2-RN or CDS-2-Full may be used as a clinical eligibility assessment for multiple approvals as long as it is not more than 6 months old and if the ASAP RN obtains verbal confirmation on an assessment that is more than 60 days old.

LENGTH OF TIME CLINICAL APPROVALS ARE VALID BEFORE EXPIRATION:

- **ADH:** 6 months prior to entering the ADH. (A new screen is required every time a consumer transfers to a new ADH.)
- **AFC:** 6 months prior to entering the AFC or upon transfer from one AFC to another as long as the member continues to meet clinical eligibility criteria.
- **GAFC:** 6 months prior to entering the GAFC or upon transfer from one AFC to another as long as the member continues to meet clinical eligibility criteria.
- **HCBW:** 1 year . Must be re-assessed and approved annually.
- **NF Pre-admission:**6 months prior to entering the NF, or upon discharge from the NF or upon transfer to another NF as long as the member continues to meet clinical eligibility criteria.

Note: *A new NF approval is not necessary if a MassHealth consumer returns to the same NF following an Acute Inpatient Hospital, Non-Acute Inpatient Hospital, or psychiatric hospitalization unless the hospitalization exceeds 6 months, or, a short term approval expired while the member was in the hospital.*

TIMELINES FOR COMPLETING A CLINICAL ASSESSMENT:

Unless otherwise noted (such as the HCBW), the ASAP has 5 business days to complete a referral for any of the MassHealth programs listed in this manual. Day one of this timeline begins when the ASAP is in receipt of all the required documentation and has received validation of the MassHealth application status if there is no MassHealth number.

For post-admission NF referrals the ASAP must conduct an onsite comprehensive face to face visit and render a clinical determination utilizing the medical record in the NF at the time of the clinical assessment.

Short-term reviews are due on or prior to the expiration date of the prior clinical eligibility notification authorizing MassHealth payment of NF services.

Nursing Facility Transfer screenings must take place on or before the day of transfer to another NF.

SCREENING GUIDELINES:

ASAPs will screen any consumer who requires MassHealth as the primary payer source from day 1 of a nursing facility stay.

Do Screen:

- MassHealth only consumers
  - i.e. CommonHealth and MassHealth Standard
- Consumers with no insurance who are applying for MassHealth
- Consumers with no primary insurance qualifiers
- MassHealth consumers on a Primary Care Clinician (PCC) plan
- If the consumer has applied for MassHealth and requires MassHealth from day 1 of the NF stay.
- If a consumer is going to a new nursing home a new screening is required, regardless of when the last screening is done unless MassHealth is not the payer source.
- Frail Elder Waiver(s) clinical eligibility for MassHealth Standard members

Do NOT Screen:

- Senior Care Organizations (SCOs) consumers. *(ASAPs only screen for initial eligibility of Frail Elder Waiver)*
- Managed Care Organizations (MCOs) consumers
  - ***Exception:*** *ASAPs will screen MCO consumers who have exhausted their 100 day benefit.*
- MassHealth MCO consumers
- PACE consumers
- One Care consumers
- Consumers with a primary insurance source that qualifies them for payment to the NF, regardless of if they have a MassHealth number or if they have applied for MassHealth.
  - ***Note:*** *the NF will submit a request for a conversion screening when the consumer's primary insurance will no longer pay for the NF stay.*
- Dually-eligible consumers for co-pay deductibles or bed hold days.
  - For MassHealth applicants, co-insurance and deductibles will be paid retroactively once MassHealth has been approved.
- If a consumer entered the hospital from a nursing home and is returning to the **same** nursing home, a new screening is not necessary as long as the prior decision is still valid, regardless if client went beyond the 20 day bed hold.
  - ***Exception:*** *If a consumer is in the hospital for more than six months, then a new screening is required, even if they are returning to the same nursing home.*
- If a consumers primary payment source or back-up source is private pay funds, a screening is not done, as of 03/10/95, Massachusetts does not recognize private pay screenings.

TYPES OF DETERMINATIONS:

Community Clinical Eligibility Determinations:

The following clinical eligibility level of care (LOC) notices are available in SIMS for pre-filling and printing. All are versions completed specifically for use by the ASAP:

- Nursing Facility (NF)
- Adult Day Health (ADH)
- Adult Foster Care (AFC)
- Group Adult Foster Care (GAFC)
- Home and Community Based Waiver (HCBW)

Nursing Facility (NF) Clinical Eligibility Determinations:

There are three clinical eligibility level of care notices used for all nursing facility determinations.

- Nursing Facility Eligibility
- Nursing Facility Eligibility/ DDS PASRR Determination
- Nursing Facility Eligibility/ DMH PASRR Determination

VALIDATION OF MASSHEALTH STATUS:

Prior to conducting an assessment, the ASAP must ensure the individual is a MassHealth member/applicant. In the absence of a MassHealth number, the ASAP must validate that the individual has applied for MassHealth by obtaining the date the application was filed.

ONSITE VISIT REQUIREMENTS:

The ASAP RN **must** conduct an in-person, comprehensive onsite assessment for MassHealth members/applicants in all of the following situations:

- Prior to a clinical denial
- NF referrals (except NF transfers with less than 48 hours' notice - refer to PI 11-03 & PI 13-01)
- Frail Elder Waiver referrals
- Strongly recommended for ADH if the consumer is not known to the ASAP

The ASAP RN must ensure that determinations are made in accordance with the clinical criteria in the applicable MassHealth regulations and guidelines and on the MassHealth website www.mass.gov/eohhs/gov/laws-regs/masshealth/regulations/.

An ASAP RN may not use a CMS form 485 to substitute as an assessment or a required onsite visit.

TRACKING GUIDELINES:

Discharges:

Each CSSM consumer must be monitored by the ASAP for 90 days after discharge from a nursing facility. This includes those consumers with whom the ASAP assisted with the discharge planning but never converted to MassHealth as the primary payer source. Monitoring of the consumer's well-being and the appropriateness of their community service care plan will be completed at days 30, 60 and 90.

All tracking must be conducted by telephone and/or a home visit. Documentation of the contact must be included in the consumer's Journal and include the following:

- Purpose of the call (e.g. post-discharge tracking at day 30)
- The consumer's health and functional status
- Any changes in the consumer's condition since the prior monitoring call

- Any adjustments in the consumer's care plan, (e.g. new living arrangements), includes being readmitted to a hospital or nursing facility
- Any anticipated activities to be completed before the next scheduled call;
- A summary statement of the monitoring call
- A summary statement of the consumer's status and the effectiveness of the community service plan at the end of the post-discharge monitoring calls
- A service record of the completed task recorded in SIMS

In addition, each consumer must have a CSSM Enrollment in SAMS, which is required to track the volume and length of time the ASAP CSSM Team works with a consumer during their nursing facility stay, as well as the reason for termination of CSSM involvement. Refer to ELD Home Care Tracking CSSM Enrollment business rule, original communication dated July 1, 2014 or subsequent updates.

Denials of Nursing Facility Eligibility:

Consumers should be tracked after being issued a denial; the frequency at which the consumer is tracked is once a month for three (3) months. Denials are tracked so the consumer's status can be monitored for the following:

- Changes in consumer status
- If the consumer appeals, it shows the consumer was tracked and there was no change in status or if there was a change in status, the consumer could be eligible for services and the appeal may be withdrawn.
- As a way to follow up on suggestions made to the consumer versus the services the consumer wanted.
- To show the consumer they're not forgotten after a denial and that they will be routinely checked for changes in status.
    - It is important to let the consumer's physician know that the ASAP will track consumer for 3 months to monitor for changes in status.

▶ Section 3

Documentation Standards

SENIOR INFORMATION MANAGEMENT SYSTEMS (SIMS):

The Executive Office of Elder Affairs (EOEA), ASAPs, and others will use SIMS to support consumer application, intake, assessment, case management, service planning, service provision, and service invoicing. For each of these functions the system will maintain data security compliance. Data generated through these functions will support EOEA/OLTSS service provider management and oversight responsibilities, allowing EOEA/OLTSS to meet its reporting commitments.

The main focus of this section will be the functionality associated with conducting various assessment activities and the required actions that need to take place within Social Assistance Management System (SAMS), a component of SIMS.

SAMS is a comprehensive consumer and case management system. It enables its users to integrate data across multiple programs with meaningful and comprehensive care planning.

COMPREHENSIVE DATA SET 2.0 (CDS-2):

Definition: A comprehensive health, functional and psychosocial assessment performed by a Registered Nurse (RN) or a Care Manager (CM) for purposes of assessment, clinical eligibility determination for various programs, and re-assessment for continued eligibility of various programs. It is also used for care planning and service implementation.

There are four versions of the CDS-2 that are comprised of a combination of one or more of the following modules:

- The Minimum Date Set-Homecare (MDS-HC)
- The Social Module
- The Nutrition Module
- The Nursing Module

The four versions of the CDS-2 are:

- CDS-2-Full
- CDS-2-CM
- CDS-2-RN
- CDS-2-NF

General Guidelines for Completion of the CDS-2:

- All sections must be completed unless specifically specified on the assessment tool.
- Every CDS-2 requires a narrative attached to the assessment which is copied and pasted into the consumer journal.
- Narratives and/or notes from previous assessments must be deleted prior to completing a reassessment.
- All previous signatures and dates, with the exception of the CDS RN when the RN is not completing any information below the line (social and nutrition modules) must be deleted prior to completing a reassessment.
- If an ASAP staff re-assesses using information gathered in a previous assessment, the new assessor assumes responsibility for the accuracy of the entire assessment. It is not permissible to update partial sections.
- The CDS "locks down" in 7 calendar days and information may not be altered at that time without performing a reassessment.
- On a joint visit of an RN and a CM, the signature of the RN attests to the fact that the CDS is complete. All assessments must be complete, accurate and signed by the person(s) completing the assessment.
- The most recent CDS must be used to reassess.
- Any CDS-2 only partially updated by an RN is not acceptable for purposes of a clinical eligibility assessment and/or determination.
- Nursing Module must be completed for each clinical determination.

CDS-2-Full:

The full consists of the MDS-HC, Social Module, Nutrition Module and the Nursing Module.

Note: *The MDS-HC and Social Module are combined into one section*

- When to use:
  - Combined visit by an RN and CM.
  - At the discretion of the RN and/or agency, the RN can utilize the CDS-Full for any purpose where the CDS-RN would be completed. The RN is required to complete all modules when using the CDS-Full.
  - When the RN is conducting a home visit for the purpose of case management, i.e., the annual or six month reassessment, as well as a clinical determination.

CDS-2-CM:

The CM consists of the MDS-HC, the Social Module and the Nutrition Module.

Note: *The MDS-HC and Social Module are combined. The Nutrition Module is separate.*

- When to use:
    - All case manager visits requiring a CDS with the exception of a combined RN/CM visit.

CDS-2-RN:

The RN consists of the MDS-HC and the Nursing Module.

Note: *The social and nutrition modules are included as separate sections of the CDS-2-RN (below the line). The RN is not required to update these sections unless she/he chooses or the agency requires it. If, however, any part of the social/nutrition module is completed, the RN assumes responsibility for the accuracy of the entire section and must sign each module. If the RN doesn't update the social/nutrition modules, the signature of the CM who did complete these sections must remain intact. The CDS-RN may only be completed by an RN.*

- When to use:
    - ADH clinical eligibility determination
    - AFC clinical eligibility determination
    - GAFC clinical eligibility determination
    - Nursing Facility acute inpatient hospital clinical eligibility determination
    - Nursing Facility pre-admission clinical eligibility determination
    - Nursing Facility non-acute clinical eligibility determination
    - Waiver Initial clinical eligibility determination
    - Waiver Re-determination

CDS-2-NF:

The NF consists of a subset of MDS-HC questions and the Nursing Module.

Note: *This version is used only for NF referral done post admission to the NF. It has no other use. When re-assessing from the CDS-2-NF, no information from the Social or Nutrition Module carried over. The Nursing Module may only be completed by an RN.*

- When to use
    - NF Continuation of Stay
    - NF Conversion
    - NF Retrospective

- Short Term Review
- NF Transfer (NF to NF)

CDS-2 Narrative:

- Must be completed for each CDS assessment regardless of the referral source or version of the CDS-2.
- Must be copied and pasted into the consumer journal.
- At a minimum the narrative must include the following:
  - Date ASAP received the RFS
  - Reason for Assessment
  - Date of face to face with consumer
  - Summary of OSA
  - Information not included in the MDS-HC
  - Determination and date the LOC was sent and to whom along with Fair Hearing
  - Name and title of assessor

CONFIRMATION OF DIAGNOSIS:

Confirmation of diagnosis is based on medical documentation signed by a physician, nurse practitioner or physician's assistant that contains diagnosis, medications, skilled treatments, therapies and any other relevant information. Such documentation includes:

- MassHealth Physician's Summary Form (PSF)
- CMS form 485 signed by a physician
- History and Physical
- MDS-HC from a hospital containing the required information signed by an RN.
- Hospital discharge documents
- Doctor's orders from the member/applicants clinical record
- Other like documents recognized in medical practice

This documentation must be current (no more than 60 days old). If the documentation is more than 60 days old but less than 91 days old the RN may use the information if he/she receives verbal confirmation of its validity from a MA licensed professional (MD, PA, NP, RN, LPN). This confirmation must be documented in the consumer journal including the name and licensure of the person providing the information.

REQUIRED DOCUMENTATION FOR CLINICAL DETERMINATIONS:

Clinical determinations must be based on the following:

- A completed Request for Service Form (RFS)

  Exception: *An RFS is not required for FEW referrals nor is it required for internal referrals or referrals made from central intake (I &R).*

- The appropriate CDS-2 or MDS-HC completed in its entirety by a RN completed within the past 6 months.

The ASAP may not render a determination based on documentation that is incomplete, regardless of whether the documentation is completed by the ASAP or a provider of Community Long-term Care (CLTC) services.

The ASAP may only render a determination for NF services in conjunction with an onsite visit and review of the consumer's clinical record.

The ASAP may not render a determination for a NF assessment based on documentation that is faxed, mailed or otherwise sent to the ASAP. In instances where the consumer is transferring to another NF in less than 48 hours the ASAP may render a determination for NF assessment based on documents that have been faxed, mailed or otherwise sent to ASAP. (See PI 11-03)

Within two business days of making a clinical determination the ASAP must issue the appropriate notice of eligibility to the MassHealth member/applicant per RFR Section 9.4.1 (9), legal guardian if applicable, and the referral source accompanied by MassHealth Appeal Rights and Fair Hearing Request Form and babel sheet.

The ASAP must participate in Fair Hearings in which a MassHealth member/applicant wishes to dispute the clinical determination made by the ASAP. (See Section 12)

NOTICE OF DETERMINATION:

A Level of Care (LOC) notice must be sent to the consumer, family or caregiver if appropriate, and the referral source requesting the screening within 2 business days of making the determination. This must be accompanied with an appeals notice, fair hearing form and babel sheet. It is important to document in the journal note the date the LOC notice was sent and to whom. Levels of Care Notices are available to print in SIMS.

JOURNAL ENTRIES:

Journal entries are part of the overall consumer record and not part of the CDS. All actions taken by the ASAP are documented in the consumer journal in accordance with EOEA documentation standards (Refer to RFR 9.1.7). Documentation may include but is not limited to:

- Request for clinical eligibility determination must include date the ASAP received the RFS.
- Change in applicant/member status
- Delay in receipt of any required documentation
- All contact with family, physician, caregivers, providers etc.

- Notice of MD appointments
- Notice of hospitalization
- Notice of NF admission or discharge
- Contact with other agencies such as DDS, DMH etc.
- Diagnosis not originally confirmed on the CDS-2
- Contact with EOEA/OLTSS
- Review of the service plan

All correspondence must include:

- Date
- Reason
- Summary
- Outcome/determination
- Date the ASAP mailed the required notices to the consumer and requesting provider which must include: copy of the LOC notice and the Request for Fair Hearing notice and babel sheet.
- Name and title of assessor

COMPLETION OF THE MDS-HC BY AN OUTSIDE PROVIDER:

The ASAP may assess applicants/consumers for various MassHealth programs that are referred by outside providers.

These providers may include but are not necessarily limited to:

- Rest Homes
- ADH providers
- GAFC providers
- AFC providers
- Another ASAP
- AIH
- Non-Acute hospitals

The following standards apply when utilizing an MDS-HC completed by an outside provider:

- Must be completed in it's entirely by a registered nurse.
- Must be signed by a registered nurse.
- Must be current, accurate and completed within 90 days (MDS-HC).
- Must be data entered into the CDS-2-RN
- The name of the provider RN who completed the MDS-HC must be entered in section R as the assessment coordinator.
- The ASAP RN making the determination must complete and sign the nursing module of the CDS-2-RN containing the data entered MDS-HC submitted by the provider.
- For an Acute Inpatient Hospital, where the hospital RN makes the determination, the ASAP must complete the nursing module and enter the name of the hospital RN as the nurse making the determination (Section R of the CDS).
- The ASAP RN must put her/his name in the Nursing Module signature section.
    - All signatures, narratives and notes must be erased from any data entered MDS-HC if being used for the purpose of re-assessment.

ACTIVITIES AND REFERRALS (A/R):

Definition: Functionality within SIMS that serves as a tracking system reminder of a particular action. The purpose is to promote consistency throughout the ASAP network. The ASAPs may use the A/R functionality for a variety of reasons at their own discretion.

CAE activities that require an A/R are:

- Short term approval tracking (PI 09-05):
    - See Job Aid titled Activities/Referrals for Short Term Approval dated July 1, 2010.
    - A/R needs to be completed at the time the STA, regardless of where the STA was initiated.
    - New A/R required for every STA.
- ASAP Provider AFC/GAFC referrals to Coastline Elder Services for clinical determinations:

    ***Note**: This process is currently under revision and when fully implemented, the guidelines will be updated to reflect that process.*

    - See Job Aid titled G/AFC Determination by Coastline in SIMS dated June 8, 2011 (Appendix A).
    - It is the G/AFC ASAP provider's role to monitor/track the status of G/AFC determinations in progress via the A/R functionality in SIMS.

- It is the ASAP G/AFC provider's responsibility to make sure all data elements are correctly visible to Coastline. Incorrect data entry will inevitably delay the client's determination process.

- Frail Elder Waiver (FEW) tracking of initial referrals, annual re-determinations and the Recipient Choice
  - See EOEA Home Care business rules for Waiver Quality Measure (WQM) 1 - WQM 3

SERVICE ORDER AND SERVICE DELIVERY:

Definition: Functionality within SIMS that measures the duration between the start of an assessment (service order) and the issuance of a determination (service delivery).

A Service Order and Delivery must be completed for all CAE assessments without exception.

- See Job Aid titled Using Service Orders & Service Deliveries for CAE Screenings dated April 10, 2008 (Appendix A).

▶ Section 4

Adult Day Health (ADH)

Within 5 business days of receipt of referral and all required documentation from a MassHealth participating ADH provider, the ASAP shall assess the MassHealth consumer's need for ADH services in accordance with 130 CMR 404.407.

REQUIRED DOCUMENTATION:

- CDS-2-Full or CDS-2-RN completed by the ASAP RN in conjunction with an onsite visit **OR** an MDS-HC completed in its entirety by the provider RN in conjunction with a completed RFS form.
- It is strongly recommended to complete an onsite visit on consumers not known to the ASAP.
- Confirmation of diagnosis
- Journal Entry
- ADH notification accompanied by appeal rights, fair hearing notice and babel sheet.

REQUIREMENTS FOR CLINICAL ELIGIBILITY:

To be clinical eligible for MassHealth payment of adult day health services, a MassHealth member must meet all of the following criteria:

- The consumer must have a medical or mental dysfunction that involves one or more physiological systems and requires nursing care.
- The consumer requires services in a structured adult day health setting.
- The consumer must have a personal physician.
- The consumer must require a health assessment, oversight, monitoring, or services provided by a licensed nurse.
- Must require one or both of the following:
    - Assistance daily with one or more activities of daily living (see 130 CMR 404.407(C)).
    - Or at least one skilled service (see 130 CMR 404.407(B)

▶ Section 5

Adult Foster Care (AFC) & Group Adult Foster Care (GAFC)

The purpose of the Adult Foster Care Program is to provide room, board, and personal care services in a protected housing environment to elderly or disabled individuals who are at imminent risk of institutional placement. Only ASAPs who provide AFC & GAFC services will complete the process below. Coastline Elderly Services reviews CDS data to make an initial determination on client eligibility for Group Adult Foster Care (GAFC) and Adult Foster Care (AFC). Refer to Job Aid G/AFC Processing within SIMS June 8, 2011 for more information.

ADULT FOSTER CARE (AFC):

Within 5 business days of receipt of referral and all required documentation from a MassHealth participating AFC provider, the ASAP shall assess the MassHealth consumers' needs for AFC services in accordance with 130 CMR 408.417

Required Documentation:

- CDS-2-Full or CDS-2-RN completed in conjunction with an onsite visit **OR** MDS-HC completed in its entirety by the provider RN in conjunction with a completed RFS form
- Physician's Screening Form (PSF) completed by consumer's PCP
- AFC cover letter submitted by provider AFC
- Confirmation of diagnosis
- Journal Entry
- Completion of the nursing module of the CDS by Coastline Elderly Services
- AFC notification accompanied by appeal rights, fair hearing notice and babel sheet.

Clinical Criteria:

- A physician must have written an order for AFC
- The MassHealth member must have a medical or mental condition that requires daily physical assistance or cueing and supervision during the task in order for the member to complete successfully at least one of the following tasks:
    - Bathing (full body or shower)
    - Dressing - including street clothes and undergarments, but not solely help with shoes, socks, buttons, snaps or zippers
    - Toileting - if the member in continent (bowel or bladder) or requires scheduled assistance or routine catheter or colostomy care
    - Transferring – if the member must be assisted or lifted into another position
    - Ambulating – if the member must be physically steadied, assisted, or guided one to one in ambulation; or is unable to self-propel a wheelchair appropriately without the assistance of another person

- Eating – if the member requires constant supervision and cuing during the entire meal or physical assistance with a portion or all of the meal

GROUP ADULT FOSTER CARE (GAFC):

Within 5 business days of referral and receipt of required documentation from a MassHealth participating GAFC provider, the ASAP shall assess the MassHealth consumer's need for GAFC services in accordance with GAFC guidelines (See Appendix D).

Required Documentation:

- CDS-2-Full or CDS-2-RN completed in conjunction with an onsite visit **OR** MDS-HC completed in its entirety by the provider RN in conjunction with a completed RFS form
- Physician's Screening Form (PSF) completed by consumer's PCP
- Confirmation of diagnosis
- Journal Entry
- Completion of the nursing module of the CDS by Coastline Elderly Services
- GAFC notification accompanied by appeal rights, fair hearing notice and babel sheet.

Note: *AGD direct process remains in the pilot stage, once AGD direct process is fully implemented, these guidelines will be updated to reflect that process.*

GAFC Participant Eligibility:

- Participants may include, but are not limited to the following:
  - Individuals who currently reside in the community or are hospitalized and are at high risk of requiring nursing home placement:
  - Patients discharged from nursing homes: and
  - Chronically disabled individuals who require supervision.
- Participants are likely to require supervision, routine assistance with activities of daily living such as bathing, dressing, walking, and assistance with management of medications.
- Participants must submit certification from their primary care physician that adult foster care services are appropriate to meet the medical needs of the participant.
- Participants must be able to meet the participant characteristics and responsibilities outlined in Section 8 of the GAFC Guidelines.

▶ Section 6

Home & Community Based Waiver (HCBW) for Frail Elder Waiver (FEW)

Within 10 business days of receipt of a referral the on-site assessment for clinical eligibility for HCBW services should be completed. Once all required documentation is received, the ASAP shall complete the clinical eligibility determinations for the FEW. The clinical eligibility determination is the same as nursing facility level of care as found in regulations 130CMR 456.409.

When a consumer is applying for community MassHealth, it is recommended that the ASAP RN completed the clinical eligibility determination which can then be submitted at the same time as the consumer's MassHealth application to the MassHealth Enrollment Center (MEC) for financial determination. The MEC will not determine a consumer financially eligible for MassHealth Standard using the HCBSW expanded income eligibility (300%) or flag a currently eligible MassHealth Standard consumer as waiver eligible, if the consumer is currently in a SNF; has discharged from the SNF but the SC1 has not been received by the MEC; or if a FEW clinical determination has not been received by the MEC.

REQUIRED DOCUMENTATION:

- CDS-2-Full or RN in conjunction with an onsite visit if visit is a case management visit being conducted by the RN
- CDS-2-Full or RN in conjunction with an onsite visit if visit is to establish clinical eligibility only
- Confirmation of diagnosis (per RFR section 9.1.3.3(p)(vi))
- Journal Entry
- FEW notification accompanied by appeal rights
- Required annual reassessment by an ASAP RN includes:
    - Completion of the CDS-2-Full or CDS-2-RN as indicated above
    - Onsite visit
    - Review of the service plan
    - Journal entry
    - Confirmed medical information (written or telephonic confirmation by licensed personnel)
- SCO/FEW screen process (IM 13-03) for initial clinical eligibility for consumers identified through the Senior Care Organization as potentially eligible for the Home and Community Based Frail Elder Waiver when the consumer is in need of the waiver to access MassHealth Standard.
- Required Activities & Referrals (A&R) should be entered according to Waiver Quality Measure (WQM) Business Rules

- WQM 1 A&R Action: **WQM – Waiver Initial Referral** – enter for all consumers referred for a FEW determination
- WQM 2 A&R Action: **WQM – Waiver Annual Re-determination** – enter for consumers determined clinically eligible for FEW who enroll in a Home Care waiver program
- WQM 3 A&R Action: **WQM – Recipient Choice (form)** – enter for all consumers determined clinically eligible for the FEW

▶ Section 7

Nursing Facility (NF) Assessments

PRE-ADMISSION NF ASSESSMENTS:

Acute Inpatient Hospital (AIH):

A nursing facility pre-admission assessment done for a MassHealth member being discharged to a nursing facility following an admission from an acute inpatient hospital where the payer source for the NF is MassHealth starting on the day of admission to the NF.

All Massachusetts AIH are responsible for determining eligibility for nursing facility services for all MassHealth inpatients and authorizing MassHealth payment of NF services. The AIH may only issue authorization for MassHealth payment of NF services in cases where the MassHealth consumer was admitted to the hospital. Consumers who are being discharged from an outpatient setting, an emergency room, or observation status are considered community consumers. The MassHealth delegated hospital is not delegated to make determinations in these cases and must be done by the ASAP.

The AIH must complete the MDS-HC in its entirety and submit it with a RFS form and LOC determination to the ASAP who is responsible for covering the AIH the consumer is currently admitted to.

Note: *The AIH may attach a copy of the member/applicants Medication Administration Record (MAR) from the AIH as a substitute for section Q5 in the MDS-HC.*

The ASAP should review the MDS-HC and ensure all documentation is completed in its entirety. The notification is date-stamped and signed by the ASAP RN and forwarded to the receiving nursing facility.

The ASAP must complete the nursing module entering the determination made by the AIH RN. The name of the AIH RN must be entered into Section R of the CDS-2-RN. The ASAP should document "AIH RN" after entering the name of the RN for purposes of identification in Section R. The ASAP RN signs her/his name under the Nursing Module Assessor's Name as the ASAP RN is responsible for the contents of the Nursing Module. The ASAP RN is also responsible for completing the narrative and corresponding journal entry.

The AIH may only issue three types of notifications for NF clinical eligibility utilizing the clinical eligibility criteria outlined in 130 CMR 456.409.

- Denial:
    - The MassHealth consumer does not meet the clinical eligibility requirements per 130 CMR 456.409.
    - The MassHealth consumer has received a denial from a Massachusetts PASRR authority.
- Nursing Facility Long Term Approval
    - The MassHealth Consumer meets one of the NF approval criteria outlined in PI 11-03 and CSSM PI 13-01 as stated below in addition to the clinical criteria outlined in 130 CMR 456.409:
        - Has a confirmed diagnosis of Alzheimer's disease or Related Disorder when supervision for consistent interventions for safety is needed.
        - Has an end-stage (less than 6 months) terminal illness, as certified by a physician.
        - Is comatose/unresponsive.
        - Has complex multi-system failure resulting in permanent dependence in all of the ADLs: bathing, dressing, toileting, transfer, mobility, and eating.
- 30 day Short Term Approval:
    - Must be issued in all other instances as long as the criteria in 130 CMR 456.409 are met.
    - Must be issued for any consumer with a diagnosis of MR/DD and a PASRR approval unless the DDS has issued a denial.

OBRA/PASRR Requirement:

The AIH is responsible for referring any individual with a diagnosis of mental illness, mental retardation and/or developmental disability to the appropriate PASRR authority. However, if a diagnosis of MI/MR/DD exists, the ASAP must ensure that PASRR requirements have been met prior to forwarding the clinical eligibility notice to the NF.

If the ASAP encounters any scenarios where PASRR compliance is in question, the ASAP should contact OLTSS, using the PASRR Non-Compliance Information Request Form, before issuing authorization of MassHealth payment of NF services.

Non-Acute Inpatient Hospital (NAIH):

A nursing facility pre-admission assessment done for a member being discharged to a nursing facility following an admission from a chronic, rehabilitation or psychiatric hospital where the payer source for the NF is MassHealth starting on the first day of admission to the NF.

The Chronic, Rehabilitation or Psychiatric Hospital must complete the MDS-HC in its entirety and submit it with a RFS form and current doctor's orders sheets to the ASAP who is responsible for covering the NAIH that the MassHealth consumer is being discharged from. The ASAP should review the MDS-HC as well as all other documents submitted and render a clinical eligibility determination. The ASAP has the right to request additional documentation if the documentation submitted does not support clinical eligibility.

The ASAP renders a decision regarding clinical eligibility and must issue a clinical eligibility notification and forward it to the appropriate NF. This signature attests to the fact that the ASAP has reviewed the documents and, based on those documents, agrees with the determination made by the non-delegated hospital.

The ASAP must data enter the MDS-HC into SIMS using the MDS-2-RN and complete the nursing module entering the determination. The name of the RN who completed the MDS-HC is data entered into section R of the CDS-2-RN and the name of the ASAP RN making the clinical determination is entered into the nursing module.

OBRA/PASSR Requirement:

The Chronic/Rehab/Psych hospital is responsible for referring any individual with a diagnosis of mental illness; mental retardation and/or developmental disability to the appropriate PASRR authority (see Section 8). However, if a diagnosis of MI/MR/DD exists, the ASAP must ensure that PASRR requirements have been met prior to issuing the clinical eligibility notice to the NF.

If the ASAP encounters any scenarios where PASRR compliance is in question, the ASAP should contact OLTSS, using the PASRR Non-Compliance Information Request Form, before issuing authorization of MassHealth payment of NF services.

Out of State Referrals:

A referral obtained from a referral source for an applicant/member who resides outside of Massachusetts.

These referrals are processed only for those applicants/members who intend to reside in Massachusetts permanently. Should the ASAP discover that the individual intends to return to their home state after a NF admission they should notify the Office of Long Term Services and Supports prior to conducting the assessment.

An onsite review, in the vast majority of cases, will not be possible. If the member comes to Massachusetts and is not transferred directly to a NF, the ASAP should follow routine pre-admission NF procedures. PASRR will be conducted by a Massachusetts PASRR authority in these cases.

Within 5 business days of receipt of referral and all required documentation the ASAP shall perform clinical eligibility determination for nursing facility services in accordance with 130 CMR 456.409. In addition, as a condition of payment, the ASAP must ensure that all PASRR requirements (see Section 8) are met prior to issuing authorization of MassHealth payment of NF services for any MassHealth consumer with a diagnosis of Mental Illness (MI) in accordance with 130 CMR 456.410.

The ASAP may provide the necessary forms to the referring entity for completion:

- MDS-HC 2.0 completed in its entirety by an RN accompanied by a RFS and confirmation of diagnosis

- MDS 3.0 Nursing Facility if transferring from another NF, with a copy of the physician's orders, medication and treatment sheets, ADL flow sheets, nurses monthly summary, daily nurses notes and any other documentation the ASAP deems necessary.

Required Actions/Documentation:

The ASAP writes a Journal Entry and completes the notification accompanied by fair hearing notice and babel sheet.

The ASAP may only give a 30 day short term approval if the member/applicant meets the clinical eligibility requirements in 130 CMR 456.409. For subsequent short term reviews the ASAP must complete the CDS-2-NF and nursing module. The applicant/member must be assessed for enrollment into CSSM.

The ASAP must follow the protocol for out of state referrals issued in PI-09—02.

OBRA/PASRR Requirements:

PASRR, if applicable, must be completed pre-admission. Once the individual applies and is approved for MassHealth, Massachusetts bears the responsibility for PASRR. It may not be possible for this person to be directly admitted to a NF. If the consumer is being transferred from an out of state NF, it is that facilities responsibility for completing the PASRR and sending that information to the receiving NF.

If the ASAP encounters any scenarios where PASRR compliance is in question, the ASAP should contact OLTSS, using the PASRR Non-Compliance Information Request Form, before issuing authorization of MassHealth payment of NF services.

Community Pre-Admission NF Assessment:

A nursing facility pre-admission assessment request for a MassHealth consumer who currently resides in the community. The community setting is referred to as any consumer who is living in but not limited to a rest home, assisted living facility, apartment, private home, congregate or group home. Please note that a consumer who is in an observation bed in a hospital is considered a community screening.

An onsite assessment is required by ASAP R.N. unless a provider is involved that can complete an MDS-HC and RFS and send to the ASAP for review and determination. A provider may be but is not limited to ALF, RH or ADH. In these situations an onsite may not be necessary unless information received is not enough to make a determination.

Within 5 business days of receipt of referral and all required documentation the ASAP shall perform clinical eligibility determination for nursing facility services in accordance with 130 CMR 456.409. In addition, as a condition of payment, the ASAP must ensure that all PASRR requirements (see Section 8) are met prior to issuing authorization of MassHealth payment of NF services for any MassHealth consumer with a diagnosis of Mental Illness (MI) in accordance with 130 CMR 456.410.

Required Actions/Documentation:

- CDS-2-Full or CDS-2-RN in conjunction with an onsite visit by the RN **OR** MDS-HC completed in its entirety by the referring entity in conjunction with a completed RFS
- Confirmation of diagnosis
- Documentation for Lahey Behavioral Health authorizing admission to a NF if there is a diagnosis of MI
- Journal Entry
- NF notification accompanied by appeal rights, fair hearing notice and babel sheet

OBRA/PASRR Requirement:

The ASAP must ensure that, regardless of the referral source, that PASRR requirements have been met prior to authorizing MassHealth payment of NF services.

If the ASAP encounters any scenarios where PASRR compliance is in question, the ASAP should contact OLTSS, using the PASRR Non-Compliance Information Request Form, before issuing authorization of MassHealth payment of NF services.

Note: *The ASAP may assess an individual for clinical eligibility for NF services prior to a Level II PASRR for Mental Illness, but may not issue an approval for MassHealth payment of NF services until the Level II PASRR screen is completed. If the MassHealth member/applicant is not clinically eligible for NF services the ASAP must issue a denial and notify Lahey Behavioral Health and the OLTSS. No Level II assessment for mental illness is required if a MassHealth member/applicant does not meet clinical eligibility per 130 CMR 456.409. If Lahey Behavioral Health issues a PASRR denial, the ASAP must likewise deny authorization for MassHealth payment of NF services.*

Note: *If the MassHealth member/applicant has a diagnosis of mental retardation and/or developmental disability, the ASAP does not determine clinical eligibility for MassHealth payment of NF service. DDS has the responsibility for this. Authorization for MassHealth payment of NF services is issued by the ASAP based on the determination letter from DDS.*

Observation Status/Emergency Room Referrals:

Observation status stays and emergency room referrals should be treated as community assessments. Please see the above section for how to complete these assessments.

Hospice Referrals:

As of February 1, 2013, Elder Affairs no longer requires an on-site assessment if the consumer is receiving hospice services or is certified by a physician to qualify for hospice services (See PI 13-01).

POST ADMISSION NF ASSESSMENTS:

Conversion Assessments:

An assessment requested by the NF for an individual who has been admitted to the NF but has had their NF services paid for by another payer source, or has been paying privately, and is now seeking to have MassHealth pay for their NF services.

Within 5 business days of receipt of a RFS form from the NF the ASAP shall perform a clinical eligibility assessment for authorization of MassHealth payment of NF services in accordance with 130 CMR 456.409. Ideally, this assessment should be conducted as close to the date the member converts to 100% MassHealth as possible.

Required Actions/Documentation:

- RFS completed by the NF
- Verification of MassHealth status if there is no MassHealth number
- CDS-2-NF completed by the ASAP RN in conjunction with an onsite face to face assessment
- Onsite review of the clinical record
- Journal entry
- MassHealth Notification with appeal rights, fair hearing notice and babel sheet

OBRA/PASRR requirement:

The ASAP must ensure that the NF has met all OBRA/PASRR requirements as a condition of payment. If not, the ASAP may only authorize payment once those conditions have been met. The date in the "official use only" box on the notification must reflect the date OBRA/PASSR obligations were met by the NF if that date is later than the date of 100% conversion to MassHealth as the primary payer source.

If the ASAP encounters any scenarios where PASRR compliance is in question, the ASAP should contact OLTSS, using the PASRR Non-Compliance Information Request Form, before issuing authorization of MassHealth payment of NF services.

Short Term Review (STR):

A short term review is an assessment that is completed for a MassHealth NF resident with a previous short term approval that is due to expire.

Within 5 business days of receipt of a RFS form from the NF the ASAP shall perform a clinical eligibility assessment for authorization of MassHealth payment of NF services in accordance with 130 CMR 456.409. Ideally, this assessment should be conducted on or before the date the previous short term approval is due to expire.

Required Actions/Documentation:

- RFS completed by the NF
- CDS-2-NF completed by the ASAP RN in conjunction with an onsite face to face assessment
- An onsite review of the clinical record
- Activity/Referral documented in SIMS (Per Job Aid and PI 09-05)
- Journal entry
- MassHealth Notification with appeal rights, fair hearing notice and babel sheet

The ASAP must work with the NF with regard to the timely completion of the STR. ASAPs must complete all STRs in a timely manner and issue all applicable notices whether or not the NF has submitted a RFS or made a referral for a clinical assessment per PI 09-05.

OBRA/PASRR requirement:

None, as long as the ASAP ensured OBRA/PASRR requirements were met upon initial determination.

Retrospective Assessments:

A retrospective screen is an assessment that is completed post-admission for clinical authorization of MassHealth payment of NF services when the expected payer source is MassHealth from the day of admission. It is primarily completed when the required pre-admission clinical assessment for admission to a NF was not completed.

- RFS completed by the NF
- Verification of MassHealth status if no MassHealth number
- CDS-2-NF completed by the ASAP RN in conjunction with an onsite face-to-face assessment and, if possible, interview with the applicant/member
- Onsite review of the clinical record
- Journal entry
- MassHealth Notification with appeal rights, fair hearing notice and babel sheet

The ASAP is required to review all documentation back to the date of admission for approval. If the applicant/member is only clinically eligible for part of the time he/she is in the NF, the ASAP may have to issue two separate notices, an approval for the time the member/applicant is eligible and a denial for the time he/she was not. Separate notices/appeal rights are required for each notice.

OBRA/PASRR requirements:

The ASAP must ensure that the NF has met all OBRA/PASRR requirements as a condition of payment. If not, the ASAP may only authorize payment once those conditions have been met. The date in the "official use only" box on the notification must reflect the date OBRA/PASSR obligations were met by the NF if that date is later than the date of 100% conversion to MassHealth as the primary payer source.

If the ASAP encounters any scenarios where PASRR compliance is in question, the ASAP should contact OLTSS, using the PASRR Non-Compliance Information Request Form, before issuing authorization of MassHealth payment of NF services.

Continuation of Stay (COS):

Each quarter the NF is required to complete the Minimum Data Set (MDS) 3.0 version for all nursing facility residents. This screening type is no longer needed due to CSSM creation. Since the MassHealth member/applicant has been identified as having the potential for discharge by the NF, the ASAP would enroll the applicant/member into CSSM and begin assessing community placement options with the IDPT and consumer.

OBRA/PASRR requirements (if this screening is used):

The ASAP must ensure that the NF has met all OBRA/PASRR requirements as a condition of payment. If not, the ASAP may only authorize payment once those conditions have been met. The date in the "official use only" box on the notification must reflect the date OBRA/PASSR obligations were met by the NF if that date is later than the date of 100% conversion to MassHealth as the primary payer source.

If the ASAP encounters any scenarios where PASRR compliance is in question, the ASAP should contact OLTSS, using the PASRR Non-Compliance Information Request Form, before issuing authorization of MassHealth payment of NF services.

Nursing Facility – Nursing Facility Transfer:

An assessment requested by the NF when the member is to be transferred from one NF to another. Within 5 business days of receipt of a RFS form from the NF the ASAP shall perform a clinical eligibility assessment for authorization of MassHealth payment of NF services in accordance with 130 CMR 456.409.

Required Actions/Documentation:

- RFS completed by the NF
- CDS-2-NF completed by the ASAP RN in conjunction with an onsite face to face assessment
- An onsite review of the clinical record
- Activity/Referral documented in SIMS (Per Job Aid and PI 09-05)
- Journal entry
- MassHealth Notification with appeal rights, fair hearing notice and babel sheet

When a NF has requested a clinical determination for a member who is transferring from one NF to another and has given the ASAP less than 2 business days' notice, the ASAP may do a paper review of the documentation submitted to the ASAP. This documentation must include a RFS submitted by the NF and the date/time stamped by the ASAP upon receipt of the referral. In this instance the ASAP may issue a STA for 30 days.

If the consumer received a NFLTA after numerous STA's, the ASAP nurse may issue a NFLTA on a transfer if the consumer is transferring within the ASAP's service area. If the consumer is transferring outside the ASAP's area a 30 day approval can be given. This is to allow the receiving ASAP time to review and explore community options in t heir geographic area that may not have been available in the original NF/ ASAP area. The on-site assessment of the consumer will be done by the new ASAP to determine any new community resources to meet the needs of the member (PI 13-01).

RETROSPECTIVE AND CONVERSION REQUESTS EXCEEDING 90 DAYS

In spite of careful tracking by the ASAP and required weekly visits to the NF sometimes a required assessment is not completed in a timely manner and goes well past the due date for the assessment.

A Retrospective Screen exceeding 90 days is an assessment that is completed post-admission for clinical authorization of nursing facility services when the expected payer source is MassHealth from date of admission. It is primarily completed when the required pre-admission clinical assessment for a MassHealth admission was not completed.

A Conversion Screen exceeding 90 days is an assessment that is completed post admission to a nursing facility for clinical authorization of nursing facility services when the MassHealth member/applicant is converting to MassHealth from another payer source, and the length of time between the date of conversion and the date of referral to the ASAP exceeds 90 days.

A Short Term Review exceeding 90 days is an assessment that is completed post admission to a nursing facility for clinical authorization of nursing facility services when the MassHealth member has received one or more previous short term approvals and the length of time exceeds 90 days from the expiration of the short term approval.

Required Process/Actions:

The NF should refer the MassHealth member/applicant to their local ASAP prior to the conversion or the STR date. The NF must indicate the date or dates of services the facility is seeking MassHealth payment. The clinical assessment must be conducted during the nurse's visit to the NF and coincide with an onsite face to face visit and review of the clinical record. The ASAP must validate and verify the MassHealth application date.

The ASAP RN must complete the CDS-2-NF and Nursing Module. For those cases where the member continues to reside in the NF, a case should be opened to CSSM unless the member meets the criteria necessary for an initial nursing facility long term approval.

The ASAP RN reviews all clinical documentation for which the nursing facility is seeking payment. In those instances where there is a change of status within that timeframe, the ASAP must issue two determinations. For example, the member may have been clinically eligible for the first 30 days of the NF stay, but was no longer clinically eligible. The ASAP RN would issue a STA for the first 30 days, and a denial beginning on day 31. Appeal rights, fair hearing notice and babel sheet must accompany each determination.

OBRA/PASRR Requirements:

The ASAP must ensure that the NF has met all OBRA/PASRR requirements as a condition of payment. If not, the ASAP may only authorize payment once those conditions have been met. The date in the "official use only" box on the notification must reflect the date OBRA/PASSR obligations were met by the NF if that date is later than the date of 100% conversion to MassHealth as the primary payer source.

If the ASAP encounters any scenarios where PASRR compliance is in question, the ASAP should contact OLTSS, using the PASRR Non-Compliance Information Request Form, before issuing authorization of MassHealth payment of NF services.

CLINICAL ASSESSMENT DETERMINATIONS:

There are four possible outcomes for a clinical eligibility assessment completed for authorization of MassHealth payment of NF services.

- **Nursing Facility Long Term Approval (NFLTA):**
    - Authorization for MassHealth payment of NF services given with no end date.
    - May only be given as an initial approval in accordance with PI-11-03which prohibits issuing a NFA pre-admission or on initial conversion unless one or more of the following conditions exist as outlined in the CSSM PI 13-01.
        - Has a confirmed diagnosis of Alzheimer ’s disease or related disorder when supervision for consistent interventions for safety are needed
        - Has an end-stage (less than 6 months) terminal illness, as certified by a physician
        - Is comatose/unresponsive
        - Has complex multi-system failure resulting in permanent dependence in all of the following ADLs: bathing, dressing, toileting, transfer, mobility
- The CDS-NF, Nursing Module, Narrative and Journal entry must be completed, with the criteria for Nursing Facility approval recorded in the Nursing Module.
    - For all other MassHealth members/applicants, including those meeting the above criteria who wish to return to the community, the ASAP shall issue a short term approval, further described below.
- **Short Term Approval (STA):**
    - Authorization of MassHealth payment of NF services with a specific end date determined by the ASAP RN in consultation with the IDPT (see Section 9), the member/applicant and their caretaker(s) and, if applicable, the discharge planner of the NF.
    - The ASAP is expected to explore all community options with the aforementioned parties.
    - The ASAP is responsible to track all short term approvals via the activity/referral functionality in SIMS, further described in Section 3 and in PI-09-05, and follow up with the applicant/member and NF prior to the end date of the STA.

- **Denial:**
    - Must be issued by the ASAP when the applicant/member does not meet the clinical eligibility requirements for authorization of MassHealth payment of NF services per 130 CMR 456.409.
    - May never be issued without an onsite face to face visit.
    - If new information is received that supports clinical eligibility the ASAP must perform an additional assessment as quickly as soon as possible. All assessment information must be updated to reflect the change and the nursing module of the CDS-2 updated to reflect the new determination and additional onsite visit.
    - New notifications must be sent to the appropriate parties who received the original notifications and documents in the journal entry date sent and to whom.
- **Withdrawal:**
    - A referral for a NF assessment may be withdrawn at any point prior to a determination but only for very limited reasons
        - A request from the member or legal guardian;
        - A current approval is in place.
        - Member is deceased or relocates out of state.
    - The ASAP may not issue a withdrawal in place of a denial as it circumvents the member's right to appeal. If the ASAP conducts a clinical assessment and the applicant does not meet clinical eligibility criteria, a denial with appeal rights must be issued.

▶ Section 8

Omnibus Reconciliation Act/ Pre-admission Screening and Resident Review (OBRA/PASRR)

The Omnibus Reconciliation Act of 1987 (OBRA'87) requires a two part assessment for MassHealth members/applicants anticipating admission to a nursing facility, to determine if there is a need for mental illness, mental retardation and/or developmental disability services, Level I PAS and Level II PASRR.

LEVEL I PRE-ADMISSION SCREENING (PAS):

- Completed by the nursing facility, must be completed for anyone entering a NF regardless of payer source. It must be done pre-admission.
- Identifies anyone with a diagnosis of mental illness (MI), mental retardation (MR) and or developmental disability (DD).
- Identifies the need for a level II PASRR assessment by the designated PASRR authority further described below.
- Indicates any categorical determination in which the individual has a diagnosis of MI, but has certain diagnosis or condition that rules out the need for a level II.
- Indicates if the expected stay in the NF will be less than 30 days after an admission to an AIH, ruling out the need for a Level II assessment for an individual with MI, MR, or DD.
    - The only categorical determination for an individual with MR/DD is the 30 day convalescent stay exemption status post an admission in an AIH.

LEVEL II PASRR (PREADMISSION SCREENING RESIDENT REVIEW):

Mental Illness (MI):

A referral must be made to the Massachusetts MI PASRR authority, Lahey Behavioral Health, contracted through the Department of Mental Health (DMH) for any person who has, or is suspected to have, any of the following diagnosis:

- Psychosis:
    - Schizophrenia (all types)
    - Paranoia
    - Atypical Psychosis
- Affective Disorders:

- Schizoaffective Disorder
- Bipolar Disorder (formerly Manic Depression)
- Unipolar Depression that is greater than 10 years duration

- Anxiety and Somatoform Disorders that meet all of the following criteria:
  - Length of illness must be at least two years and
  - Inpatient psychiatric treatment for anxiety disorder and
  - Psychoactive medication for anxiety disorder.
    - Examples of Anxiety and Somatoform Disorders include but are not limited to:
      - Panic Disorder
      - Agoraphobia
      - Obsessive Compulsive Disorder (OCD)
      - Post-Traumatic Stress Disorder
      - Depersonalization Disorder
      - Phobias
      - Somatization Disorder
      - Conversion Disorder
      - Generalized Anxiety Disorder
      - Dissociate Disorders such as amnesia and/or fugue

Note: *When in doubt, always refer the case to Lahey Behavioral Health for evaluation.*

Categorical Determinations for MI Level II PASRR:

The following conditions/situations exempt the individual from the MI Level II PASRR requirement:

- Primary diagnosis of dementia with documentation of a least one of the following criteria.
  - Results of a neurological exam and/or testing (CT scan, MRI, etc.).
  - Results of a mental status exam focusing on cognitive functioning.
  - Progress notes citing the progressive decline in cognitive functioning and/ or behavior consistent with a diagnosis of dementia.
- Severe Brain Injury
- Terminal illness with less than six months to live as documented by an physician
- Unipolar depression less than 10 years duration
- Convalescent care as certified by a physician not to exceed 30 days following an acute inpatient hospital stay. (excludes psychiatric hospitalization, emergency room discharge, or discharge from an outpatient clinic regardless of the length of stay)

- End stage Disease (must be debilitating and bed-bound/bed to chair only):
    - COPD with 24 hour oxygen
    - CHF with 24 hour oxygen
    - Amyotrophic Lateral Sclerosis (ALS)
    - Huntington's Chorea
    - Parkinson's Disease

Role of the MI PASSR Authority-Lahey Behavioral Health:

Lahey Behavioral Health conducts the Level II PASRR assessment to determine whether the individual requires the level of services provided by a NF and whether specialized services are required.

Specialized services for mental illness are synonymous with the need for acute psychiatric hospitalization.

Role of the ASAP in the MI Level II PASRR Process for MassHealth Applicants/Members:

- Determine if a diagnosis of major MI exists (see above list).
- Determine if an appropriate categorical determination exists.
- Determine if the MassHealth member/applicant meets clinical eligibility per 130 CMR 456.409.
    - If no, issue denial per MassHealth guidelines. No further action is necessary with regard to PASRR.
    - If yes, the nursing facility refers the case to Lahey Behavioral Health for level II PASRR. Do NOT issue notification prior to completion of Level II MI PASRR assessment.
    - Review Level I PAS form for compliance during LOC screening for MH payment for new admissions and new conversions to MH payment.
    - Identify possible non-compliant cases
        - If the ASAP encounters any scenarios where PASRR compliance is in question, the ASAP should contact OLTSS, using the PASRR Non-Compliance Information Request Form, before issuing authorization of MassHealth payment of NF services.
    - Authorize approval/denial of MassHealth payment of NF services in conjunction with the Lahey Behavioral Health PASRR determination.
        - ASAP determines duration of approval in NF per CSSM and NF approval criteria.
        - Individual is considered for CSSM discharge planning.

Intellectual Disability/Developmental Disability (ID/DD):

If an individual has a known or suspected diagnosis of mental retardation and/or developmental disability identified during a pre-admission assessment for NF services, the ASAP must refer the individual to the Massachusetts MR/DD PASRR authority which is the Department of Developmental Disabilities (DDS).

If an individual has a ***related condition*** which could result in substantial functional limitations that individual must also be referred to DDS. The related condition must manifest prior to the age of 22 and result in substantial functional limitations in three or more of the following areas.

- Self-Care
- Understanding and use of language
- Learning
- Mobility
- Capacity for independent living

Some examples of related conditions include but are not necessarily limited to:

- Cerebral Palsy
- Autism
- Spinal Cord Injury
- Head/Brain Injury
- Multiple Sclerosis
- Epilepsy/seizure disorder
- Spine Bifida
- Blindness/severe visual impairment
- Cystic Fibrosis
- Muscular Dystrophy
- Speech/language impairment
- Deafness/severe hearing impairment
- Learning disability;

Note: *When in doubt, always refer the case to DDS for evaluation.*

Categorical Determination for the MR/DD Level II PASRR:

- Convalescent Care of thirty days or less. Must be admitted from an acute inpatient hospital. (Excludes the psychiatric unit, emergency room or outpatient department of a hospital regardless of the length of stay) This must be certified by the hospital physician prior to discharge.

Role of the ID/DD Level II PASRR Authority – Department of Developmental Services (DDS):

DDS determines if an individual may enter a NF; remain in a NF; the duration of stay; and what, if any, specialized services are needed.

Specialized services for MR/DD are services specific to the disability and are in addition to services received in the NF. They may be in the NF or at an off-site area. The services are provided by MR/DD professionals and are services that are complimented and reinforced in the NF.

DDS coordinates and plans a safe and orderly discharge on those individuals who are not approved for admission or continued stay in a NF.

Role of the ASAP in the ID/DD Level II PASRR Process:

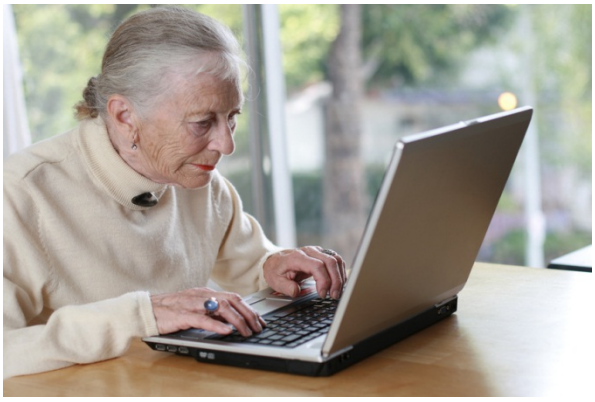
The ASAP process for DDS 90 day PASRR has not changed; the ASAP may only issue a nursing facility approval if DDS has issued a PASRR notice approving NF admission or continued stay with no end date.

The ASAP also processes all DDS provisional notices. When DDS issues a PASRR denial with a 30 day provisional notice, the ASAPs will issue a short term approval and a denial at the time same time, see PI 12-04 for further details.

If the ASAP encounters any scenarios where PASRR compliance is in question, the ASAP should contact OLTSS, using the PASRR Non-Compliance Information Request Form, before issuing authorization of MassHealth payment of NF services.

MISCELLANEOUS PROTOCOL:

- Members/applicants returning to the same NF after an acute medical stay do not require a new Level II PASRR assessment as long as there is a current PASRR and no significant changes in the member/applicant's status.
- Members/applicants do not require a new Level II when transferring from one NF to another NF, except when the member/applicant has a "no serious mental illness" exemption letter. These exemption letters are nontransferable. The ASAP must call OBRA and request a new exemption letter.
- The ASAP must ensure a current Level II is in place prior to issuing authorization of MassHealth payment for NF services.
- A Level II PASRR referral is required when a member/applicant is returning to the same NF after a psychiatric hospitalization.
- If an individual has received a 30 day convalescent stay determination and remains in the NF past 30 days, a PASRR assessment must be completed before the ASAP can authorize MassHealth payment of NF services.
- The ASAP must document all actions and correspondence with DSS in the consumer's journal.



▶ Section 9

Comprehensive Service and Screening Model (CSSM)

OVERVIEW OF CSSM:

The CSSM program is intended to ensure that MassHealth members/ applicants, as well as their family members and caregivers, and other consumers as identified receive the information and care planning supports on the least restrictive setting necessary to make decisions about their future care plans and residential settings. The model is designed to ensure that consumers can participate directly in their care planning through face to face meetings with members of an Interdisciplinary Discharge Planning Team (IDPT). In addition, the program is intended to provide the support necessary to consumers and discharge planners of nursing facilities that will ensure that consumers returning to the community receive the appropriate care and supports necessary to ensure that discharges are successful. The program model recognizes the value of communication and collaboration between consumers, CSSM staff, nursing facilities, state agency staff, and community resource agencies. This collaboration enables the development of an appropriate plan as it relates to the consumers unique situation.

The role of the ASAP is to work with the member/applicant, family, and nursing facility to overcome the barriers and assist with discharge planning by formulating and implementing a care plan that meets the member/applicant's needs in the community.

ASAPs are required to report to Elder Affairs on specific metrics for consumers who have been assisted by the CSSM staff; they must identify barriers that were identified and overcome in order for a community service and support plan to be developed for the consumer. Alternatively, in cases where a consumer is not discharged to the community, the reporting must identify all barriers that could not be overcome by the IDPT and/or the consumer. This information will be used by Elder Affairs and Health and Human Services to identify opportunities for the development of additional community capacity or partnerships.

Any member/applicant in a nursing facility who is 22 years of age or older is considered a potential CSSM consumer and must be considered for CSSM participation.

DEFINITIONS:

Case Closure & Tracking Form (CCTF) – The Elder Affairs issued assessment form designed to record monthly actions and outcomes of the IDPT.

Clinical Assessment and Eligibility (CAE)– Assessment process by which ASAP RNs evaluate MassHealth members or applicants for clinical eligibility for nursing facility care, adult day health, adult foster care, group adult foster care, and Waiver Services.

Community Service Planning – The Care manager directed process including the coordination, arrangement, and tracking of services required to facilitate a safe discharge.

Comprehensive Screening and Service Model – A service offered by ASAPs intended to ensure that MassHealth members and applicants in nursing facilities and their family members and caregivers are actively involved in considering discharge options and, where a discharge plan is established, the consumers receive the appropriate care and support necessary to ensure a successful discharge.

Core Team – Those ASAP staff members who are responsible for CSSM activities, including the CSSM Program Manager and at least one Registered Nurse (RN) and one Care Manager (CM).

CSSM Program Manager –The key designated ASAP staff member responsible for the administration of the CSSM program and who serves as the primary contact with Elder Affairs.

Initial Assessment – The first clinical assessment for authorization of MassHealth payment of nursing facility services is completed by an ASAP RN, including a visual observation of the consumer and a personal interview, unless the consumer's cognitive status would prohibit such an interview.

Interdisciplinary Discharge Planning Team (IDPT) – A planning team organized for each case under review composed at a minimum of the consumer, any family members or caregivers identified by the consumer, an ASAP Care Manager as appropriate, an ASAP Registered Nurse, and a nursing facility discharge planner.

Nursing Facility Long Term Approval (NFLTA) – An approval issued by an ASAP RN when a consumer meets the clinical criteria for MassHealth payment for nursing facility services for an indefinite length of stay after all attempts to overcome identified barriers to discharge have ended. For an initial clinical assessment a nursing facility approval must be based on the criteria found in Program Instruction 13-01.

Request for Services Form (RFS) – A Nursing Facility referral form to request an ASAP assessment to determine clinical eligibility for:

- Dually eligible consumers with both Medicare and MassHealth
- MassHealth members
- MassHealth applicants, (the date the MassHealth application was submitted to the MEC must be written on it)
- MassHealth members who have expressed an interest, either directly, or through a representative, or a positive response to Section Q of the MDS, to receive services in a community setting
- MassHealth members, previously approved for a long term stay, (i.e. Those to whom the ASAP has previously issued a "Long Term Approval"), who the nursing facility has now identified as having potential to reside in a community setting
- Any dually eligible MassHealth member converting to MassHealth as their primary payer source within the next 10 days
- Any member who previously received a short term approval set to expire within the next 10 days

ASAP STAFFING REQUIREMENTS:

Each ASAP shall establish a CSSM Core Team. The ASAP must identify a lead staff person, hereafter known as the CSSM Program Manager, who will be accountable for the performance of all CSSM related activities. The CSSM Program Manager will be responsible for the following:

- Ensuring the quality of the overall administration of the CSSM program in accordance with program requirements.
- Ensuring the timeliness and quality of all CSSM documentation, including consumer and service data in SIMS. In the event that certain required reports will be delayed for some reason, the CSSM Program Manager must explain the reasons for this exception to Elder Affairs.
- Serving as the primary contact for the program to Elder Affairs staff.

The individual may have additional responsibilities within the organization and does not necessarily have to directly manage the nurse(s) and care manager(s) who perform CSSM activities.

In addition to the CSSM Program Manager as the lead, the ASAP CSSM Core Team must include at least one Registered Nurse and one Case Manager. Elder Affairs encourages the inclusion of an Administrative Assistant as part of the Core Team for clerical and data entry purposes. Each ASAP must attest that the CSSM Core Team staffing level is sufficient within each discipline to perform CSSM program activities in the manner and timeframe required.

CSSM INTERDISCIPLINARY DISCHARGE PLANNING TEAM (IDPT) MEMBERS:

The CSSM staff must convene an IDPT for each CSSM consumer. The IDPT must include, at a minimum, the following:

- the consumer
- the family members or caregivers identified by the consumer
- the CSSM Registered Nurse (RN)
- the CSSM Care Manager (CM) as appropriate
- the nursing facility discharge planner
- other representatives as needed or requested by the consumer

RESPONSIBILITIES OF IDPT MEMBERS:

CSSM Registered Nurses (RN):

The ASAP RN is responsible for:

- Timely completion of nursing facility clinical determination activities, including visiting all consumers within 5 business days of the date of the referral.

- Weekly on-site comprehensive assessments for the purpose of reviewing the clinical data, meeting with all pertinent nursing facility staff, meeting and assessing face to face with the consumer.
- Reviewing all clinical records related to assessment activities on-site in nursing facilities; the ASAP may request that the nursing facility submit required documentation that was inadvertently not obtained or available during an on-site visit.
- Prioritizing who should begin receiving the active assistance of the CSSM Care Manager and other IDPT members to be discharged from the nursing facility, according to their current stage of rehabilitation and/or recuperation.
- Per section 9.4.3.1 of the RFR, in instances where a nursing facility is small or has minimal admission and discharge activity, on site visits may be less frequent than weekly, but never less than monthly.

CSSM Care Managers (CM):

An ASAP CM is responsible for:

- All aspects of service planning, including coordination, arranging and tracking of services to facilitate the discharge;
- Attending IDPT meetings as appropriate;
- Scheduling visits to each nursing facility based on the individualized needs of the consumer(s).

Nursing Facilities:

MassHealth-participating nursing facilities are responsible for assigning a discharge planner to work in collaboration with the IDPT to participate in regularly scheduled meetings.

Section Q Requirements:

The Nursing Facilities are required to submit **affirmative** Section Q referrals to the applicable ASAP/ADRC as the Local Contact Agent in the assigned area on all residents regardless of payer source. Please refer and follow the Section Q process outlined in MassHealth Bulletin dated (9/20/2012) and process outlined in MFP/ ADRC Section Q Referral Process.

A referral must be completed on new admissions that are:

- Dually-eligible consumers with both Medicare and MassHealth
- MassHealth members
- MassHealth applicants

Additionally, the referrals must identify:

- MassHealth members who have expressed an interest, either directly or through a representative, to receive services in a community setting.
- MassHealth members, previously approved for a long term stay, (i.e. those to whom the ASAP has previously issued a “Long Term Approval”), who the nursing facility has now identified as having potential to safely reside in a community setting.

- Any dually eligible MassHealth member converting to MassHealth as their primary payer source within the next 10 days.
- Any member who previously received a short term approval set to expire within the next 10 days.
- Affirmative Section Q referrals on all residents who express interest in returning back to the community regardless of payer source. ASAP to follow the required Section Q referral process as outlined in the MFP/ADRC Section Q referral process.

CLINICAL DETERMINATIONS:

Clinical determinations with regard to authorization/denial of MassHealth payment of nursing facility services is the responsibility of the ASAP RN. Each consumer's assessment must include a visual observation of the consumer and a personal interview, (unless the cognitive status of the consumer would prohibit the interview) to determine the consumer's goals and preferences. The types of clinical assessments are conversion, short term review, nursing facility transfer, continuation of stay and retrospective.

At the conclusion of the determination process, the RN must issue one of the following determinations:

- Short Term Approval (STA)
- Nursing Facility Long Term Approval (NFLTA)
- Nursing Facility Denial.

In those cases where a nursing facility has requested a nursing facility transfer and has given the ASAP less than 2 business days' notice, the ASAP may do a paper review based on documentation submitted to the ASAP. This documentation must include a Request for Service Form submitted by the nursing facility and date/time stamped by the ASAP upon receipt of the referral. In this instance, the ASAP may issue a short term approval for 30 days.

If the member received a nursing facility long term approval (NFLTA) after numerous STA's, the ASAP nurse may issue a NFLTA on a transfer if the consumer is transferring within the ASAP's service area. If the consumer is transferring outside the ASAP's areas a 30 day approval can be given. This is to allow the receiving ASAP time to review and explore community options in their geographic area that may not have been available in the original nursing home/ASAP area. In those cases where the ASAP has received a request for a retrospective clinical eligibility assessment and the consumer no longer resides at the facility, the ASAP may conduct a review of medical information submitted to the ASAP by the nursing facility as per PI 11-10.

Short Term Approval:

A short term approval is issued when a consumer meets the clinical criteria for nursing facility services and requires nursing facility services to rehabilitate or recuperate, and time is needed to develop and implement a community service plan. On the initial visit to determine clinical eligibility a short term approval must be issued **unless** the consumer meets at least one of the nursing facility approval criteria found in Program Instruction 13-01. Multiple short term approvals may be issued as necessary to meet the needs of consumer and ensure the successful implementation of the community service plan as long as the consumer continues to meet the nursing facility clinical eligibility criteria.

The RN, in consultation with the IDPT, nursing facility, and in consideration of the consumer's needs, must determine the duration of the short term approval.

The CDS-2-NF, Narrative and Journal entry must be completed and the end date of the short term approval must be recorded in Nursing Module.

The ASAP is responsible to track all short term approvals, utilizing the activity/referral functionality in SIMS and in accordance with PI-09-05. The ASAP nurse must complete a Short Term Review prior to the expiration of the STA regardless of whether or not the NF has submitted a RFS.

Nursing Facility Long Term Approval:

A nursing facility long term approval, issued for an indefinite length of stay, may only be issued by the RN on an initial determination under limited circumstances, PI 13-01 (as described below) and only in conjunction with a clinical screening assessment performed during an in-person visit with a consumer. The initial Nursing Facility Long Term Approval must meet one or more of the following criteria:

- Has a confirmed diagnosis of Alzheimer's Disease or Related Disorder when supervision for consistent interventions for safety is needed.
- Has end-stage (less than 6 months) terminal illness, as certified by a physician.
- Is comatose/unresponsive.
- Has complex multi-system failure resulting in permanent dependence in all of the following ADLs: bathing, dressing, toileting, transfer, mobility.

The CDS-2-NF, Narrative and Journal entry must be completed and the criteria for nursing facility approval must be recorded in the Nursing Module.

If, after the issuance of an initial short term approval or multiple short term approvals, the IDPT cannot develop a successful community service plan, the RN may issue a Nursing Facility Long Term Approval as long as the member/applicant continues to meet nursing facility eligibility criteria. All barriers to discharge and attempts to overcome those barriers must be documented in the CSSM Enrollment (See CSSM Business Rule dated July 1, 2014).

In the case of an initial Nursing Facility Long Term Approval the CDS-2-NF, a Narrative and Journal entry are required. A CCTF is not required.

A CCTF is completed only if the consumer is discharged.

Nursing Facility Denial:

In cases of a Nursing Facility Denial, CDS-2-NF, Narrative and Journal entry are required. A CCTF is not required.

DOCUMENTATION REQUIREMENTS:

CSSM Care Enrollment – should be added with the date the CSSM case is opened.

Journal Entry - All related CSSM activities including but not limited to; phone calls, onsite visits/assessments and meetings must be documented in the consumer journal. The documentation should include the community services the IDPT is attempting to secure to meet the consumer's needs.

CDS-2 Documentation - The ASAP RN is required to complete the CDS-2-NF, Narrative and Journal entry for all conversions (includes retrospective screenings), nursing facility transfers, continuation of stay and short term reviews. If a consumer is discharged from a nursing facility and enrolled in any MassHealth funded services/program, or receiving Home Care Services, the ASAP CM, must complete the CDS-CM thus using the most current CDS for assessment. If the RN and CM are both doing an assessment then it would be appropriate to use the CDS-2-Full.

For consumers participating in the Money Follow the Person (MFP), the risk plan and backup plan must be completed and also identified in the journal entry.

Case Closure and Tracking Form (CCTF) Documentation - If a consumer has been discharged to a rest home, an assisted living site, a DMH group home or congregate housing with no additional state funded Home Care services, a CDS-2 assessment is not required. The CM is not required to complete a CDS-2-CM. However, a complete CCTF, further described below, is required.

Please refer to and follow the CCTF requirements as outlined in the CSSM PI 13-01

Monitoring Consumer Well-Being After They Have Returned to a Community Setting - Each CSSM consumer must be monitored by the ASAP for 90 days after discharge from a nursing facility. This includes those consumers with whom the ASAP assisted with the discharge planning but never converted to MassHealth as the primary payer source. Monitoring of the consumer's well-being and the appropriateness of their community service care plan will be completed at days 30, 60 and 90.

All tracking must be conducted by telephone and/or a home visit. Documentation of the contact must be included in the consumer's Journal and include the following:

- Purpose of the call (e.g. post-discharge tracking at day 30)
- The consumer's health and functional status
- Any changes in the consumer's condition since the prior monitoring call
- Any adjustments in the consumer's care plan, (e.g. new living arrangements), includes being readmitted to a hospital or nursing facility
- Any anticipated activities to be completed before the next scheduled call;
- A summary statement of the monitoring call
- A summary statement of the consumer's status and the effectiveness of the community service plan at the end of the post-discharge monitoring calls
- A service record of the completed task recorded in SIMS

REQUIREMENTS FOR REPORTING TO ELDER AFFAIRS:

Changes in CSSM Core Team Staffing Requirements:

The CSSM Program Manager must report any issues that have interfered, or will interfere, with the ASAPs ability to perform CSSM program activities in the timeframes and manner described in PI 13-01. An ASAP cannot suspend in-person visits to nursing facilities at any time without prior consultation with Elder Affairs.

IDPT Processes and Relationships:

The CSSM Program Manager must report to Elder Affairs any issue(s) that may impair the effectiveness of IDPT and make recommendations to alleviate or resolve the issue.

▶ Section 10

Clinical Assessment and Eligibility (CAE) Notifications

The ASAP is required to address all requests for clinical assessments for authorization of MassHealth payment of certain MassHealth programs.

GENERAL PROTOCOL FOR CAE NOTIFICATIONS:

- The ASAP must respond to every MassHealth member/applicant's request for a clinical assessment
- The ASAP must issue an approval or denial for every request for a clinical assessment. The ASAP may not issue a withdrawal unless the member/applicant specifically asks for one.
- The ASAP must issue a Fair Hearing Request form and babel sheet with every clinical eligibility notice regardless of the determination.
- Copies of the clinical eligibility notification are issued to the member/applicant, legal guardian and referral source.
- The ASAP must maintain a hard copy of each notice completed and signed by the RN making the determination in the member/applicant's permanent record
- The clinical notice must have the name of the agency and the printed name of the RN as well as the signature of the RN issuing the clinical notice.
- The ASAP RN rendering the clinical determination holds accountability for preparing an appeal should the MassHealth member/applicant submits a request for a fair hearing
- The clinical eligibility notice must be mailed with 2 business days of it being filled out and dated to ensure the applicant/member is afforded their 30 day appeal rights.

The upper right hand corner of the notification, regardless of the type of referral, must always contain the following information:

- Member/applicants full legal name
- 12 digit MassHealth number or, if unavailable, full date of birth
- Date of Notice – date the notice is completed and mailed to the appropriate parties

Note: *The ASAP must not use the member/applicant's social security number anyplace on the notification.*

COMMUNITY CLINICAL ELIGIBILITY NOTIFICATIONS:

The following clinical eligibility level of care notices are available in SIMS for pre-filling and printing. All are versions completed specifically for use by the ASAP:

- Nursing Facility
- Adult Day Health (ADH)
- Adult Foster Care (AFC)
- Group Adult Foster Care (GAFC)
- Home and Community Based Waiver (HCBW)

Official Use Only Box:

- Must have the date of the determination in the lower left hand corner of the notification
- Must have the signature of the registered nurse in the lower right hand corner
- Must have the printed name of the registered nurse in the lower right hand corner
- Must have the name and address of the ASAP in the lower right hand corner

NURSING FACILITY (NF) ELIGIBILITY DETERMINATIONS:

There are three clinical eligibility level of care notices used for all nursing facility determinations.

- Nursing Facility Eligibility
- Nursing Facility Eligibility/ DDS PASRR Determination
- Nursing Facility Eligibility/ DMH PASRR Determination

Official Use Only Box:

Conversions to MassHealth as the primary payer source:

- For MassHealth applicants who required a clinical eligibility notice and the date of conversion is available, the date the applicant converts to 100% MassHealth as the primary payer is put in the lower left hand corner.
- For dually eligible members (a member who is admitted to a NF under their Medicare benefit but also has MassHealth) who are seeking to convert to MassHealth as their primary payer source the date the member converts to 100% MassHealth is the date is put in the lower left hand corner.
- If a NF is seeking a clinical assessment after the date of conversion to 100% MassHealth, the ASAP must ensure that the applicant/member is clinically eligible for the entire timeframe the NF is seeking payment. If not, a denial must be issued for any timeframe the member/applicant was not clinically eligible for MassHealth payment of NF services.

Short Term Review (STR):

- For those members who require a short term review, the date after the expiration date of the prior short term approval is put in the lower left hand corner. All documentation that covers the STR period must be reviewed.
- If the ASAP is conducting a STR after the expiration date of the previous STA, the ASAP must review all documentation that covers the period the NF is seeking payment for. A denial must be issued for any timeframe the member is not clinically eligible for MassHealth payment of NF services.

Retrospective Assessment:

- For those members who have entered a NF with the expectation that MassHealth will be the primary payer from the day of admission, but the ASAP is assessing after the day of admission, the date of admission is put in the lower left hand corner. All documentation must be reviewed to ensure the member is clinically eligible for the entire time period the NF is seeking payment. If not, a denial must be issued for any timeframe the member was not clinically eligible for MassHealth payment of NF services.

NF Transfer:

- For those members seeking to transfer to another NF with the intention that MassHealth is the primary payer on day one of the admission to the new NF, the date the RN makes the determination is the date put in the lower left hand corner.

ACUTE INPATIENT HOSPITAL CLINICAL ELIGIBILITY NOTICE:

- Must be dated and signed by an ASAP RN prior to forwarding to the receiving NF
- Must be accompanied by a completed MDS-HC and RFS. ASAP should date stamp the RFS the day it is received.
- May only be a nursing facility approval or a 30 day STA or NFLTA if the requirements are met.
- Must be data entered into SIMS and tracked via the activity/referral functionality in SIMS.

AUTHORIZATION OF MASSHEALTH PAYMENT OF NF SERVICES FOR INDIVIDUALS WITH A DIAGNOSIS OF MENTAL ILLNESS:

- Reserved for those individuals who require a Level II PASRR assessment prior to admission to a NF
- Completed as a community assessment (pre-admission NF assessment).

AUTHORIZATION OF MASSHEALTH PAYMENT OF NF SERVICES FOR INDIVIDUALS WITH A DIAGNOSIS OF MENTAL RETARDATION/DEVELOPMENTAL DISABILITY:

Please refer to and follow the outlined process for OBRA/PAS noncompliance cases per PI 12-04.

Review of Pre-Admission Screening and Record Review (PASRR) requirements prior to authorization of MassHealth Payment of Nursing Facility Services.

▶ Section 11

Administrative Approval:

An Administrative Approval is issued in cases where a referral has been made for a clinical eligibility assessment and a clinical denial is imminent. In these cases, the NF may be issued an Administrative Approval authorizing payment for 30 days only. This allows the NF to bill MassHealth during the appeal process.

Administrative Approvals are not issued by the ASAP. They are issued by non-clinical personnel at the MassHealth OLSS

An Administrative Approval may only be authorized if no other authorization for MassHealth payment of NF has been issued by the ASAP, MassHealth or the AIH.

If the ASAP, during the course of business, sees the need for an Administrative Approval they should contact MassHealth OLSS and be prepared to provide the following information:

- Member/applicants full legal name
- 12 digit MassHealth number if available
- Full date of birth
- Name of the nursing facility
- Date of conversion to 100% MassHealth

The ASAP must do a Journal entry indicating that a request for an Administrative Approval was made and include all of the information above.

▶ Section 12

Participation in Fair Hearing Process

The fair hearing process is a legal proceeding where MassHealth applicants/members (appellant) may appeal the actions or inactions by MassHealth or the ASAPs. It is designed to secure and protect the interests of both the appellant, MassHealth and the ASAPs.

Any MassHealth CAE clinical determination is subject to appeal, regardless of the determination made by the ASAP.

TIMEFRAMES:

The applicant/member has 30 days from the date of the clinical eligibility notice to request a fair hearing.

Note: *The MassHealth member/applicant cannot be transferred nor benefits be terminated during the appeal process. However, if the MassHealth applicant/member loses the appeal, MassHealth can recover from the individual, the amount of assistance that the individual received.*

REGULATIONS:

The Board of Hearings (BOH) is an independent authority of MassHealth. BOH administer the fair hearing process and render decisions based on MassHealth regulations and the evidence presented.

Guidelines for the conduct of the fair hearing process have been promulgated as regulations found at 130 CMR 610.000.

ASAP INVOLVEMENT IN THE FAIR HEARING PROCESS:

MassHealth member/applicants have the right to request a fair hearing related to any decision to deny or approve a MassHealth service. The following procedures must be adhered to:

- When the ASAP RN authorizes or denies MassHealth payment of any MassHealth service, the Request for a Fair Hearing form must be attached to the clinical eligibility notice.
- The name of the ASAP, as well as the name of the RN making the clinical determination must be on the MassHealth notice.
- The ASAP nurse manager assumes responsibility for the appeal and contacts MassHealth if there are any concerns or questions.
- The BOH will inform the appellant; his/her authorized representative, the ASAP representative and the MassHealth representative of the hearing date, time and location.
- The ASAP should begin preparation for the fair hearing immediately upon receiving notification unless the issue can be resolved prior to the hearing date.

- The ASAP must have copies of all documents that support their decision (they also have to provide copies for all parties at the hearing). Some examples are, but not limited to:
  - NF MDS 3.0 or current version
  - Certified Nursing Assistant Flow Sheets
  - Monthly Nursing Summaries
  - Nursing progress notes
  - Physician's orders and progress notes
  - Therapy notes
  - Activity Notes
  - Social Service Notes
  - Medication and treatment sheets
  - CDS-2-NF
- The ASAP must conduct an onsite visit of the MassHealth member/applicant at least one week prior to the hearing.
  - If at the time of the onsite assessment, new information is received that supports a change in the determination, the ASAP may change the determination using the date the new data was received.
  - The CDS-2-NF must be updated to reflect the change of status and determination

CASE SUMMARY PREPARATION:

The case summary is the responsibility of the ASAP RN under the direct supervision of the ASAP nurse manager. The ASAP nurse manager may contact MassHealth OLSS for assistance if necessary.

Heading:

Identify who the case summary is for; i.e. "Case Summary for (MassHealth member/applicant's name)".

Appeal number.

Introduction:

The introduction will include the following:

- Type of referral
- Date of request
- Referral Source
- Member/applicant's current residence; i.e. nursing facility, own home or with relative, etc.;
- Reason for clinical assessment request; i.e. short term review, conversion, annual waiver re-determination

Clinical Data:

- Diagnoses
- Nursing Care & Treatments
- Medications
- Skin integrity
- Recent vital signs
- Height & Weight
- Diet
- Pertinent Lab Work
- Functional Status
- Elimination
- Senses (vision, hearing & speech)
- Mental Status & Behavior
- Rehab potential
- Informal supports

Results of On-Site Assessment:

After conducting the required onsite assessment document the date, purpose of the assessment and the results of the assessment. Clearly document the consumer's current clinical status, especially a change, observed by the ASAP RN.

Narrative Summary:

Develop a chronological summation of the ASAP RN's actions that lead to his/her determination of findings.

State the applicable regulations to support each determination.

All community/housing alternatives explored by the ASAP and CSSM IDPT must be included. You must document why these alternatives were unsuccessful, for example, if the applicant/member refused all alternative placement options and why.

ASAP RN Determination:

A precise statement of the action taken and justification for the determination shall be documented.

Example:

- "The ASAP RN's determination was to deny the original request of (indicate original request). Documentation could not be found to support the need for continued nursing facility stay. This ASAP RN made a recommendation for congregate housing with home care services in the community. This environment would provide the client a safe community environment as well

as assist with cleaning, laundry, shopping and personal care, if needed. The consumer will be tracked for 90 days."

Closing Statement:

It is important for both the appellant and hearings officer to be informed of the ASAP's continuing role with the consumer.

Examples:

(Name of applicant/member) will be tracked for 90 days to ensure that his/her condition remains stable and that the care needs are being met. Another request for assessment of (name of applicant/member) may be submitted to the (name of ASAP) should there be a change in status.

RECEIVING NEW INFORMATION AFTER ISSUING DENIAL:

The ASAP RN receives additional information that clearly supports the need for an approval; the following steps must be taken:

- The ASAP must conduct an additional assessment. General screening guidelines must be followed.
- The ASAP must update the previous CDS-2 and enter any new information as well as validate any existing information. The approval determination must be entered into the nursing module as well as the date of the new onsite assessment.
- Enter a Journal Entry documenting all actions as specified in Section 2.
- New notice must be issued to member/applicant, legal guardian, if applicable, and referral source.

CASE SUMMARY EXAMPLE:

CASE SUMMARY FOR: Mary Smith

APPEAL #: 123456

INTRODUCTION: A Request for Service (RFS) form for a NF short term review was received on January 10, 2013, from Jane Doe, LSW, at Marion Manor Nursing Home, for this 89 year old female resident.

CLINICAL DATA:

DIAGNOSES: Seizure Disorder, Hypertension, Depression, IDDM, Diverticulitis

NURSING CARE AND TREATMENTS: Monitoring of vital signs weekly, Assessment of medication side effects, Assess gastrointestinal status

MEDICATIONS: NPH Insulin 20 units daily in am, Zocor 10 mg daily, by mouth, Tegretol 200 mg, 3x/day, by mouth, Paxil 20 mg daily, by mouth

SKIN CONDITION: Intact

HEIGHT: 56 inches

WEIGHT: 110 pounds

DIET: low fat, no concentrated sweets, and no added salt

PERTINENT LAB WORK: Sodium 140

FUNCTIONAL STATUS: Independent with bathing, grooming, oral hygiene, dressing, transfers, eating and ambulating with a walker. Administers own medications.

ELIMINATION: Continent of bowel and bladder.

SENSES: Sight good; Hearing fair; Speech is good.

MENTAL STATUS AND BEHAVIOR: Alert and oriented. Displays no cognitive deficit or behavior problem

REHAB POTENTIAL: No information provided.

INFORMAL SUPPORTS: Son and daughter-in-law are unwilling to have client return to live in their home.

ON-SITE ASSESSMENT:

An on-site assessment of this member and review of the clinical record was conducted on 2/19/2014. . CDS-2-NF was completed based on a face to face interview with the member, discussion with the NF staff and review of the clinical record. The member is seeking additional time in the NF

The member's medical record was reviewed and a conference with Jane Doe, LSW and XX, RN indicate that the member does not meet clinical eligibility criteria per MassHealth regulations 130 CMR 456.409 This writer observed the consumer came to a standing position and ambulated independently with the assistance of a walker. Consumer stated that she completes her bath and dresses independently, but that it takes her some time to complete these tasks. Her blood glucose levels, monitored 2X daily are consistently stable.

SUMMARY STATEMENT:

Based on the information provided through the record review, consultation with the nursing facility staff, consumer and client's physician, it was found that this consumer does not meet clinical eligibility to remain in a skilled nursing facility under Medicaid Regulations 130 CMR 456.409.

ASAP RN DETERMINATION:

Community alternatives recommended to the consumer as an alternative to nursing facility placement were Rest Home, Adult Foster Care and Assisted Living. The ASAP is also willing to discuss HCBW services with family members to explore the possibility of returning home if adequate services are in place, including ADH 5x week.

CLOSING STATEMENT:

Consumer will be tracked by the ASAP RN for 90 days at a minimum, more often depending on service package upon discharge.

Another screening request may be submitted to the ASAP for re-evaluation should the consumer's condition change significantly.

(Signature of ASAP RN) (Name and address of ASAP)

CASE FOLDER PREPARATION:

The case folder is prepared for all hearings. Please see the table below for the suggested set up of the folder.

Left Side of Folder	Right Side of Folder
MassHealth Board of Hearings Appeals Notice	
MassHealth Clinical Eligibility Notice	Case Summary For Hearing
Mass Health Appeal Notice	Supporting documentation related to the clinical determination that is being appealed
Appropriate MassHealth Regulations	Assessment Forms related to the determination, MDS 2.0, CMS form 485, Request for Service Form, Physician's Summary Form etc.
Reference Materials: Program Instructions, ASAP completed CDS-2	

The ASAP must have a folder for each person expected to attend the appeal. In general, five copies are sufficient.

There may be a significant lapse time between the ASAP's determination and the date of the hearing. Any additional information obtained during this time may be added to the case folder.

FAIR HEARING PRESENTATION:

ASAPs are required to testify and present evidence in support of their decision during the hearing, under oath which is administered by a hearings officer who is responsible to conduct the fair hearing.

Note: This includes AIH determinations

- Hearings are tape recorded.
- All documents submitted by the ASAP and the appellant and their representatives become part of the BOH records.
- ASAP RN states education, number of years a nurse, certifications and background.
- Generally, the ASAP presents their findings first but this is at the discretion of the hearings officer. This is done by reading the case summary.
    - It is helpful for the ASAP RN to cite specific regulatory citations
    - The hearings officer may have questions for the ASAP RN after testimony is presented
    - The appellant and/or their representatives will be given an opportunity to ask questions
- The Appellant presents their case next.
- It is best to try and avoid tense/confrontational situations. Should this occur questions should be directed to the hearings officer.

- Once the fair hearing is completed the ASAP may be required to answer questions or provide additional information to the BOH or MassHealth.

AFTERMATH:

- A decision is generally rendered within 90 days.
- The hearings officer may choose to keep an appeal open after presentation of all evidence.
- A continuance is granted so the appellant may further establish their case.
- To allow time for the appellant to submit additional documentation to support their case.
- Submission of new evidence that was not available to the ASAP prior to the hearing.
- The ASAP RN may request a continuance to complete an additional assessment in order to evaluate additional evidence or new information.
- The hearings officer will direct all parties with regard to submitting new evidence.

Complaints for Judicial Review:

When an appellant is dissatisfied with a hearing officer's decision, he/she has the right to petition the Superior Court to have the decision reviewed.

MassHealth's legal division and the BOH will receive notice of this action for the court.

Should this happen the ASAP must be prepared to cooperate with the MassHealth legal division.

▶ Section 13
Home Care Programs

PERSONAL CARE AND HOMEMAKING SERVICES:

The goal of Personal Care (PC) Services is to provide care in the community setting with the aim of maintaining dignity and independence of the consumer. PC Services provide physical assistance and verbal cuing with personal care tasks such as bathing, dressing, grooming, ambulation, and transfers. PC services are provided to consumers who, based on an assessment performed by the ASAP RN, need assistance with these types of services.

The ASAP RN assesses the consumer's overall functional and clinical status, the type and amount of care needed, the consumer's environment, and current formal and informal support systems in determining the appropriateness for PC. When the ASAP RN determines the consumer is not appropriate for Personal Care Homemaker (PCHM) level of care, the ASAP RN may authorize a home health aide to provide these services. ASAPs provide payment for Home Health Services as defined by PI 09-13 Home Care Program Service Descriptions. These services include Skilled Nursing (SN), Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), and Home Health Aide (HHA) to eligible consumers from both federally certified home health and non-certified home care agencies. Consumers with conditions and/or diagnoses that may not be appropriate for PC services include, but are not limited to:

- Consumers with extensive paralysis or total immobility
- Consumers who cannot transfer more than 50% of their body weight or require assist of two or use of a mechanical lift
- Consumers who have open wounds
- Certain types of fractures including, but not limited to those casted to immobilize
- Unstable medical conditions
- Consumers that require special skin care

Definitions:

Homemaker (HM) service includes assistance with shopping, menu planning, laundry, and the performance of general household tasks (i.e. meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him/herself or others in the home.

Personal Care (PC) services may take the form of hands on assistance or cuing and supervision to prompt a consumer to perform a task. Such assistance may include bathing dressing, personal hygiene, other activities of daily living, and reminders with medications in accordance with the EOEA's Personal Care Guidelines. This service may include assistance with meal preparation. When specified in the care

plan, this service may also include housekeeping chores such as bed-making, dusting, vacuuming, which are incidental to the care furnished, or which are essential to the health or welfare of the consumer, rather than the consumer's family. Personal Care Services must be provided in accordance with the EOEA's Personal Care Guidelines.

Supportive Home Care Aides (SHCA) performs personal care and/or homemaking services in accordance with the above definitions. Additionally they provide emotional support, socialization, and escort services to a consumer with Alzheimer's Disease/Dementia or emotional and/or behavioral problems.

Supervision:

The ASAP RN will collaborate with the provider RN to ensure an individualized, comprehensive, and effective care plan for each consumer. The provider RN is responsible for orientation and ongoing supervision of the PCHM to the care plan developed in collaboration with the ASAP RN.

- Supervision shall be available during regular business hours and on weekends, holidays, and evenings when HM, PC workers, SHCAs are providing services to consumers during these times.
- Supervision will be carried out once every 3 months by a qualified supervisor. In-home supervision shall be done in a representative sample of customers.
- PC introductory visits (including SHCAs providing PC): On the first day of service in the consumer's home, a PC worker shall receive orientation from an RN to demonstrate the PC tasks. During this visit the PC will demonstrate competence in the PC tasks assigned in the care plan.
- PC Supervision: An RN shall provide in-home supervision of PC workers at least once every 3 months with a representative sample of consumers. A written performance of PC skills shall be completed after each home visit.
- SHCA Weekly Support: Each SHCA shall receive weekly support through training/in-services, team meetings, or supervision that includes in-home, by telephone, or in person. Team meetings shall be held quarterly and shall include SHCAs, supervisors, and other appropriate personnel involved in providing SHCA services. The focus of these meetings is to provide training and group supervision, to conduct case reviews or interdisciplinary case conference, and to provide support to the SHCA.

PERSONAL CARE GUIDELINES (See Appendix D)

HOME HEALTH AIDE SERVICES

Required Actions:

The ASAP RN Care Manager (CM) and RN will determine the need for home health aide service via an interdisciplinary conversation based on the ASAP RN's comprehensive in home person centered assessment with the consumer. Each ASAP should have its own process for interdisciplinary communication between the ASAP RN and ASAP CM on HHA level cases.

After the home assessment, the ASAP will communicate with the provider RN regarding this assessment and the needs identified. A consumer's need for HHA services is solely based on his/her situation and individual needs, whether the condition is acute, terminal, chronic, stable, or expected to extend of a long period of time.

Establishing the Plan of Care:

- The provider agency will be required to conduct an initial assessment by an RN to establish the plan of care for the home health aide service. This is a reimbursable visit.
- The ASAP interdisciplinary team will develop a service plan encompassing the IADLs, home making, meal prep, etc. while the provider RN w3ill be writing the care plan encompassing the consumer's personal care needs.
- ASAPs must work with provider agencies to ensure a mutually agreed upon communication method to share care plans and provide updates on the consumer status. Additionally, the provider agency will forward a copy of the care plan to the ASAP.
- In complex care cases there will be a documented communication between the ASAP RN and the provider RN to discuss assessment findings and the plan of care.
- The ASAP is required to do a home visit and reassessment when a consumer experiences a significant change in health or functional status per RFR 9.1.5.8
- The ASAP RN and provider RN will assume joint responsibility to communicate with each other regarding the consumer's health and/or functional change. Service plans and any changes to the service plan remain the responsibility of the ASAP. The provider RN will update the care plan as needed to reflect HHA service changes. Visits for these purposes are not reimbursable.
- The ASAP shall comply with the required Home Care Program reassessment schedule based on the consumers' program enrollment and risk level in home care.
- When the only service provided by the ASAP is HHA level of care, the ASP RN shall visit the consumer annually to assess the level of care is still appropriate for the consumer. The ASAP must convey to the provider RN any changes the ASAP interdisciplinary team notes.
- When as ASAP consumer continues on HHA service for one year, the provider agency will be required to conduct and annual assessment, update the plan of care, and communicate this to the ASAP RN via documentation of the care plan. This is a reimbursable visit.
- In some cases the consumer who requires HHA services also requires skilled oversight of their care needs. The ASAP shall authorize skilled nursing services in addition to HHA services as appropriate.

- The ASAP shall evaluate the consumer's potential to qualify for skilled services that could be billed to another third party. (See Attachment A of PI 14-03).

Supervision of the HHA Service:

- An agency providing HHA level of care must perform an in-home review of the care plan at least quarterly to ensure the level of service is reviewed, updated if necessary and meeting the needs of the consumer.
- The agency providing HHA level of care must perform quarterly in home supervision of the aide on a representative sample of consumers.

APPENDIX

APPENDIX A – JOB AID

- Job Aid Using Service Orders and Service Deliveries for CAE Screenings January 13,2010
- Job Aid Activities and Referrals for Short Term Approval July 1, 2010
- Job Aid G/AFC Determination by Coastline in SIMS June 8, 2011

APPENDIX B – INFORMATION MEMORANDUM (IM)

- IM 13-03

APPENDIX C – PROGRAM INSTRUCTION (PI)

- PI 09-02
- PI 09-05
- PI 09-13
- PI 11-03
- PI 11-10
- PI 12-04
- PI 13-01
- PI 14-03

APPENDIX D – GUIDELINES

- GAFC Guidelines
- PC Guidelines

APPENDIX E – BUSINESS RULES

- CSSM Business Rule July 1, 2014