Enhanced Community Options (ECOP)

Q.1. How is AGE defining or determining the "cost of services actually provided?" Can you please explain the difference between "delivered" vs. "authorized" services?

R.1. *Transferring a consumer from Home Care Basic to ECOP considers the cost of services. With the latest Program Instruction, the service threshold is determined by consideration of the costs of "delivered" services rather than the cost of "authorized" services. "Delivered" services (i.e., the cost of services actually provided) refers to when a Consumer has an identified provider and is* ***expected*** *to receive services for the service month. "Authorized" services refers to the* ***planned*** *services, inclusive of those services which were pending a provider, or suspended for a long duration, and in either case are not actually being provided to the consumer. Pending services are not counted towards the total care plan threshold cost because the service status is pending, a provider has not accepted the Consumer's case, and the service is not expected to be delivered. This consideration of the cost of delivered services is a return to the application of the service cost threshold from the prior program instructions communicated in 2019. The service cost threshold and delivered service criteria are precedented.*

Delivered Services	Authorized Services
When service(s) have an identified provider(s); and the service(s) is **expected** to be provided in the service month	When service(s) are **planned** and monthly cost, is inclusive of those services which are pending a provider and therefore not expected to be delivered, or a service is suspended for a long duration and not being provided to the consumer

Q.2. At what point can an ASAP transfer a Home Care Basic consumer to ECOP related to determining service threshold?

R.2. *The minimum cost threshold for ECOP and Choices requirements effective 2/1/2025 is an actual monthly service cost of two (2) times the Home Care Basic POS amount. This cost threshold is determined when a Consumer is expected to receive services that are within the service month cost two (2) times the Home Care Basic POS amount. A Consumer's total service plan(s) is expected to be clearly documented within the care plan section of the Consumer's A & D record, which includes identifying providers who will be providing the service. See also the response to Q.1.*

Q.3. PI-25-01 states that a review of service costs must happen at 6 months and Annual assessments, and Consumers who do not meet the minimum service threshold amounts must be transferred. Are Consumers who were enrolled in ECOP prior to 2/1/25 exempt from this requirement?

R.3. No, among other factors, ECOP eligibility includes a care plan (i.e., service) cost threshold. *Reviews of service costs are required to be reviewed at the 6-month and annual assessments for all ECOP Consumers as outlined in PI-25-01 in order to ensure care planning needs are assessed, updated and needs are being met for these nursing facility level of care*

Consumers. Reviewing the care plan, service plan(s) as well as comparing service deliveries, provides insight into services being delivered as expected and are meeting the threshold requirement.

Q.4. If a Consumer was enrolled in ECOP prior to 2/1/25 and using the minimum care plan threshold of 1.75x the Home Care Basic POS amount, would they be able to stay in ECOP if their care plan costs are lower than two times the home care cost?

R.4. *For Consumers who enrolled in ECOP on 1/31/25, they may continue to stay in ECOP and receive a service plan based on the service threshold of 1.75 times the Home Care Basic Purchase of Service (POS) rate.*

Q.5. What is the Home Care Basic POS Rate now? What is the new ECOP service threshold amount?

R. 5. *The Home Care Purchase of Service (POS) Rate is $457.41 effective January 1, 2025, as established by rate regulation at 101 CMR 417 Certain Rates for Elder Services*, promulgated pursuant to emergency process. *The ECOP service cost threshold for Consumers enrolled in ECOP after 2/1/2025 is $914.82; for Consumers enrolled in ECOP as of 1/31/25, the applicable ECOP service cost threshold is $800.46. For reference, the ECOP POS reimbursement rate is $1025.12 effective 1/1/2025.*

Q. 6. If a MassHealth FEW Consumer loses their FEW eligibility and needs to be transferred to a Non-Waiver Program, can the Consumer be transferred to ECOP?

R.6. *If the ASAP is working with a waiver Consumer to reinstate MassHealth coverage, and the Consumer has not been denied MassHealth coverage, then the ASAP may leave the Consumer in the waiver program until such approval or denial. In instances where the Consumer is denied MassHealth coverage, the Consumer should be transferred to Home Care Basic Non-Waiver or ECOP, but only in instances where the individual ASAP's ECOP enrollment maximum has not been reached.*

Consumers transferred to Home Care Basic Non-Waiver or ECOP due to the MassHealth coverage denial can only appeal the MassHealth denial decision to MassHealth.

Q.7. If a person's service plan changes for any reason, the cost may fall below the service threshold while different services are being arranged, a worker is potentially out, or there is a transition in direct care workers. What is the mechanism for consistent monitoring of this criteria across ASAPs?

R.7. *If a Consumer's actual monthly service delivery cost is below the service threshold for two consecutive months, the Consumer should be transitioned to Home Care Basic. ASAPs should, on*

a regular basis, monitor these Consumers to ensure they are not remaining enrolled in a special program and/or consistently not meeting the actual cost threshold requirements. If the Consumer has experienced a status change and is no longer in need of an increased service plan, the Consumer shall be transitioned to Home Care Basic.

Q.8. If a Consumer is enrolled in Home Care / Percent Based, can I refer and enroll them in ECOP?

R.8*. Consumers enrolled in the Home Care Percent Based Program are not eligible for the ECOP program. The ASAP should ensure the financial assessment is up to date, discuss additional community benefits, & review the Frail Elder Waiver (FEW) Program with the Consumer. Consumers have the right to apply to the FEW program at any time, irrespective of income. The FEW has specific income eligibility rules, including a 300% Federal Benefit Rate (FBR), which is an expanded eligibility requirement for MassHealth Standard.*

Q.9. Our ASAP has a Consumer who appears clinically eligible for ECOP, but is temporarily living in another state receiving medical care. Can I enroll the Consumer in ECOP?

R.9. *No, Consumers must be living in the state of Massachusetts and meet all other clinical eligibility as well as the service threshold to be enrolled in ECOP.*

Q.10. Our ASAP has a Consumer who is in need of personal care, should I make a referral for ECOP?

R.10. *A referral for ECOP should be based on the Consumer meeting the ECOP eligibility requirements, inclusive of the Consumer's clinical eligibility and meeting the services threshold. The need for personal care service does not automatically initiate an ECOP referral.*

Q.11. Our Home Care Consumer has MassHealth standard and needs more help in the home. Should we make a referral for ECOP?

R.11. *Consumers who have been identified as having MassHealth should have their MassHealth benefit confirmed via the Eligibility Verification System. Consumers who have been identified as having MassHealth Standard should be encouraged to apply for the Frail Elder Waiver (FEW) Program.*

Additionally, MassHealth Consumers, depending on their MassHealth benefit type, may be eligible for other state plan services, such as Adult Day Health, Medical Transportation, Personal Emergency Response Systems, and Behavioral Health Services. MassHealth coverage types for seniors and people who need long-term-care services | Mass.gov

ASAPs are able to identify consumer needs through the Comprehensive Data Set assessment, develop a care plan, provide non-duplicate home care services other than state plan services, which address the consumer's goals and assessed needs.

Q.12. Our ASAP has a home care basic Consumer who recently fell and broke a bone. This Consumer was at a hospital and transferred to a nursing facility. The Consumer doesn't have a discharge date and might be there for several months due to complications. Can we make a referral and enroll them in ECOP now?

R.12. *No. As the consumer is not in the community and had a status change due to the fall, an assessment should be conducted to determine what consumer's unmet needs are, which will also then inform the consumer's comprehensive care plan. In instances in which a Consumer becomes temporarily unavailable to receive services in their home, the ASAP should continue with engagement with the Consumer. If the Consumer maintains unavailable to receive services for a period up to 90 days, the ASAP can initiate termination of such Consumer, however, ASAPs have the ability to extend the suspension of Home Care Services beyond 90 days for reasonable cause, including discharge date. If no cause is determined to extend the suspension, the ASAP shall proceed with termination as outlined in the Home Care Program Regulations 651. CMR 3.07. Once the consumer is ready to begin to receive services, ECOP can be reviewed to determine if the consumer will meet clinical and service cost thresholds.*

Q. 13. If an ECOP enrolled Consumer transfers from another ASAP, should the consumer remain in ECOP at the receiving ASAP?

R.13*. The consumer should be transferred to the receiving ASAP and may temporarily remain enrolled in ECOP. The ASAP Transfer Business Rule Final 9-2023 outlines requirements of the transferring and receiving ASAPs for continuation of services, care planning and assessments. The receiving ASAP must conduct an in-person assessment with the consumer in their new environment to determine unmet needs in the new environment, and interventions for care and the minimum service cost threshold. The receiving ASAP must ensure that the consumer clinically qualifies for ECOP, including having a ECOP Clinical Re-Determination that is within one year of the prior determination. If ECOP enrollment is still necessary based on the level of services needed in the new environment, the consumer may remain enrolled in ECOP.*

Q.14. Will Choices be affected by the ECOP changes? If so, could you provide some details about how that would work?

R. 14. *Program Instruction (PI 25-02) describes the elements related to moving a Consumer from Home Care Basic – Waiver to Choices, inclusive of the service threshold, which is when the cost of delivered services within the waiver plan of care is two (2) times the Home Care Basic POS amount. A Consumer's total service plan(s) is expected to be clearly documented within the care plan section of the Consumer's A & D record which includes identified providers who will be providing*

the service. Pending services are not counted towards the total care plan threshold cost as the service status is pending, and the provider has not accepted the Consumer's case, and the service is not expected to be delivered.