# 1915 (c) Home and Community Based Services Waiver for Frail Elders

# Program Guidelines

Executive Office of Elder Affairs

Operating a program of services under the authority of section 1915(c) of the Social Security Act permits a state to waive certain Medicaid requirements in order to furnish home and community-based services that promote community living for Medicaid beneficiaries; thereby, avoid institutionalization. Section 1915(c) waivers, known as Home and Community-Based Services (HCBS) waivers, are subject to the approval of the Centers for Medicare and Medicaid Services (CMS) of the federal Department of Health and Human Services. Services provided pursuant to HCBS waivers must be cost-effective and assist in preventing or reducing the use of institutional services. Since 1984, Massachusetts has operated the Frail Elder Waiver (“FEW” or “Waiver Program”), an HCBS waiver for elders aged 60 and above.

* MassHealth is responsible for the administration of Home and Community Based Services Waivers, including determining financial eligibility for MassHealth.
* The Executive Office of Elder Affairs (“EOEA” or “Elder Affairs”), in accordance with M.G.L. c. 19a § 4b, retains authority for the overall management, administration, and oversight activities related to the operation of the Massachusetts Home Care Program, including services provided under the 1915(c) Home and Community Based Services Waiver for Frail Elders. EOEA is also responsible for waiver program management, including billing for federal reimbursement.
* Aging Services Access Points (ASAPs) are responsible for conducting level of care assessments to determine clinical eligibility for the FEW, including initial Level of Care (LOC) determinations for individuals choosing SCO, conducting service needs assessments, developing, and monitoring waiver service plans, monitoring quality and collecting and reporting required data to Elder Affairs.
* Senior Care Options (SCO) organizations are responsible for conducting annual clinical assessments to gather eligibility data to support redetermination of clinical eligibility for the FEW, conducting service needs assessments, developing, and monitoring waiver service plans, monitoring quality and collecting and reporting data to Elder Affairs for FEW participants who are enrolled in a SCO (SCO FEW members).

**Frail Elder Waiver**

1. **ELIGIBILITY**
   1. To qualify for the FEW, an applicant must meet the following criteria;
      1. Must be 60 years of age or older and, if younger than 65 years old, permanently and totally disabled in accordance with Title XVI disability standards;
      2. Individuals found eligible for FEW who are between the ages of 60-64 may not choose to enroll in SCO.
      3. Must have MassHealth Standard and meet the financial eligibility requirements for the HCBS Frail Elder Waiver (FEW) according to 130 CMR 519.007(B);
      4. Must meet the clinical eligibility criteria for nursing facility services in accordance with 130 CMR 456.409;
      5. Must meet the Home Care Program eligibility and enrollment criteria in accordance with 651 CMR 3.00.
      6. Must need and typically receive at least one waiver service each month as determined by the ASAP or SCO;
      7. Must reside in a community setting in accordance with the CMS Community Rule at 42 CFR 441.301(C)(4). *See definition of “HCBS CMS Community Rule.”*
      8. HCBS Waiver Participants living in settings including a private residence owned or leased by an unrelated Adult Foster Care (AFC) caregiver, are considered provider-owned or provider-controlled settings and must comply with additional CMS Community Rule requirements, including,
         1. a lease or other legally enforceable agreement providing similar protections to the individual;
         2. privacy in the individual’s unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit;
         3. the individual controlling their own schedule and having access to food at any time;
         4. the individual being allowed visitors at any time; and a physically accessible setting.
         5. See MassHealth Adult Foster Care Bulletin 27, 28 and additional Bulletin’s released for more information
2. **PROGRAM ENROLLMENT**

To participate in the Frail Elder Waiver Program, an applicant must be both financially and clinically eligible for and enrolled in the waiver, either through the state Home Care Program (Home Care Basic Waiver or Community Choices) or through a SCO (SCOFEW).

1. Waiver Program Enrollment:
   1. A participant may not be enrolled into the FEW prior to the date that MassHealth issues the eligibility notification of “MassHealth Standard plus HCBS Waiver” (i.e. retroactive enrollment is not available for this program).
   2. The ASAP must verify the Member’s MassHealth Standard plus HCBS Waiver coverage prior to recording in SAMs the member’s eligibility for Home Care Basic/Waiver or Community Choices.
   3. The ASAP must verify the coverage type monthly thereafter.
2. Required Forms (Each included as attachment to these guidelines);
   1. Intent to Refer: This form documents the applicant’s decision to be screened for the Frail Elder Waiver and must be signed by the applicant or the applicant’s representative prior to a clinical determination of waiver eligibility. The ASAP must maintain a signed copy of the Intent to Refer in the applicant record. (*Attachment A*)
   2. Recipient Choice Form: This form documents the applicant’s choice to receive waiver services in a community setting as opposed to services provided in a nursing facility. This document must be signed by the applicant or the applicant’s representative when it is determined that the applicant is likely to require waiver services. The ASAP must maintain a signed copy of the Recipient Choice Form in the applicant record. (*Attachment B*)
   3. Frail Elder Waiver Initial Service Plan (ISP): This document identifies the initial plan of care for waiver services for applicants who choose to receive waiver services through the ASAP. The ISP must be signed by the applicant or applicant’s representative prior to receiving waiver services. The ASAP must maintain a signed copy of the ISP in the applicant record. (*Attachment C*)
   4. Waiver Notice of Non-Participation: The ASAP is required to submit this document to the MassHealth Enrollment Center (MEC) on behalf of a waiver participant who is no longer receiving waiver services in a Home Care Program/Waiver Program or SCO. The ASAP must maintain a copy of the Waiver Notice of Non-Participation in the participant record. (*Attachment D*)
3. **Assessments:**
   1. An **applicant** is defined as an individual who is potentially eligible for waiver services and has been referred to an ASAP RN to be assessed for clinical eligibility.
   2. **Aging and Disability Documentation in the Consumer Record**
      1. **Activity and Referral: WQM – Waiver Initial Referral** is the action utilized to document the **status** of the waiver initial referral, the date the referral was formally communicated to the ASAP RN (**status date**), the **due date** of the assessment and the **completion date** of the assessment.
   3. **Waiver Quality Measure 1** 
      1. Applicants’ initial clinical eligibility was assessed by an ASAP RN on the approved tool within 10 business days of their identified need.
   4. The **initial assessment** for eligibility and development of the Comprehensive Service Plan (CSP) is conducted by a Case Manager or an ASAP RN. Assessments are documented using the Comprehensive Data Set (CDS), a uniform tool that includes demographic, ADL/IADL, social, emotional, cognitive, medical, environmental and nutrition information. The CDS contains, in its entirety, the MDS-HC.
   5. The **annual clinical assessment** is completed by the ASAP RN to review ongoing clinical eligibility for the FEW. Assessments are documented using the Comprehensive Data Set (CDS).
      1. **Annual Clinical Assessments** for individuals with SCOFEW enrollments are to be completed by the SCO in which that individual is enrolled.
4. **COMPREHENSIVE CARE PLANNING**
   1. All waiver service plan development must be conducted in a person-centered manner in accordancewith the approved CMS FEW Application*.*
   2. The waiver service plan cannot be authorized retroactively, and cannot start prior;
      1. to the date that the participant’s MassHealth Standard Plus Frail Elder Waiver coverage is verified;
      2. to the date of a signed Waiver ISP.
   3. All waiver services must be based on assessed needs and preferences of the participant as determined through the person-centered process and authorized in the waiver service plan.
   4. The Comprehensive Care Plan must address needs and supports beyond waiver services (e.g., State Plan LTSS, informal supports, other formal supports etc.)

**Home Care FEW Participants:**

1. The waiver service plan shall be developed and managed in accordance with Program Instructions (Community Choices PI).
2. Each waiver participant shall be evaluated for risk and/or safety concerns according to EOEA Home Care program directives and sub regulatory guidance to mitigate risk, including falls and health and welfare.

**SCO FEW Participants:**

1. An individualized waiver service plan for each SCO FEW participant shall be developed by the participant’s PCP and care team according to MassHealth directives.
2. Each SCOFEW participant shall be evaluated for risk and/or safety concerns, including falls and health and welfare according to OLTSS/SCO Contract.
   1. All waiver participant’s waiver service plans must be reviewed and updated at least annually and more frequently as needed, as determined to be appropriate as a result of the required assessment described in (f) below.
   2. Assessment must be conducted and completed at a minimum according to the timeframes specified below, as appropriate, and at times of significant status change:

**Home Care FEW Participants:**

1. Home Care Basic/Waiver: Annually and 6-month visit
2. Choices: Annually, 3, 6, 9-month visits
3. Extended Hour Service Plan: at least every other month

**SCO FEW Participants:**

1. At least quarterly
   1. All waiver participants must have a required assessment tool, as specified below:
      1. Home Care Waiver Participants:
         1. CDS-RN completed annually
         2. A CDS-CM completed every 6 months
         3. A CDS-RN may be substituted for a CDS-CM
      2. SCOFEW Members:
         1. An MDS-HC completed annually
         2. SCO specific Health & Safety assessment completed quarterly
2. **SERVICE DELIVERY**

**Home Care & SCO FEW Participants:**

* 1. The ASAPs and SCOs are responsible to ensure that home and community-based services are provided to waiver participants through person-centered service planning, including provision of choice of services and service providers
  2. Waiver services must be scheduled on at least a monthly basis. The waiver participants must be in need of and typically receive at least one waiver service each month in order to maintain eligibility for the FEW.
  3. A waiver participant may need to suspend services for a short period, typically up to 90 days, such as for a hospital or rehab facility stay. In the event of a service suspension or when a participant does not receive scheduled waiver services for longer than a one-month period, the ASAP or SCO shall monitor the participant’s status monthly. Monitoring may include contact via face-to-face, telephone, video conferencing, and/or other electronic modalities with the participant or their informal support which includes a response and engagement from the recipient. Contacts shall be documented in the participants’ record. Service suspensions shall reflect the status of the participant.
     1. Waiver participants service suspension may extend over 90 days with reasonable cause. Documentation in the participant’s record must support the extended service suspension

1. **WAIVER SERVICES**

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| --- | --- | --- | --- | --- |
| Alzheimer’s / Dementia Coaching | Home Health Aide | Homemaker | Personal Care | Respite |
| Chore | Companion | Complex Care Training and Oversight | Enhanced Technology / Cellular PERS | Environmental Accessibility Adaptation |
| Evidence Based Education Programs | Goal Engagement Program | Grocery Shopping and Delivery | Home Delivery of Pre-Packaged Medication | Home Safety/Independent Evaluations |
| Laundry | Medication Dispensing Machine | Orientation and Mobility Services | Peer Support | Supportive Day Program |
| Supportive Home Care Aide | Transitional Assistance | Transportation | Home Based Wandering Response System | Home Delivered Meals |

The following services are included in the current 1915 (c) Home and Community Based Services Frail Elder Waiver:

Waiver participants also have access to all MassHealth state plan services available to MassHealth members, such as Adult Day Health, Personal Care Attendant (PCA), Personal Emergency Response (PERS), Medical Transportation, and Home Health Services. According to the Home Care program regulation found at 651 CMR 3.04 (1)(a), waiver services provided to eligible participants must not duplicate other available MassHealth services.

For SCO FEW members, the SCO must authorize, arrange, coordinate, and provide all covered services. This includes all waiver and non-waiver services, and MassHealth state plan services.

All waiver services must be rendered in a community setting in accordance with the CMS Community Rule at 42 CFR 441.301(C)(4). See definition of “HCBS CMS Community Rule.”

1. **TERMINATION OF WAIVER ENROLLMENT**
2. A participant is ineligible for the FEW when they;
   1. Are financially ineligible for MassHealth
   2. Clinically ineligible for the waiver
   3. Enroll or are enrolled in another HCBS waiver
   4. Enroll or are enrolled in Program for All Inclusive Care of the Elderly (PACE)
   5. Permanent suspension or permanent refusal of all waiver services
      1. no longer need a waiver service,
      2. are refusing waiver services
3. When an enrolled participant no longer meets the eligibility criteria for the FEW or terminates waiver services, the participant must be disenrolled from the FEW or transferred to another program, as appropriate.
4. The ASAP representative shall forward a Notice of Non-Participation (*attached as Appendix D*) to the MassHealth Member Enrollment Center (MEC), which will terminate the participant’s coverage type of MassHealth Standard Plus Frail Elder Waiver. The MEC will redetermine the participant’s MassHealth eligibility in accordance with the applicable financial eligibility regulations.
5. When a participant’s MassHealth coverage changes due to a decision made by MassHealth, MassHealth provides participant the opportunity to appeal that decision. The appeal process shall be completed prior to submitting the Notice of Non-Participation to the MassHealth Member Enrollment Center (MEC).

**Home Care Waiver Participants:**

1. When terminating or reducing waiver services, the ASAP shall issue a Voluntary Assent Form (VAF) and ask the participant to sign and return it to the ASAP.
2. If a signed VAF is not received from the participant, a Notice of Action (NOA) is required according to 651 CMR 3.07. In accordance with 651 MR 3.07 (4)(b) a waiver participant has 30 days after a Notice of Action is sent to appeal the reduction or termination of waiver services by requesting an ASAP review. If the waiver participant files a timely request for review, the ASAP shall, in accordance with 651 CMR 7.08 (2), either continue the suspension or continue the provision of FEW services during the Review and Appeal period, as appropriate.
3. If participant is ineligible for MassHealth Standard, a VAF or NOA is not required. As with other MassHealth service types, waiver services may not be provided to persons ineligible for MassHealth. The participant has an opportunity to appeal MassHealth’s decision regarding their financial eligibility for MassHealth. The participant does not have a right to appeal the termination of waiver services due to a decision regarding their eligibility for MassHealth.
   1. Consumer should be evaluated and enrolled in another non-waiver Home Care program by the ASAP
   2. If a consumer is no longer MassHealth eligible and does not wish to enroll in another Home Care program, the ASAP must evaluate and refer the consumer to other community resources
4. If a waiver participant is found clinically ineligible for the waiver, the ASAP must conduct an interdisciplinary case review of the clinical assessment to support the termination from the waiver program
5. If waiver participant is denied waiver due to Clinical ineligibility and enrolls in another ASAP program with a downgrade in services, the ASAP must issue a VAF or NOA as required

**SCOFEW Members:**

* 1. If a SCO FEW member disenrolls from a SCO and does not enroll in a Home Care Waiver Program, the member is no longer waiver eligible
  2. If a SCO FEW member becomes clinically ineligible for the waiver, the SCO Operations Unit will notify the MassHealth Enrollment Center of the clinical denial.
  3. In any instance above where a SCO FEW member will not remain on MassHealth Standard and eligible for the SCO, the member will be notified by the SCO that they have been disenrolled from the FEW and termination of waiver services
  4. In any instance above where a SCO FEW member will not remain on MassHealth Standard and eligible for the SCO, the SCO will refer the member to the ASAP for other service options

1. **WAIVER QUALITY OVERSIGHT**

ASAPs and SCOs are required to capture and maintain data, monitor quality on-going, calculate and review quality measures and submit required reports to the appropriate entity in accordance with specifications, templates, and timeframes issued by EOHHS and EOEA. Reporting requirements for ASAPs & SCOs are as follows:

**ASAP Requirements:**

1. ASAPs are required to follow EOEA directives for data entry, data collection, and data reporting which includes but is not limited to:
   1. Waiver Quality Measures and associated Business Rules
   2. Home & Community Based Services Explorer
   3. Harmony Advanced Reporting (HAR)
   4. Aging & Disability (A&D) Reports
   5. Other reporting requirements as outlined by EOEA, such as the Provider Workbook or Case Management Workbook
   6. Other data collection and data reporting tools
   7. Each ASAP must review required reports according to EOEA directive to ensure adherence to quality standards and data entry requirements for waiver participants.

**SCO Requirements:**

1. SCOs are required to submit reports to the MassHealth Office of Long-Term Services and Supports in accordance with specifications, templates, and timeframes issued by EOHHS and EOEA.
2. **FOR ADDITIONAL INFORMATION**
3. Contact the local Aging Services Access Point (ASAP) for an assessment of clinical eligibility, needs assessments, and service plan development.
4. Contact the MassHealth Member Enrollment Center (MEC) regarding financial eligibility.
5. For additional Waiver Program information, contact the Elder Affairs Home Care Waiver Program Manager, at 617-727-7750

# Definitions, in addition to Home Care Definitions found in 651 CMR 3.02:

**MassHealth Standard:** The most complete benefit coverage type under MassHealth, which allows the consumer access to MassHealth Insurance Coverage, Waiver services, and MassHealth State plan services.

**Senior Care Options/Frail Elder Waiver (SCO FEW) Participant:** A Frail Elder Waiver participant who is eligible for MassHealth Standard (MH STD) only through use of the expanded income eligibility available through an HCBS waiver (300% FBR) and who chooses to receive all MassHealth services (both waiver and non-waiver) through enrollment in a Senior Care Options (SCO) Plan.

**HCBS Community Rule (“Community Rule”)**: Federal regulation 42 CFR 441.301(C)(4), effective March 2014, that described required standards and qualities for settings in which HCBS consumers’ services can be delivered. ASAPs are required to evaluate service settings according to Community Rule requirements. Attached are review tools for each type of setting to be completed. All settings in which HCBS are delivered must comply with the standards outlined in the Community Rule, summarized below. Such settings typically must be:

1. A setting that is **not** a publicly or privately owned facility that provides inpatient treatment; on the grounds of, or immediately adjacent to a public institution; or have the effect of isolating an individual;
2. Integrated in and support full access to the greater community;
3. Selected by an individual from community setting options;
4. Free from restraint and coercion, ensuring the individual’s right to privacy, dignity, and respect;
5. A supportive environment which optimizes autonomy and independence in making life choices;
6. Able to provide choice to the individual in the types of services provided and who provides them;
   1. In addition, in provider-owned or -controlled residential settings the community setting must meet additional requirements;
      1. The individual has a lease or other legally enforceable agreement providing similar protections;
      2. The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish and decorate;
      3. The individual controls his/her own schedule including access to food at any time;
      4. The individual can have visitors at any time; and
      5. The setting is accessible to the individual.
   2. Any modification to these community-based setting requirements for a provider owned setting must be supported by a specific need and justified in the person-centered plan of care.

For more information and fact sheets visit: [www.medicaid.gov/medicaid/hcbs](http://www.medicaid.gov/medicaid/hcbs)