The Commonwealth of Massachusetts
Executive Office of Elder Affairs
One Ashburton Place, Boston, MA 02108

DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

ANN L. HARTSTEIN
Secretary

SANDRA K. ALBRIGHT
Undersecretary

PROGRAM INSTRUCTION

Tel: (617) 727-7750
Fax: (617) 727-9368
TTY/TTD 1-800-872-0166
www.mass.gov/elder

EOEA-PI-13- 01

TO: Aging Service Access Points (ASAPs)
Executive Directors
Nurse Managers

FROM: Ann L. Hartstein

DATE: 01/17/2013

RE: Requirements for Comprehensive Screening and Service Model (CSSM) Activities

1. Purpose

The purpose of this Program Instruction is to issue requirements for Aging Service Access Points (ASAPs) in the performance of Comprehensive Screening and Service Model (CSSM) program related activities. This Program Instruction requires all ASAPs to adopt a specified management and staffing model and protocols to perform CSSM-related activities.

This Program Instruction revises and restates CSSM program requirements, and supersedes the following previously issued instructions regarding CSSM: the ASAP RFR Sections 9.4.4, Section 9.4.3.9 and PI 11-03 Conditions for Certain Nursing Facility Approvals.

2. Background

The CSSM program, in effect since January 2005, is intended to ensure that MassHealth members and applicants seeking MassHealth coverage for nursing facility services, as well as their family members and caregivers, 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 consumer's unique situation.

The Executive Office of Elder Affairs (Elder Affairs) has worked with the ASAP network to evaluate the CSSM program design. Our collaborative Assessment and Eligibility Workgroup has identified opportunities for improvement, including clarifications of specific staff role requirements, standardization of program protocols across the Commonwealth, and the implementation of best practices.

The CSSM program is designed to ensure that the MassHealth member or applicant and his/her family or caregivers are aware of all potential community service options. The role of the ASAP is to work with the member/applicant, family, and nursing facility to overcome barriers and assist with discharge planning by formulating and implementing a care plan that meets the member/applicant's needs in the community.

3. Definitions

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

3.2. 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, PACE, and Waiver Services.

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

3.4. Comprehensive Screening and Service Model (CSSM) – 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.

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

3.6. 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.

3.7. Denial – The finding issued by an ASAP RN when a consumer does not meet the clinical eligibility criteria for nursing facility services.

3.8. Initial Assessment –The first clinical assessment for authorization of MassHealth payment of nursing facility services 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.

3.9. Nursing Facility Approval – 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. In limited circumstances, a Nursing Facility Approval may be issued based on the initial clinical assessment. See further clarification in "Nursing Facility Approval" on page 6 of this PI.

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

1. Dually-eligible consumers with both Medicare and MassHealth;
2. MassHealth members;
3. MassHealth applicants, (the date the MassHealth application was submitted to the MEC must be written on it);
4. MassHealth members who have expressed an interest, either directly, through a representative, or a positive response to Section Q of the MDS, to receive services in a community setting;
5. 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;
6. Any dually eligible MassHealth member converting to MassHealth as their primary payer source within the next 10 days; and
7. Any member who previously received a short term approval set to expire within the next 10 days.

3.11. Retrospective Referral – A MassHealth referral that is received post-admission or post-conversion that requests retroactive MassHealth payment of nursing facility services to the date of admission or date of conversion.

3.12. Short Term Approval - An approval issued by an ASAP RN when a consumer continues to meet the clinical criteria for MassHealth payment for nursing facility services **and** requires time in a nursing facility to rehabilitate or recuperate, **and** time is needed to develop and implement a community service plan.

4. Actions

4.1 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 responsible for the following:

1. Ensuring the quality of the overall administration of the CSSM program in accordance with program requirements;
2. Ensuring the timeliness and quality of all CSSM documentation, including consumer and service data in SIMS; and,
3. 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 Care Manager and one Registered Nurse. 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.

4.2 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 MassHealth Member or Applicant;
- any family members or caregivers identified by the MassHealth Member or Applicant;
- the CSSM Care Manager (CM) as appropriate;
- the CSSM Registered Nurse (RN);
- the nursing facility discharge planner;
- as appropriate and available, a representative from the local Independent Living Center; and
- Other professionals or representatives as needed or requested by the MassHealth member or applicant.

4.3 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 receipt of a 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 a safe 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.

4.4 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 to determine the consumer's goals and preferences.

- 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.

- At the conclusion of the determination process, the RN must issue one of the following determinations: 1.) Short Term Approval (STA), 2.) Nursing Facility Approval (NFA) (formerly known as a "Long Term Approval"), or 3.) Nursing Facility Denial.

- As noted in the RFR section 9.4.9, the ASAP must issue within two business days of making the clinical determination, the appropriate Notice of Eligibility to the MassHealth member or applicant, his/her legal guardian or eligibility representative, the provider of the Nursing Facility or community long-term care; and a MassHealth Appeal Rights and Fair Hearing Request Form with each Notice of Eligibility.

In those cases where a nursing facility has requested a nursing facility transfer and has given the ASAP less than two 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 approval (NFA) after numerous STA's, the ASAP nurse may issue a NFA on a transfer if the consumer was transferring within the ASAPs 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 their geographic area that may not have been available in the original nursing home/ASAP areas. The on-site assessment of the consumer will be done by the new ASAP to determine any new community resources to meet the member's needs.

Short Term Approval (STA):

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.

- Multiple short term approvals may be issued as necessary to meet the needs of the 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 consumer, IDPT, nursing facility, and in consideration of the consumer's needs, must determine the duration of the short term approval.
- The CDS-NF, Nursing Module, 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 for tracking all short term approvals, utilizing the Activity/Referral functionality and Service Delivery within SAMS, as outlined in PI-09-05 (Nursing Facility Clinical Eligibility, Short Term Approval Tracking, and Noticing Procedures).
- The ASAP is responsible for notifying the nursing facility one week in advance of the expiration of the short term approval.
- The ASAP nurse must complete a Short Term Review prior to the expiration of the STA.

Nursing Facility Approval (NFA): (formerly known as a "Long Term Approval")

A nursing facility approval, issued for an indefinite length of stay, may be issued by the ASAP RN at the time of initial assessment only if the MassHealth member or applicant meets the clinical requirements for nursing facility services and meets at least one of the following criteria:

- Has a confirmed diagnosis of Alzheimer's Disease or Related Disorder when supervision for consistent interventions for safety are 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: bathing, dressing, toileting, transfers, and mobility.

The CDS-NF, Nursing Module, Narrative and Journal entry must be completed, and the criteria for nursing facility approval must be recorded in 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 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 nursing module and the journal notes. The "Other" selection is not permissible to use for this purpose.

In cases of an initial Nursing Facility Approval and of Nursing Facility Denial, the CDS-NF, and Nursing Module, Narrative and Journal entry are required.

4.5 Documentation Requirements: Journal Entry, CDS, CCTF

Journal Entry:
The date the CSSM case is opened, as well as 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 community services the IDPT is attempting to secure to meet the consumer's needs.

CDS Documentation:
The RN is required to complete the current CDS-NF, as a new assessment, 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 Home Care Service Program, the 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-Full.

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

Case Closure and Tracking Form (CCTF) Documentation:

For **any** consumer that the CSSM team assisted with discharge, a CCTF is required with the following exceptions:

- For DDS consumers;

- When an initial Nursing Facility Approval is granted;

- When a Nursing Facility Denial is granted.

For any consumer who is participating in MFP, the questions in the MFP section must also be completed on the CCTF.

The SIMS CCTF assessment form must be completed within 5 business days from the date of discharge, and at days 30, 60, and 90.

4.6 Monitoring Consumer Well-Being After They Have Returned to a Community Setting:

Each CSSM consumer must be monitored by either the CM or RN 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 done at 30, 60 and 90 days.

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), including readmission to a hospital or nursing facility;
- Any anticipated activities to be completed before the next scheduled 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.

4.7 Requirements for Reporting to Elder Affairs:

Changes in CSSM Core Team Staffing Requirements:
The CSSM Program Manager must report any issues that have interfered with, or will interfere, with the ASAPs ability to perform CSSM program activities in the timeframes and manner described in this Program Instruction. An ASAP cannot suspend in-person visits to nursing facilities at any time without prior consultation with and permission from Elder Affairs.

Effective Date:
This PI is effective February 1, 2013.

Contact Information:
All questions regarding this Program Instruction should be directed to Mary DeRoo, RN, Director of Home and Community Programs, at Mary.deroo@state.ma.us.