Community First:

A Proposal for Preventing or Delaying Nursing Facility Admission

Section 1115 Demonstration Application

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Commonwealth of Massachusetts
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I. Introduction

A. Overview of the Demonstration

The Commonwealth of Massachusetts (Commonwealth), Executive Office of Health and Human Services (EOHHS) submits to the Centers for Medicare and Medicaid Services (CMS) this Section 1115 Demonstration Proposal, entitled "Community First: A Proposal for Preventing or Delaying Nursing Facility Admission". This proposal is designed to prevent and/or delay admission to, or facilitate discharge from, nursing facilities for targeted elders and adults with disabilities in Massachusetts. Under the Community First 1115 Demonstration, an array of community-based supports will be available to participants to help them stay in the community as long as possible and divert or delay a Medicaid-covered nursing facility stay. In some cases, access to community based supports under the Demonstration will be available before an individual's health condition and functioning declines to a point where he or she needs a nursing facility or comparable level of care in the community. The Community First 1115 Demonstration will facilitate the growth of a more flexible community-based supports delivery system, as Demonstration participants will have the option to use certain Demonstration benefits in a self-directed manner through an Independence Plus model. Additionally, some participants residing in nursing facilities will be able to access a time-limited Demonstration benefit of transition services to help them transition from a nursing facility setting to the community.

Services provided in nursing facilities are generally the most medically intensive and expensive forms of long-term care. In State Fiscal Year (SFY) 2006, the Massachusetts Medicaid program (MassHealth) paid over $2.57 billion for long-term care services, of which over $1.61 billion (63%) paid for nursing facility services. Expenditures for nursing facility services have increased over $247 million (18.5%) since SFY 2000, primarily due to provider rate increases.

There are several reasons why people are more likely to utilize long-term care in nursing facilities rather than in a community setting. First, Title XIX financial eligibility rules make it easier for an individual to qualify for Title XIX benefits while in a nursing facility than while in the community. Second, many people enter a nursing facility for a short-term stay following an acute hospital admission, but remain in that setting longer than expected. This can occur because the individual becomes dependent on the care, because family members who may have been caring for the individual are relieved to pass that responsibility to the nursing facility providers, and because individuals deplete the resources necessary to return to the community by the time they may want to access community-based alternatives. Finally, there may be a bias on the part of medical providers who make referrals to refer people to nursing facilities over community settings because they may be less aware of community alternatives or believe institutions are safer. The Title XIX changes proposed in this Demonstration are designed to make it easier for low-income individuals who are at risk of admission to a nursing facility to choose community-based supports. To do so, the Demonstration will remove some eligibility barriers to community-based supports and enhance the

community-based supports that individuals can access, while building on the resources already in place in Massachusetts.

B. Context for the Demonstration

Based on well-accepted evidence that elders and individuals with disabilities can transition to and reside safely in the community with sufficient community-based supports, Massachusetts has taken steps to increase accessibility, capacity, and expenditures for community-based services through optional Title XIX services and Section 1915(c) Home and Community-based Services waivers and waiver expansions. In 2003, the Commonwealth established the “Community First” policy, an overarching policy manifested in various activities. The goal of Community First is to prevent or delay admission to, or facilitate discharge from, nursing facilities by making community-based supports available to eligible elders and adults with disabilities who, by using these community-based supports, can live in the community.

A major milestone occurred on August 3, 2006, when Governor Mitt Romney signed a law (Chapter 211 of the Acts of 2006 “AN ACT RELATIVE TO CHOICE OF LONG TERM CARE”) that provides low-income senior citizens and disabled residents with broader access to publicly-funded community-based supports. The legislation directs MassHealth to submit an 1115(a) Research and Demonstration waiver to CMS that will expand MassHealth income and asset financial eligibility rules. A copy of the law is contained in Appendix A. The Commonwealth submitted a Community First 1115 Demonstration Concept Paper to CMS in June 2006. This Demonstration application

proposal builds off of the Concept Paper and incorporates a wide range of input obtained through numerous public forums from consumers, providers, and other stakeholders.

Under the Community First 1115 Demonstration, EOHHS proposes to:

- enable participants to access an array of community-based supports to help them remain in the community;
- increase Medicaid income and asset limits to expand eligibility for Medicaid-covered community-based supports to specific individuals who are at risk of future nursing facility admission;
- provide certain nursing facility residents with transition services that will facilitate their return to the community;
- offer qualified participants the opportunity for increased independence by offering flexible, consumer-directed community-based supports, such as personal care attendant services, using an Independence Plus option[1]; and
- ensure case management is available to Community First 1115 Demonstration participants to assist them in accessing their Demonstration services.

[1] Independence Plus is a federal initiative designed to expedite the ability of states to offer individuals who require long-term care, or families with a member who requires long-term care, greater opportunities to take charge of their own health and direct their own services. Under the program, individuals and families can exercise greater choice, control, and responsibility for their services within cost neutral standards. The program builds on the experience of and research from a number of pioneer states that have pre-tested these concepts. For more information see http://www.cms.hhs.gov/independenceplus/.

C. Research Hypotheses

In developing this proposal, the Commonwealth conducted an extensive literature review and data analysis on approaches to delaying and preventing admission to nursing facilities and related outcomes. The Commonwealth also considered the experience of other States (including Washington, Oregon, South Carolina, and Colorado) in implementing innovative programs to achieve these ends. The research shows that there are substantial benefits to preventing or delaying admission to nursing facilities, including a reduction in future Medicaid long-term care costs and improved quality of life for those individuals who are able to remain in the community. The research also posits which populations are most likely to enter a nursing facility and, among them, who could utilize community-based supports to avoid or delay nursing facility admission. Study findings include the following:

- Community-dwelling older adults at high risk for entering a nursing facility include those with dementia (such as Alzheimer's), a physical and/or mental disability, neurological problems (such as stroke), and those in need of assistance with multiple activities of daily living (ADLs).[2]

[2] MMWR Weekly. (2003). Public Health and Aging: Hospitalizations for stroke among adults aged over 65 years: United States, 2000. *MMWR Weekly, 52(25)*, 586-589. Tsuji, I., Whalen, S., et. al. (1995). Clinical investigation: Predictors of nursing home placement in community-based long-term care. *Journal of the American Geriatrics Society, 43(7)*.

- Aged and disabled individuals who received home and community-based services under waiver programs in five states cost six times less than the national average for nursing home residents.[3]
- Programs in Oregon, Washington, and South Carolina offering community-based supports with a focus on in-home supports and case management have reduced the probability of admission to a nursing facility.[4]
- Certain services are effective in preventing or delaying admission to a nursing facility, such as respite care for informal caregivers.[5]
- Providing targeted services based on a comprehensive assessment of the high-risk individual's health needs helps to reduce the likelihood of admission to a nursing facility.[6]

In light of this research, the Commonwealth anticipates that the proposed Community First 1115 Demonstration will support these findings and will achieve the following outcomes:

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[3] Doty, P. 2000. "Cost-Effectiveness of Home and Community-Based Long-Term Care Services." Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[4] Fischer, L.R., Green, C.A., et. al. (2003). Community-based care and risk of nursing home placement. *Medical Care, 41(12),* 1407-1416. Blackman, D.K., Brown, T.E., et. al. (1986). Four years of a community long term care project: The South Carolina experience. *Pride Institute Journal of Long Term Home Health Care*, *3*, 30-49.

[5] Greenberger, H. and Litwin, H. (2003). Can burdened caregivers be effective facilitators of elder care-recipient health care? *Journal of Advanced Nursing, 41(4),* 332-341.

[6] Weissert, W., Chernew, M., et. al. (2001). Beyond managed long-term care: Paying for home care based on risk of adverse outcomes. *Health Affairs, 20(3)*, 172-180.

- Those individuals most likely to avoid or delay a nursing facility admission with earlier access to effective community-based supports will remain in the community longer than they would have without access to those community-based supports.
- Individuals who utilize the consumer-directed Independence Plus option will be able to use community-based supports more efficiently and effectively than they would under traditional delivery system models.
- Increased access to community-based supports will divert or delay nursing facility admissions.
- The availability of funds for community-based supports will increase.
- Certain individuals who otherwise would have had a long-term, MassHealth-paid nursing facility stay will instead transition to the community.
- On average, per capita expenditures on long-term care will decrease.

The Commonwealth will develop and implement a comprehensive evaluation plan during the Community First 1115 Demonstration to test whether it achieves these outcomes. The proposed evaluation plan design is described in Section IX.

II. Eligibility and Enrollment

A. Eligibility Criteria

The Demonstration will cover three groups of adults (ages 21 and older): an **Imminent Risk group** consisting of elderly and disabled individuals at nursing facility level of care (NF LOC) who are residing in the community; a **Prevention group** consisting of elderly and disabled individuals residing in the community who do not

currently meet NF LOC, but have clinical and functional profiles that deem them likely to enter a nursing facility in 9-12 months; and a **Transition group** consisting of certain elderly and disabled individuals who have been in a nursing facility for at least three months and seek to transition to the community.

For the purpose of this Demonstration, elders are individuals ages 65 and older, and disabled individuals are those under age 65 who have been determined disabled in accordance with current MassHealth rules, which incorporate the rules under Title XVI of the Social Security Act.[7]

Through the Community First 1115 Demonstration, the Imminent Risk and Prevention groups will be able to access an array of community-based supports, a consumer-directed delivery approach for certain community-based supports, case management, and all Title XIX State Plan services. The Transition group will be able to access case management and certain transition services designed to help them return to the community. If these individuals return to the community within six months of Demonstration enrollment in the Transition group, they will be covered in the Imminent Risk eligibility group.

The Community First 1115 Demonstration will not affect the income or asset eligibility rules for MassHealth-paid nursing facility stays. When a Demonstration

[7] Current eligibility rules for the Commonwealth's frail elder 1915(c) waiver include individuals 60 years of age and older. If the individual is under age 65, however, he or she must be permanently and totally disabled in accordance with Title XVI standards. See MassHealth regulations at 130 CMR 519.007(B). For purposes of this Community First 1115 Demonstration, all individuals ages 60-64 will be classified as disabled, where such a distinction is relevant. However, these individuals will be able to access all of the community-based supports to which they had access under the frail elder 1915(c) waiver.

participant enters a long-term care institution (e.g., nursing facility, chronic disease or rehabilitation hospital, or Intermediate Care Facility for the Mentally Retarded (ICF/MR)), he or she will be disenrolled from the Demonstration. The traditional MassHealth eligibility rules for those settings will apply.

Enrollment in the Community First 1115 Demonstration will be voluntary. Some individuals who are eligible for the Community First 1115 Demonstration may already be eligible for and enrolled in MassHealth. For example, they could be enrolled in MassHealth Standard, MassHealth CommonHealth, or the Mental Retardation/Developmentally Disabled (MR/DD) 1915(c) waiver. These individuals can choose to enroll in the Community First 1115 Demonstration if eligible. However, individuals will not be allowed to be enrolled in two waivers at the same time. Therefore, any individual enrolled in the MassHealth 1115 Demonstration, for example, who is eligible for and chooses to enroll in the Community First 1115 Demonstration will have to disenroll from the other program.

1. Imminent Risk Group

Individuals eligible for the Imminent Risk group must be at NF LOC and reside in the community. To meet NF LOC, an individual must require one skilled service daily, or have a medical or mental condition that requires a combination of at least three (3) services defined as skilled services, nursing services, and physical assistance with activities of daily living. One of the three required services must be either a skilled or nursing service a minimum of three times per week. Skilled services include

tracheostomy care and suctioning, ventilator or respiratory services, skilled therapies (physical, occupation, and speech) wound care, feeding tubes, and IV care. Nursing Services included skilled services, or services that require a registered nurse to oversee or provide and ADLs are bathing, dressing, toileting, transfers, mobility/ambulation, and eating. These criteria for nursing facility coverage are contained in MassHealth regulations at 130 CMR 456.409. A copy of the regulation is contained in Appendix B.

By definition, the clinical eligibility criteria for the Imminent Risk group include individuals who already are Medicaid-eligible and enrolled in the Frail Elder or TBI 1915(c) waivers. These two existing 1915(c) waivers will be eliminated and replaced by the Community First 1115 Demonstration.[8] Although individuals in the TBI 1915(c) waiver must also have been determined to have TBI, this requirement will not be a requirement under the Community First 1115 Demonstration.

Individuals will be financially eligible for the Imminent Risk group if their countable income is at or below 300% of the Supplemental Security Income (SSI) Federal Benefit Rate (FBR) and countable assets are at or below $10,000. For applicants with income above 300% SSI FBR, a one-time six-month spend-down to the MassHealth income standard ($522 for a single person) will apply.[9] The current MassHealth definition of countable assets will apply.

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[8] The Commonwealth also operates an MR/DD 1915(c) waiver. Clinical eligibility for the MR/DD waiver is an Intermediate Care Facility for the Mentally Retarded (ICF-MR) level of care. This waiver is not being eliminated and replaced by the Community First 1115 Demonstration.

[9] Persons who provide verification that medical expenses have been incurred in excess of the spend-down amount will be financially eligible for the Imminent Risk group without having to meet a spend-down again. The one-time spend-down will provide a meaningful control on caseload, while ensuring that those

Individuals will be eligible for the Imminent Risk group if they meet the following criteria[10]:

Imminent Risk Group Eligibility

Income Eligibility	Asset Limit	Clinical Eligibility	Spend-Down Rules
Monthly income at or below 300% SSI FBR	$10,000 or less	Meets NF LOC criteria	If monthly income above 300% SSI, one-time spend-down to $522 per month

2. Prevention Group

Individuals eligible for the Prevention group must reside in the community and meet a specified clinical and functional profile (described below) that indicates they are likely to be on trajectory into a nursing facility within 9-12 months. Spend-down rules for income eligibility and countable assets for the Prevention group are the same as those for the Imminent Risk group.

Individuals will be eligible for the Prevention group if they meet the following criteria[11]:

Prevention Group Eligibility

Income Eligibility	Asset Limit	Clinical Eligibility	Spend-down rules
Monthly income at or below 300% SSI FBR	$10,000 or less	Minimum diagnosis-based clinical risk score (TBD) and ADL requirement	If monthly income above 300% SSI, one-time spend-down to $522 per month

who have high medical need have access to Demonstration services without the undue administrative burden of having to meet and verify recurring spend-downs that could threaten continuity of care.

[10] Meeting eligibility requirements does not guarantee placement in the Community First 1115 Demonstration. Other qualifications, such as enrollment caps (described in Subsection C), apply.

[11] Meeting eligibility requirements does not guarantee placement in the Community First 1115 Demonstration. Other qualifications, such as enrollment caps (described in Subsection C), apply.

There are two components of the clinical eligibility requirements for the Prevention group: a diagnosis-based clinical risk score and a need for assistance with at least three ADLs.

Diagnosis-Based Clinical Risk Score: EOHHS developed a model for selecting clinical criteria that is predictive of admission to a nursing facility. The comprehensive model is based on Medicaid and Medicare claims data for all individuals in Massachusetts (including dually eligible, Medicaid-only, and Medicare-only individuals) and evaluates individuals' diagnoses 9-12 months before admission to a nursing facility. The model has separate assessment components for elderly and disabled individuals. The assessments are based on diagnoses selected to be risk factors for nursing facility admission. Of the current 1,000 ICD-9 diagnosis codes, roughly 130 were determined to be statistically significant predictors of nursing facility admission within 9-12 months, and in combination even more significant predictors of nursing facility admission. The model enables assessors to convert an individual's diagnoses into a risk score. The higher the risk score the more likely an individual is on a trajectory into a nursing facility.

EOHHS will set risk score thresholds above which all individuals (both elderly and disabled) who have been assessed will be eligible to enroll in the Prevention group if they meet the other eligibility criteria. The risk score threshold will enable the Commonwealth to enroll, within the constraints of the enrollment caps on eligibility groups (described in Subsection C below) only those individuals most likely to enter a nursing facility in the absence of the Demonstration. EOHHS will monitor the

Community First 1115 Demonstration program caseload and costs and adjust the risk score threshold as budget neutrality allows.

The model is the product of extensive data analysis, factors in all significant co-occurring diagnoses and diagnosis groups, and is statistically predictive of whether individuals will or will not enter a nursing facility within 9-12 months. EOHHS will include in its evaluation plan a component that evaluates the accuracy and efficacy of using this clinical assessment tool to target applicants for the Prevention group who are most likely to be on a trajectory into a nursing facility in the absence of Community First 1115 Demonstration services.

ADL Requirement: The second component of clinical eligibility criteria for the Prevention group is functional need. Individuals must demonstrate a need for assistance (hands-on assistance, cueing, or supervision) with at least three ADLs (which include bathing, dressing, toileting, and eating assistance). The Commonwealth believes that this functional need requirement, in conjunction with a clinical risk score above the threshold, will most effectively target individuals likely to be admitted to a nursing facility within 9-12 months in the absence of Community First 1115 Demonstration community-based supports.

In developing the clinical eligibility criteria for the Prevention group, the Commonwealth explored factors beyond clinical risk score and ADL needs that might further target individuals who are on a trajectory into a nursing facility or who would be most likely to have nursing facility admission delayed or diverted with community-supports (i.e., their nursing facility admission will be delayed or diverted). These factors

include age, efficacy of intervention, ability to live safely in the community, presence or absence of family supports or housing, and time since an acute episode. The Commonwealth will continue to analyze these factors and evaluate whether the criteria being used are sufficiently effective, or whether Demonstration data supports the use of any other criteria in the future, at which time the Commonwealth could refine its clinical eligibility model accordingly.

3. Transition Group

To be eligible for the Transition group, an individual must reside in a nursing facility for at least three months and be enrolled in MassHealth. This includes individuals for whom MassHealth is paying for the nursing facility stay, as well as individuals dually eligible for MassHealth and Medicare for whom Medicare is paying for the stay (i.e., the individual is on an approved Medicare stay of between 90 and 100 days).

For initial implementation of the Demonstration, the Transition group will not include a financial eligibility expansion for nursing facility residents at income or asset levels higher than those set by existing MassHealth rules. EOHHS does not believe there has been sufficient data analysis to be able to predict which nursing facility residents at higher incomes are likely to become eligible for long-term nursing facility stays paid by MassHealth, and to make accurate assumptions about their costs. The rationale for starting with MassHealth-covered nursing facility residents is that EOHHS knows what this group costs in the nursing facility, knows that they will be a Medicaid

cost if they remain in the nursing facility beyond 100 days, and can estimate potential savings if these individuals transition to the community. Successful transition to the community for many of these individuals will have a direct and measurable impact on MassHealth spending. By including dual eligibles whose stays are paid for by Medicare, the Community First 1115 Demonstration targets individuals for whom MassHealth is already paying Medicare cost-sharing, transportation, and any other medically necessary costs not covered by Medicare while in a facility, and for whom nursing facility stays are likely to be paid for by MassHealth in the future. The Commonwealth will continue to refine its data analysis of the higher income and asset nursing facility group, and may amend the Transition group eligibility criteria to include this group pending a review of budget neutrality.

Individuals will be eligible for the Transition group if they meet the following eligibility criteria[12]:

Transition Group Eligibility

Eligibility	Spend-Down Rules
Individuals with MassHealth residing in nursing facilities for at least three months, and seeking to live in the community	Current MassHealth spend-down rules

Because most nursing facility admissions are for short-term stays, the Commonwealth is imposing a three-month stay requirement before an individual can apply for the Transition group. This requirement enables the Commonwealth to be more certain of enrolling only individuals who would have stayed in a nursing facility for a

[12] Meeting eligibility requirements does not guarantee placement in the Community First 1115 Demonstration. Other qualifications, such as enrollment caps (described in Subsection C), apply.

long-term, Medicaid-paid stay in the absence of transition services, and to avoid investing Medicaid funds in non-Medicaid eligible individuals who would most likely return to the community before ever converting to a Medicaid-paid stay even without transition assistance.

The Commonwealth does not propose conducting a financial or clinical eligibility assessment for MassHealth eligible individuals who are residing in nursing facilities at the time they apply for transition services because they will have already undergone both to have been determined eligible for MassHealth.[13] If an individual uses Community First 1115 Demonstration transition services to successfully transition to the community, he or she will be enrolled in the Imminent Risk group, regardless of any enrollment cap. Once in the community, the individual will be re-screened for financial and clinical eligibility through an annual redetermination process.

B. Eligibility Determination, Enrollment, and Redetermination

1. Determining Clinical Eligibility

In the case of elders who apply for the Imminent Risk and Prevention groups, EOHHS will utilize and build upon the existing process for determining clinical eligibility (also referred to as screening) for the Frail Elder 1915(c) waiver. Aging Service Access Points (ASAPs) currently are responsible for this function under State law, MGL c. 19A, §4B. A copy of the law is contained in Appendix C. Clinical assessments for elders,

[13] The clinical and financial eligibility determination process for any additional eligibility groups will be determined at a later date.

including a determination of whether an individual meets NF LOC, will be performed by a registered nurse (RN) from the ASAP using the existing standard clinical assessment tool in face-to-face visits with clients at their residences, a hospital, a nursing facility, or an ASAP site. All ASAP staff will be trained on the appropriate clinical assessment tools for the Prevention group under the Demonstration.

For Demonstration applicants with traumatic brain Injuries, the existing process for determining clinical eligibility for the TBI 1915(c) waiver will be utilized as an entry point to the Community First 1115 Demonstration. Currently, clinical professionals from the Massachusetts Rehabilitation Commission (MRC), one of the EOHHS agencies, are responsible for determining clinical eligibility for the 1915(c) TBI waiver. Applicants with TBI (which is not a requirement for eligibility for the Demonstration) will be able to apply for the Community First 1115 Demonstration through MRC or one of the other entities performing screening under the Demonstration. For individuals potentially eligible for the Imminent Risk group who apply for the Demonstration through MRC, MRC staff will use the existing standard assessment tool to determine NF LOC. All staff conducting screening activities will be trained on the appropriate clinical assessment tools for the Prevention group under the Demonstration.

For disabled Demonstration applicants who are not elderly and do not have TBI, a process for clinical assessment will be developed that builds upon existing systems and/or uses a new process that potentially includes entities such as Independent Living Centers (ILCs), and/or other state agencies.

As noted in the Transition group eligibility section, there is no distinct clinical eligibility determination process for applicants who apply for the Transition group. These individuals already have been clinically screened for MassHealth nursing facility eligibility while in the nursing facility. Individuals who are enrolled in the Frail Elder or TBI 1915(c) waivers at the time the Community First 1115 Demonstration is implemented will automatically become part of the Imminent Risk group and will not have to re-qualify financially or clinically until their annual redetermination.

2. Determining Financial Eligibility

MassHealth Enrollment Centers (MECs) will determine financial eligibility for the Community First 1115 Demonstration. Transition group applicants have no distinct financial eligibility determination at the time they apply for the Transition group because they already have been found to be financially eligible for MassHealth while in the nursing facility.

3. Enrollment

Once an individual is determined to be clinically and financially eligible for the Community First 1115 Demonstration, they will be enrolled into the appropriate eligibility group. If the eligibility group's enrollment cap[14] has not been reached, the eligible individual will be enrolled in the Demonstration and linked with the appropriate entity (most often the entity that performed the clinical assessment) that will help them

[14] Subection C discusses eligibility group enrollment caps.

develop a Demonstration care plan and provide case management services. (Section X describes care plan development and case management under the Demonstration.) If the enrollment cap has been reached, this entity will educate the applicant about service options that are available while on the Demonstration waiting list.

MassHealth will notify all Frail Elder and TBI 1915(c) waiver participants in writing that they will be transitioned into the Community First 1115 Demonstration. The written notice to Frail Elder and TBI waiver enrollees will inform them of the Demonstration benefit package, explain the Independence Plus option, and provide instructions about how to request a change to their care plan. Participants who were 1915(c) waiver enrollees will be offered in-person meetings with their existing case managers to discuss the transition to the Community First 1115 Demonstration.

4. Redetermination of Eligibility

All Demonstration participants will have their clinical and financial eligibility for the Community First 1115 Demonstration redetermined annually. The entity that conducted the initial clinical assessment and helped develop the individual's Demonstration care plan likely will conduct the clinical eligibility redetermination. An exception is that individuals who were in the Frail Elder or TBI 1915(c) waivers at the time of Community First 1115 Demonstration implementation will be re-screened for the Imminent Risk group 12 months from their last screening, and annually thereafter. Additionally, individuals who are enrolled in the Transition group and leave the nursing facility within six months of Demonstration enrollment will automatically convert to the Imminent Risk

group. Once in the community, the individual will be re-screened for financial and clinical eligibility for the Imminent Risk group 12 months from their last nursing facility screening, and annually thereafter.

C. Enrollment Caps

To manage caseload and costs, enrollment in the Community First 1115 Demonstration will be capped. Enrollment caps will allow the Commonwealth to test the hypotheses of the Community First 1115 Demonstration, particularly for the new services and new eligibility groups, and make any necessary program design improvements. Separate enrollment caps for each eligibility group (rather than a single aggregate cap) will be applied to ensure a meaningful mix of targeted participants from across the diverse eligibility groups. However, all Community First 1115 Demonstration participants can move between eligibility groups irrespective of caps if they meet the eligibility criteria for the group they seek to enter.

1. Demonstration Eligibility Group Enrollment Caps

Determination of the number of slots to be allotted to each eligibility group was based on several factors. First, the Commonwealth had to ensure that the number of slots in the Imminent Risk group would be sufficient for enrollment of all existing Frail Elder and TBI 1915(c) waiver enrollees, as those programs will be replaced by the Demonstration. Second, the number of slots would have to be sufficiently great enough to absorb Transition group participants who leave the nursing facility within six months of Demonstration enrollment. Third, consideration had to be given to ensure equitable

access to the Demonstration by both elders and non-elderly disabled participants. Finally, enrollment caps were necessary to help EOHHS maintain state and federal budget neutrality. The Commonwealth proposes the following four enrollment caps for the Community First 1115 Demonstration:

Proposed Enrollment Caps for the Community First 1115 Demonstration

Eligibility Group	Number of Slots Allocated
Transition Group – Elderly	500
Transition Group - <65 Disabled	500
Imminent Risk Group	10,600
Prevention Group	4,000

Transition Group: For the Transition group, the Commonwealth proposes implementing and managing two enrollment caps: one for elderly individuals and one for non-elderly disabled individuals. While the current MassHealth-covered nursing facility caseload is 90% elderly and 10% disabled[15], it is unclear whether demand for transition services will be similarly proportional. In addition, non-elders in nursing facilities stay in the facilities on Medicaid longer on average than do elders. Consequently the Commonwealth proposes a participant mix of 50% elders and 50% disabled under age 65. Starting off with two enrollment caps will ensure a meaningful and equitable opportunity for both groups to access transition services. Based on whether demand and use of transition services is disproportionate or naturally equitable among the groups, EOHHS may amend the enrollment caps or implement a single enrollment cap for the Transition group.

[15] Figures from Massachusetts Department of Public Health.

Imminent Risk and Prevention Groups: Initially, the Commonwealth recommends using a single enrollment cap for each of the community-based groups. The Commonwealth expects that outreach and education efforts by community-based providers will result in a natural mix of seniors and disabled individuals in these groups, rendering age-based caps unnecessary.

2. Waiting Lists

For each of the four enrollment caps, the Commonwealth will maintain and manage a waiting list for the Community First 1115 Demonstration as needed. Being on the waiting list for the Demonstration will not affect an individual's MassHealth eligibility. Although the populations are quite different, MassHealth will draw on its experience monitoring an enrollment cap and managing a waiting list in the MassHealth Essential program regarding how and when to make slots available.

III. Benefit Packages

There will be two benefit packages for Community First 1115 Demonstration participants. The Imminent Risk and Prevention groups will have access to a comprehensive menu of community-based supports. The Transition group will have access to a time-limited Demonstration benefit of transition services to facilitate their transition from a nursing facility to the community. Demonstration participants who would qualify for MassHealth in the absence of the Community First 1115

Demonstration will not lose access to any Title XIX State Plan services by virtue of enrolling in the Demonstration.

A. Benefit Package for the Imminent Risk and Prevention Groups

Members of the Imminent Risk and Prevention groups will be able to access a comprehensive array of community-supports that includes Title XIX State Plan services and additional services covered under 1915(c) Home and Community-Based Services (HCBS) waivers. The additional community-support services may be covered under the Demonstration when the service is not offered under the Title XIX State Plan, or its coverage under the Demonstration differs in scope and nature from the coverage under the Title XIX State Plan.

The following table lists services for which Imminent Risk and Prevention Group participants will be eligible under the Community First 1115 Demonstration.

Services for Imminent Risk and Prevention Group Participants

1. Abortion services
2. Acute inpatient hospital services
3. Adult day health services
4. Adult foster care services
5. Ambulance services
6. Ambulatory surgery services
7. Assistive technology
8. Audiologist services
9. Behavioral health (mental health and substance abuse) services, including diversionary services
10. Chapter 766: home assessments and participation in team meetings
11. Chiropractor services
12. Chore Service
13. Chronic disease and rehabilitation inpatient hospital services*
14. Community health center services
15. Companion Service
16. Day habilitation services
17. Day services
18. Dental services
19. Durable medical equipment (DME) and supplies
20. Early intervention services

21. Environmental adaptation
22. Family planning services
23. Family support and community habilitation
24. Grocery shopping and home delivery
25. Hearing aid services
26. Home health services
27. Home-based wandering service
28. Home-delivered meals
29. Homemaker
30. Hospice services
31. Individual support and community habilitation
32. Laboratory services
33. Laundry
34. Medical and non-medical transportation
35. Medication management
36. Nurse midwife services
37. Nurse practitioner services
38. Nursing facility services*
39. Orthotic services
40. Outpatient hospital services
41. Oxygen and respiratory therapy equipment
42. Peer Counseling
43. Personal care services
44. Pharmacy services
45. Physician services
46. Podiatrist services
47. Private duty nursing services
48. Prosthetic services
49. Rehabilitation services
50. Renal dialysis services
51. Residential habilitation (prior authorization will be required)
52. Respite care
53. Specialized medical equipment
54. Speech and hearing services
55. Supportive employment
56. Therapy services: physical, occupational, and speech/language
57. Vision care
58. X-ray/radiology services

*A short-term benefit only under the Community First 1115 Demonstration, until the individual either transitions back to the community or is assessed under traditional institutional rules.

B. Benefit Package for the Transition Group

Members of the Transition group will be eligible to receive a time-limited package of transition services while they are in the nursing facility to aid their return to the community.

The following table lists the services for which Transition group participants will be eligible.

Services for Transition Group Participants

1. Adult Day Health (visiting benefit, during transition)*
2. Behavioral Health: Structured Outpatient Addiction Programs*
3. Day Habilitation (visiting benefit, during transition)*
4. Family Supports and Community Habilitation
5. Individual Supports and Community Habilitation
6. Non-medical Transportation
7. Peer Counseling
8. Purchasing of Assistive Technology (in advance)
9. Purchasing of Specialized Medical Equipment (in advance)
10. Transition Services

* Time-limited trial of the community-based support

Transition group participants will be eligible for transition services for a benefit period of up to six consecutive months while they remain in the nursing facility. EOHHS recognizes that there are circumstances under which a participant may wish to use transition services again after the six-month benefit period has expired. For example, an individual can successfully transition to the community based on use of the transition services (and, therefore, no longer be part of the Transition group), and then re-enter a nursing facility due to another event. As such, the Commonwealth proposes that nursing facility residents who are otherwise eligible for the Transition group should be able to access two transition service benefit periods. The two benefit periods can be used during one nursing facility stay, or during separate nursing facility stays. However, if a participant leaves the nursing facility in fewer than six months, he or she is not able to accumulate “unused” days for later use. For example, if a person in a first transition benefit period were to leave the nursing facility in less than six months and later return

and seek to utilize their second six-month benefit period, they would not be allowed to use “unused” days from the first six-month transition benefit period.

To account for individuals who may go in and out of nursing facilities numerous times as their conditions worsen or are complicated by aging, additional benefit periods may be considered through a prior approval process.

The Demonstration evaluation plan described in Section IX includes an assessment of whether six months is appropriate for most participants, whether a maximum of two benefit periods (before prior approval) is reasonable, and whether the transition service package includes the most appropriate and effective services.

IV. Service Delivery System

Under the Demonstration, the Commonwealth will build on the service network infrastructure that is in place for the Frail Elder and TBI 1915(c) waiver programs, which use a combination of State-managed and contractor-managed providers in a fee-for-service environment. The contractual arrangements and quality management of these provider networks will be administered on a day-to-day basis by the State agency staff or contractors that contract with the particular network and, in turn, will be overseen by the Commonwealth staff administering the Community First 1115 Demonstration. (Section X describes how the Demonstration will be administered.) The Commonwealth will develop comprehensive descriptions of the types of Demonstration services that would be required in each network, including standards for service delivery, requirements for quality measurement and reporting, expected outcomes, and rates.

A. Frail Elder 1915(c) Waiver Service Delivery Network

The Office of Medicaid currently delegates administration of the Frail Elder 1915(c) waiver to the Executive Office of Elder Affairs (EOEA), which is also under the Executive Office of Health and Human Services. EOEA, in turn, contracts with 27 ASAPs. Built into the contracts is payment for the ASAPs to purchase waiver services through contracts with individual service providers, most of which do not independently have Medicaid provider contracts. ASAPs also oversee the quality of service delivery of the network providers. EOHHS will require the ASAPs to contract with providers to deliver Demonstration community-based supports not currently provided within the Frail Elder waiver delivery system.

B. TBI 1915(c) Waiver Service Delivery Network

The Office of Medicaid delegates administration of the TBI 1915(c) waiver to the Statewide Head Injury Program (SHIP) in the Massachusetts Rehabilitation Commission, which in turn contracts with providers to deliver waiver services. The Commonwealth will build on this delivery network to serve persons with brain injuries under the Community First 1115 Demonstration. The Commonwealth will delegate day-to-day oversight of this service delivery network to SHIP staff. The SHIP will procure providers to deliver additional Demonstration community-based supports currently not offered by SHIP network providers.

C. MassHealth Behavioral Health Services

While behavioral health services are not provided under the 1915(c) waivers, MassHealth members can access behavioral health services through the Title XIX State Plan or the existing MassHealth 1115 Demonstration, if enrolled. Although the delivery system for behavioral health services for Community First 1115 Demonstration participants has yet to be determined, EOHHS will ensure that all participants have access to behavioral health services either through a fee-for-service or capitated delivery system.

D. Delivery System for Persons not Enrolled in a 1915(c) Waiver Program

The Commonwealth will also consider several options for new delivery systems or additions to the current delivery systems to serve Demonstration participants. ASAPs and/or MRC could expand their networks to cover Demonstration services for all participants. Additionally, the State could contract with a new service delivery network by procuring an administrative entity to develop and manage the network, or by designating State staff to perform this function and procure providers directly. The specific approach(s) the Commonwealth will utilize will be determined with input from stakeholders during the operational planning stage prior to Demonstration implementation.

E. Implications for PACE and SCO

For Community First 1115 Demonstration participants ages 65 and older who would not be eligible for Title XIX State Plan services (i.e., MassHealth Standard

services) but for the 1115 Demonstration financial eligibility rules, Senior Care Options (SCO) will be a delivery system option under the Community First 1115 Demonstration. Elders who would have been eligible for Title XIX State Plan services in the absence of the 1115 Demonstration may only choose to enroll in SCO outside of the Demonstration. The eligibility requirements for SCO are described in MassHealth regulations at 130 CMR 508.008. These regulations are contained in Appendix D.

Eligibility for the Program of All-Inclusive Care for the Elderly (PACE) is guided by federal statute (42 U.S.C. 1396u-4) and regulations (42 CFR 460.2 - 460.210), and is part of the Title XIX State Plan in Massachusetts. Because PACE eligibility has its own eligibility rules and eligibility for PACE is not linked to eligibility for any other MassHealth program, the Commonwealth will not include PACE as a choice under the Demonstration. The Commonwealth plans to seek an amendment to the PACE State Plan to increase the asset standard to $10,000 to enable all Community First 1115 Demonstration-eligible individuals to have the option to choose to enroll in PACE rather than the Demonstration . The eligibility requirements for PACE are described in MassHealth regulations at 130 CMR 519.007(C)(2). These regulations are contained in Appendix E.

F. MassHealth 1115 Demonstration Participants in Managed Care

With respect to managed care, it should be noted that certain individuals already participating in managed care as part of the existing MassHealth 1115 Demonstration may be eligible for the Community First 1115 Demonstration. If any individual in the

MassHealth 1115 Demonstration chooses to enroll in the Community First 1115 Demonstration, they will be disenrolled from the MassHealth 1115 Demonstration, and therefore from their managed care plan. All of their acute and long-term care services will then be covered under the Community First 1115 Demonstration.

G. Independence Plus Option

Community First 1115 Demonstration participants who reside in the community will have the option to choose Independence Plus, which will allow them to convert certain community-based supports to a personal budget and to self-direct use of this budget. To enable this component of the delivery system, an Independence Plus designation is also requested by the Commonwealth under the Community First 1115 Demonstration.

1. Overview

When developing a Demonstration care plan with a case manager, Demonstration participants in the Imminent Risk and Prevention groups will determine their interest in Independence Plus, under which they can receive a budget for certain community-based supports, rather than obtaining care from a provider that is directly reimbursed by MassHealth. Interested participants will be given easy-to-read and accessible information on this self-directed model, describing which services can be cashed out and participant responsibilities. Participants will also receive information on their rights and responsibilities, including descriptions of termination rules and appeal rights.

Individuals who choose Independence Plus will work with their Demonstration case manager who has been specially trained to also function as a support broker, or with a support broker to whom they are referred by their case manager, to develop a care plan for the Independence Plus option and an individual budget that corresponds to those services. The Commonwealth may require that all case management entities provide support broker services with specially trained staff to any participant who elects the Independence Plus option, or develop separate contracts with support broker entities to provide this service. Regardless of whether the support brokers are in the same or a different agency from the case manager, they will be required to work in close collaboration because Independence Plus will only cover a portion of a participant's Demonstration benefits, and there may be distinct (but linked) care plans for each portion.

Once the budget has been determined and the plan for how it will be utilized has been established, Demonstration participants choosing Independence Plus will undergo training on how to effectively utilize the budget, and will work with selected agencies and staff to use these Community First 1115 Demonstration benefits. Support brokerage services will be provided to Demonstration participants who choose Independence Plus to assist them on a routine basis with identifying ongoing needs; designing and modifying spending plans; and hiring, training, and managing individual workers. The support broker will provide general oversight of the participant's use of his or her individual budget, and of the quality of supports obtained with the individual budget through a range of safeguards that will be developed as part of the operational

protocols following approval of the Demonstration. Support brokers will be extensively trained on self-direction philosophy so they can advocate in support of participants' independence.

2. Services To Be Cashed Out

The following table lists the proposed Community First 1115 Demonstration supports that can be cashed out. The Commonwealth will explore adding services to or removing services from this list in subsequent years of the Demonstration.

Services that Can be Cashed Out Through Independence Plus

Assistive technology
Chore service
Companion service
Durable Medical Equipment – only certain disposable supplies[16]
Environmental adaptation
Family support and community habilitation
Grocery shopping and home delivery
Home-delivered meals
Homemaker
Individual support and community habilitation
Laundry
Non-emergency medical transportation
Non-medical transportation
Peer counseling
Personal care services
Respite care
Specialized medical equipment
Supportive employment

[16] The only DME that can be cashed out are certain disposables including: absorbent products; enterals (oral only); medical supplies, including stockings (surgical), gauze pads/bandages, gloves, wipes (as ostomy product), and alcohol wipes (for injections); Diabetic supplies, including test strips, lancets, glucometers, andcalibrations; Ostomy products; BP monitor; vaporizers; urologicals; and items for mobility, including walkers, canes, raised toilet seats, grab bars, and grabbers.

3. Developing the Individual Budget

After the participant's Community First 1115 Demonstration service needs have been assessed, the care plan will be converted to an individual budget with the assistance of the case manager and/or the support broker. The needs assessment and related budget development methodology will utilize a combination of participant-specific service utilization history to project future service utilization, and expenditure formulas related to specific Demonstration supports. A detailed methodology will be developed as part of the Demonstration operations protocol.

Demonstration participants will be obligated to utilize their budgets to hire caregivers and/or to purchase supports. Allowable purchases will include community-based supports that assist the individual to remain safely in the community. The planned purchases and/or services matched with the individual's budget will be laid out in the Independence Plus portion of the participants' Demonstration care plan. A process will be implemented with the participants' case manager and support broker to assess when and how changes to a participant's condition or circumstance (e.g., loss of informal supports) warrant a change in the individual budget, or even a shift from Independence Plus to the traditional delivery system model without interruption of benefits.

4. Surrogacy

Community First 1115 Demonstration participants will likely have varying degrees of experience and capabilities in terms of directly managing their supports. As part of

Demonstration care plan development, the case manager will use an assessment tool to determine whether the participant requires support in decision-making through a surrogate. A participant who is determined to need a surrogate will not be able to choose the Independence Plus option until the second year of Demonstration implementation, as the Commonwealth would like to gain some experience with the Independence Plus approach. EOHHS will provide details on the surrogacy assessment and its implementation in the Demonstration operation protocol.

5. Fiscal Agents

Demonstration participants who qualify for and choose to participate in Independence Plus will have the option to utilize fiscal agent services. These fiscal agents will provide payment for one-time purchases and ongoing supports in accordance with the spending plan. They also will perform the participants' fiscal employer responsibilities, such as payment of worker compensation and unemployment taxes and payroll administration. The fiscal service agent also will provide monthly statements of spending (inclusive of information on payments made and balances) to the participant and the participant's support broker.

V. Participant Cost-Sharing

Community First 1115 Demonstration participants in the Imminent Risk and Prevention groups with assets above $2,000 will be charged premiums. The Commonwealth is requiring premiums from individuals who achieve Demonstration

eligibility by virtue of the asset expansion ($2,001-$10,000 in assets) to align its cost-sharing policies across the MassHealth program for individuals who have higher resources and gain MassHealth eligibility due to financial expansions beyond traditional Title XIX rules. Under the terms of the MassHealth 1115 Demonstration program (for individuals not residing in a nursing facility under age 65), many MassHealth members with incomes at or above 114% FPL are required to pay premiums. The Commonwealth does not impose asset limits under the MassHealth 1115 Demonstration.

Under the Community First 1115 Demonstration, Transition group participants will not be charged premiums because there will not be an expansion to individuals in nursing facilities at higher income or asset levels than under current Title XIX rules. Initially, Transition group participants will include only individuals for whom the Commonwealth currently does not require premiums.

To implement the premium requirement, the Commonwealth will first look at an individual's assets. If assets fall within the expansion range (between $2,000 and $10,000), the Commonwealth will then examine income and apply the CommonHealth premium schedule that was established under the MassHealth 1115 Demonstration. These premium rules will ensure that premiums are not charged under the Community First 1115 Demonstration to any persons who do not currently pay MassHealth premiums.

The MassHealth CommonHealth premium schedule, which is contained in MassHealth regulations at 130 CMR 506.011, is as follows.

Recommended Monthly Premium Schedule (Current CommonHealth Schedule) (300% SSI = Approximately 210% FPL)

FPL Range	Full Premium*	Supplemental Premium*
115%-160% FPL	$15.00	$9.00
160.1% -170% FPL	$20.00	$12.00
170.1%-180% FPL	$25.00	$15.00
180.1%-190% FPL	$30.00	$18.00
190.1%-200% FPL	$35.00	$21.00
Above 200% FPL	$40-$192 Start at $40 and add $8 for each additional 10% FPL until 400% FPL	65% of full premium
Above 400% FPL	$202-$392 Start at $202 and add $10 for each additional 10% FPL until 600% FPL	70% of full premium
Above 600% FPL	$404-$632 Start at $404 and add $12 for each additional 10% FPL until 800% FPL	75% of full premium
Above 800% FPL	$646-$912 Start at $646 and add $14 for each additional 10% FPL until 1000% FPL	80% of full premium
Above 1000% FPL	$928+ Start at $928 and add $16 for each additional 10% FPL	85% of full premium

*Full premiums are charged to individuals with no other insurance paid for by the individual.
Supplemental premiums are charged to individuals with other insurance paid for by the individual.

VI. Appeals Process

Procedures for notifying individuals in the Community First 1115 Demonstration of the opportunity to request a Fair Hearing include: (a) a determination that the individual is not eligible for MassHealth; (b) a determination to deny enrollment in the Community First 1115 Demonstration; and (c) actions to deny, suspend, modify, reduce, or terminate benefits to a Demonstration participant. Community First 1115

Demonstration applicants and participants will have the opportunity to request a Fair Hearing and will be informed in writing of any of the adverse actions listed above, and of the right to a Fair Hearing. Information regarding the Medicaid appeal process is found in MassHealth regulations at 130 CMR 610.000. Any other State agencies which may be authorized to provide Fair Hearings to Community First 1115 Demonstration participants are conducted in accordance with the Massachusetts Administrative Procedures Act and the Standard Adjudicatory Rules of Practice and Procedure (see 801 CMR 1.00 et. seq.). Individuals are notified that they may appeal Fair Hearing Decisions to the Superior Court pursuant to M.G.L.c 30A (the Mass. Administrative Procedures Act).

A. MassHealth Eligibility Determinations

All applicants and members will receive a written notice of the determination of their eligibility for MassHealth. The notice will contain the eligibility decision for each member of the household who has requested MassHealth. Approvals will provide the coverage type for which the member is eligible, the medical coverage date, and the amount of the premium or subsidy payment (if applicable). Denials will provide the reason, the regulatory cite, and the deductible amount and deducible period (if applicable). Members will also receive a notice of loss of coverage or any changes in a coverage type, premium payment, or subsidy. These notices will inform the applicant or member of a right to a fair hearing, according to the appeal process described in MassHealth regulations at 130 CMR 610.000.

B. Enrollment in Demonstration

Any MassHealth eligible applicant who is denied enrollment in the Community First 1115 Demonstration may appeal that denial according to existing Medicaid appeal procedures described in MassHealth regulations at 130 CMR 610.000.

C. Benefit Decisions

Any MassHealth eligible individual who is enrolled in the Community First 1115 Demonstration may appeal an action to deny, suspend, modify, reduce, or terminate a covered benefit under the Demonstration according to existing Medicaid appeal procedures described in MassHealth regulations at 130 CMR 610.000.

VII. Quality Monitoring and Management

The Commonwealth is committed to managing the quality of the community-based supports delivery system in Massachusetts. The Commonwealth, with the University of Massachusetts Medical School Center for Health Policy Research, was a 2005 recipient of a CMS Systems Transformation Grant and has developed a strategy as part of Transformation Grant implementation for establishing a system-wide quality management approach that encompasses all of the State's community-based supports, including the Community First 1115 Demonstration. The quality management approach for the Community First 1115 Demonstration will be integrated with that process and will evolve over time.

The overarching community-based supports quality management approach is being designed to utilize and build on the federal CMS community-based supports Quality Framework, which entails establishing a system that focuses on quality management and attempts to ensure the following quality outcomes:

- Individuals have access to community-based supports in their communities.
- Supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences, and decisions concerning his or her life in the community.
- Providers possess and demonstrate the capability to effectively serve participants.
- Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
- Participants receive support to exercise their rights and accept personal responsibilities.
- Participants are satisfied with their supports and achieve desired outcomes.
- The system supports participants efficiently and effectively, and constantly strives to improve quality.
- The system will ensure quality in the service delivery for individuals who choose Independence Plus.

Additional areas of outcome will be added, as necessary, if the State determines that this framework is not broad enough to fully address all elements contemplated in the Community First 1115 Demonstration. The Commonwealth will incorporate in its

operations plan for this Demonstration process features to ensure that these (and any additional) quality outcomes are met throughout the Demonstration term. These will include identifying quality indicators for each area, and developing an approach for systematically using the processes of discovery, remediation, and improvement to ensure the Community First 1115 Demonstration has the intended impact, and if not, that the Commonwealth can identify areas that need improvement, understand reasons for the issues, and implement positive changes.

Just as the State has initiated and sustained an inclusive process for stakeholder involvement in the design of the Demonstration, the State is committed to working with stakeholders, including consumers, to design an effective quality management strategy for the Demonstration. In particular, the State will ensure that stakeholders participate in identification of quality indicators in each of the above outcome areas, design of instruments to collect participant experience data, and design of reports.

VIII. Budget Neutrality: Caseload and Cost Analysis

A. Overview

This section provides caseload and cost estimates for the Demonstration population and describes the federal budget neutrality analysis. Three budget neutrality worksheets are contained in Appendices F through H. These worksheets include: five years of historical cost and caseload data, five years of projected cost and caseload for the Demonstration population in the absence of the Demonstration, five years of projected cost and caseload for the Demonstration population with the Demonstration,

and a summary budget neutrality "cushion" worksheet. The analysis provided uses state fiscal year 2005 as the base year for this Demonstration, and assumes that the Demonstration period will begin in state fiscal year 2009 (July 1, 2008).

Historical expenditures, as well as projections, include both acute and long-term care expenditures.

Over the life of the Demonstration (state fiscal years 2009-2013), there is a projected cushion of $1.26B on $12.9B of total expenditures (10%).

Federal Budget Neutrality Summary

	Total		
State Fiscal Year	Date of Service Budget Neutrality Ceiling	CMS 64 Waiver Date of Service Expenditures	Variance
Original Waiver Period	-	-	-
SFY09	$ 2,552,951,673	$ 2,394,594,162	$ 158,357,510
SFY10	$ 2,702,201,902	$ 2,511,845,197	$ 190,356,705
SFY11	$ 2,823,929,093	$ 2,550,811,979	$ 273,117,114
SFY12	$ 2,952,279,261	$ 2,647,350,984	$ 304,928,277
SFY13	$ 3,087,691,774	$ 2,755,702,079	$ 331,989,695
Total -- Original Waiver Period	**$14,119,053,702**	**$12,860,304,401**	**$ 1,258,749,301**
Remaining "Room"			**$ 1,258,749,301**

B. Data sources

Historical data was obtained through the Massachusetts Medicaid Management Information System (MMIS), as well as the Managed Care Payment System (MCPS), and the MA21 Medicaid eligibility system. Projected caseload and cost data was

developed using enrollment information from state-funded programs at the Executive Office of Elder Affairs and the Massachusetts Rehabilitation Commission, as well as utilization experience from Medicaid-funded programs across EOHHS.

Cost data includes all fee-for-service, managed care, supplemental, and Medicare Part B cost-sharing spending, and removes spending that is covered by Medicare Part D.

In addition, a set of matched Medicare and Medicaid data was used to identify risk of entry to a nursing facility, as well as projected cost for the non-1915(c) waiver Demonstration populations.

C. Historical data

1. Caseload

Between SFY 2001 and SFY 2005, nursing facility member months increased for the disabled population under age 65, and decreased for the elderly population age 65 and older. The Frail Elders 1915(c) waiver showed high levels of steady caseload growth, as did the Traumatic Brain Injury (TBI) 1915(c) waiver (implemented in SFY 2002).

Caseload data for the “Base, Imminent Risk, no 1915(c) waiver” group includes all Medicaid disabled and elderly individuals who are in the community and who are not part of a 1915(c) waiver. There is no adjustment made to the historical caseload data to capture only individuals who meet the clinical eligibility for the Demonstration; this is not possible based on currently available data. Historical spending data is used, however,

to project the per member per month (PMPM) trend for these populations in the absence of the Demonstration. This is discussed further in the “Projected Caseload and Cost Without the Demonstration” section, below.

Over the historical period, the group of disabled individuals under age 65 in the community increased slightly each year. Community, non-1915(c) waiver elderly individuals showed flat growth. Data for the elderly population in 2001 is unreliable and so has been removed from the calculation.

Annual trend rates (member months)						
	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005	Geo. Mean
Nursing Facility						
<65, Disabled		3.78%	1.67%	0.22%	-1.24%	1.09%
65+		-3.81%	-2.91%	-3.15%	-3.57%	-3.36%
Imminent Risk						
Frail Elders 1915		10.20%	0.51%	13.47%	8.20%	7.99%
TBI 1915			-13.53%	25.90%	171.88%	43.58%
No 1915 <65		2.12%	1.86%	1.52%	1.24%	1.69%
No 1915 65+		0.00%	-5.23%	-0.59%	3.02%	-0.74%
Prevention						
No 1915 <65		2.12%	1.86%	1.52%	1.24%	1.69%
No 1915 65+		0.00%	-5.23%	-0.59%	3.02%	-0.74%

2. Per member per month cost

Over the course of the historical period, nursing facility PMPM costs increased by roughly seven percent per year in both the elderly and disabled groups. PMPM growth was similar in the TBI 1915(c) waiver group. Frail elders in the 1915(c) waiver and community disabled individuals showed relatively flat growth, and non-1915(c) waiver community elders grew at ten percent per year. The community disabled trend is

currently the subject of additional analysis, as it appears low, and so projections with the Demonstration use a higher rate, which is consistent with recent experience. Also, as noted above, since caseload data for elders in state fiscal year 2001 has been deemed unreliable, that year has been removed from the PMPM calculation.

As stated above, the “Imminent Risk, no 1915”, and “Prevention, no 1915” groups below are projected using SFY 2001 PMPM data for the targeted group only, but trended according to the historical PMPM trend for all non-1915(c) waiver disabled and elderly individuals. This substitution of data is essential to capture the high level of acuity in the Imminent Risk and Prevention groups, compared to the rest of the elderly and disabled populations.

PMPM							
	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005	Geo, Mean	Total 5-yr
Nursing Facility							
<65, Disabled	$4,034	$ 4,253	$ 4,567	$ 4,952	$ 5,297	7.05%	31.30%
65+	$3,189	$ 3,296	$ 3,631	$ 4,012	$ 4,273	7.59%	34.01%
Imminent Risk							
Frail Elders 1915	$3,947	$ 3,727	$ 4,102	$ 3,877	$ 4,315	2.25%	9.32%
TBI 1915		$16,571	$26,962	$24,263	$22,942	11.45%	38.45%
No 1915 <65	$1,211	$ 1,227	$ 1,242	$ 1,259	$ 1,275	1.30%	5.30%
No 1915 65+	$ 829	$ 915	$ 1,009	$ 1,114	$ 1,229	10.32%	34.28%
Prevention							
No 1915 <65	$1,211	$ 1,227	$ 1,242	$ 1,259	$ 1,275	1.30%	5.30%
No 1915 65+	$ 829	$ 915	$ 1,009	$ 1,114	$ 1,229	10.32%	34.28%

D. Projected Caseload and Costs Without the Demonstration

1. Caseload

The nursing facility population is projected to grow at historical trend rates through the Demonstration period, in the absence of the Demonstration. The Demonstration's eligibility groups are capped, and the non-subsumed (1915 (c)) groups are projected to reach the enrollment caps outlined below by the end of year one of the Demonstration, and maintain those levels throughout the five-year period. For these groups, six member months per member are projected in year one, to account for enrollment ramp-up. Subsumed 1915(c) waiver groups are projected to maintain full enrollment from implementation through the Demonstration. The enrollment caps are as follows:

Transition group – 1,000 (500 elderly, 500 disabled)

Imminent risk group – 10,600

Prevention group – 4,000

These enrollment caps are based on current enrollment trends, as well as analysis of existing state-funded programs and other indicators of demand for community-based supports, within the Demonstration's eligibility criteria. In addition, in the case of the Prevention group, the cap is set to allow enrollment of a limited number of those projected to have the highest probability of entry to a nursing facility within 9-12 months, as described in Section II of this document.

Member months							
	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	Geo. Mean	Total 5-yr
Nursing Facility							
<65, Disabled	45,402	45,898	46,400	46,907	47,419	1.09%	4.44%
65+	313,113	302,586	292,413	282,581	273,081	-3.36%	-12.79%
Imminent Risk							
Frail Elders 1915	78,000	78,000	78,000	78,000	78,000		
TBI 1915	1,200	1,200	1,200	1,200	1,200		
No 1915 <65	5,400	10,800	10,800	10,800	10,800		
No 1915 65+	0	0	0	0	0		
Prevention							
No 1915 <65	2,160	4,320	4,320	4,320	4,320		
No 1915 65+	12,960	25,920	25,920	25,920	25,920		

2. Per member per month cost

PMPM costs for all populations in the absence of the Demonstration are projected to maintain growth at historical rates during the Demonstration period.

As with all other PMPMs, spending covered by Medicare Part D is removed from the projections.

PMPM							
	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	Geo. Mean	Total 5-yr
Nursing Facility							
<65, Disabled	$6,955	$ 7,445	$ 7,970	$ 8,531	$ 9,132	7.05%	31.30%
65+	$5,726	$ 6,161	$ 6,629	$ 7,132	$ 7,674	7.59%	34.01%
Imminent Risk							
Frail Elders 1915	$ 4,717	$ 4,824	$ 4,932	$ 5,043	$ 5,157	2.25%	9.32%
TBI 1915	$35,401	$39,456	$43,975	$49,012	$54,625	11.45%	54.30%
No 1915 <65	$ 1,343	$ 1,360	$ 1,378	$ 1,396	$ 1,414	1.30%	5.30%
No 1915 65+	$ 1,820	$ 2,008	$ 2,215	$ 2,444	$ 2,696	10.32%	48.15%
Prevention							
No 1915 <65	$ 1,343	$ 1,360	$ 1,378	$ 1,396	$ 1,414	1.30%	5.30%
No 1915 65+	$ 1,820	$ 2,008	$ 2,215	$ 2,444	$ 2,696	10.32%	48.15%

3. Total expenditures

Total expenditures for all populations in the absence of the Demonstration are projected to maintain growth at historical rates during the Demonstration period. The geometric mean for the Demonstration period is 4.84%.

Total expenditures (in millions)							
	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	Geo, Mean	Total 5-yr
Nursing Facility							
<65, Disabled	$ 316	$ 342	$ 370	$ 400	$ 433	8.22%	37.14%
65+	$1,793	$ 1,864	$ 1,938	$ 2,015	$ 2,096	3.98%	16.87%
Imminent Risk							
Frail Elders 1915	$ 368	$ 376	$ 385	$ 393	$ 402	2.25%	9.32%
TBI 1915	$ 42	$ 47	$ 53	$ 59	$ 66	11.45%	54.30%
No 1915 <65	$ 7	$ 15	$ 15	$ 15	$ 15	3.87%	110.60%
No 1915 65+	$ -	$ -	$ -	$ -	$ -		
Prevention							
No 1915 <65	$ 3	$ 6	$ 6	$ 6	$ 6	3.87%	110.60%
No 1915 65+	$ 24	$ 52	$ 57	$ 63	$ 70	19.09%	196.30%
Total							
	$2,553	$ 2,702	$ 2,824	$ 2,952	$ 3,088	4.84%	20.95%

E. Projected Caseload and Costs with the Demonstration

1. Caseload

The nursing facility population is reduced by three factors with the Demonstration. First, it is estimated that 25% of individuals receiving nursing facility transition services will move from the nursing facility to the Imminent Risk group. Second, the length of stay in a nursing facility is projected to decrease for those who still enter nursing facilities during the Demonstration. Third, based on the additional service dollars provided to the population, the percentage of enrollees who enter nursing

facilities is projected to decrease, from between 40-100% per year, depending on the group, to between 6-32% per year.

The estimates of diversion and reduction in duration of stay through the community groups is based on extensive data analysis of the effect of 1915(c) waiver services on the probability of an individual entering a nursing facility in any given year. This analysis followed the calendar year 2001 population, adjusted for 1915(c) waiver history and underlying frailty and disability, for four years to measure how payments for waiver services affected nursing home outcomes. As described above, higher levels of investment in 1915(c) waiver services correlated with lower risk of nursing home entry.

The combination of transition, decreased length of stay, and diversion through community groups decreases the rate of growth in the disabled nursing facility population under age 65 from 1% per year to a decrease of 3%, and in the elderly nursing facility population from a decrease of 3% per year to a decrease of 8% per year. This reflects a decrease of approximately 60,000 nursing facility member months annually.

As stated above, the non-subsumed (1915 (c)) groups are projected to reach the enrollment caps outlined below by the end of year one of the Demonstration, and maintain those levels throughout the five-year period. For these groups, six member months per member are projected in year one, to account for enrollment ramp-up. Subsumed 1915(c) waiver groups are projected to maintain full enrollment from implementation through the Demonstration.

Member months							
	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	Geo. Mean	Total 5-yr
Nursing Facility							
<65, Disabled	41,110	36,859	36,551	36,393	36,350	-3.03%	-11.58%
65+	293,425	256,157	234,140	221,092	209,332	-8.10%	-28.66%
Transition							
<65, Disabled	6,000	6,000	6,000	6,000	6,000		
65+	6,000	6,000	6,000	6,000	6,000		
Imminent Risk							
Frail Elders 1915	78,000	78,000	78,000	78,000	78,000		
TBI 1915	1,200	1,200	1,200	1,200	1,200		
No 1915 <65	6,000	12,000	12,000	12,000	12,000		
No 1915 65+	18,000	36,000	36,000	36,000	36,000		
Prevention							
No 1915 <65	2,400	4,800	4,800	4,800	4,800		
No 1915 65+	21,600	43,200	43,200	43,200	43,200		

Note: 1 Transition group members are included in both the Nursing Facility line and the Transition line.

2. Per member per month cost

PMPM costs for all populations with the Demonstration are expected to maintain growth at historical rates during the Demonstration period, with the exception of the non-1915(c) waiver disabled groups, which are projected to grow at 7% PMPM, versus the lower historical rate of 1.30%, which is still being analyzed. 7% is used as a substitute as it is consistent with the SFY 2005 growth rate.

Cost estimates for the Transition group, as well as the community-based groups, were developed using existing 1915(c) waiver expenditure data from CMS-372 reports, as well as agency data and projections for currently state-funded or new services. State Plan expenditures are based on CMS-372 data, where available, as well as other

PMPM data described above. All cost projections were developed using SFY 2005 as a base year, and are trended according to historical growth rates.

PMPM							
	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	Geo. Mean	Total 5-yr
Nursing Facility							
<65, Disabled	$ 6,955	$ 7,445	$ 7,970	$ 8,531	$ 9,132	7.05%	31.30%
65+	$ 5,726	$ 6,161	$ 6,629	$ 7,132	$ 7,674	7.59%	34.01%
Transition							
<65, Disabled	$ 1,388	$ 1,486	$ 1,591	$ 1,703	$ 1,823	7.05%	31.30%
65+	$ 1,053	$ 1,133	$ 1,219	$ 1,311	$ 1,411	7.59%	34.01%
Imminent Risk							
Frail Elders 1915	$ 2,528	$ 2,585	$ 2,643	$ 2,703	$ 2,764	2.25%	9.32%
TBI 1915	$24,997	$27,860	$31,051	$34,608	$ 38,572	11.45%	54.30%
No 1915 <65	$ 5,824	$ 6,232	$ 6,668	$ 7,135	$ 7,634	7.00%	31.08%
No 1915 65+	$ 3,476	$ 3,835	$ 4,231	$ 4,668	$ 5,150	10.32%	48.15%
Prevention							
No 1915 <65	$ 5,824	$ 6,232	$ 6,668	$ 7,135	$ 7,634	7.00%	31.08%
No 1915 65+	$ 3,476	$ 3,835	$ 4,231	$ 4,668	$ 5,150	10.32%	48.15%

Note: 2 Transition group members receive both the Nursing Facility and Transition PMPMs.

3. Total expenditures

The geometric mean of total expenditure growth during the Demonstration period, with the Demonstration, is 3.57%. This is lower than the 4.84% rate in the absence of the Demonstration, through reduction in the nursing facility caseload.

Total expenditures (in millions)							
	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	Geo. Mean	Total 5-yr
Nursing Facility							
<65, Disabled	$ 286	$ 274	$ 291	$ 310	$ 332	3.80%	16.10%
65+	$1,680	$ 1,578	$ 1,552	$ 1,577	$ 1,606	-1.12%	-4.40%
Transition							
<65, Disabled	$ 8	$ 9	$ 10	$ 10	$ 11	7.05%	31.30%
65+	$ 6	$ 7	$ 7	$ 8	$ 8	7.59%	34.01%
Imminent Risk							
Frail Elders 1915	$ 197	$ 202	$ 206	$ 211	$ 216	2.25%	9.32%
TBI 1915	$ 30	$ 33	$ 37	$ 42	$ 46	11.45%	54.30%
No 1915 <65	$ 35	$ 75	$ 80	$ 86	$ 92	27.25%	162.16%
No 1915 65+	$ 63	$ 138	$ 152	$ 168	$ 185	31.20%	196.30%
Prevention							
No 1915 <65	$ 14	$ 30	$ 32	$ 34	$ 37	27.25%	162.16%
No 1915 65+	$ 75	$ 166	$ 183	$ 202	$ 222	31.20%	196.30%
Total							
	$2,395	$ 2,512	$ 2,551	$ 2,647	$ 2,756	3.57%	15.08%

See Appendices F through H for complete budget neutrality tables.

IX. Evaluation of the Demonstration

A. Evaluation Proposal

As indicated in Section I, the Commonwealth anticipates that the Community First 1115 Demonstration will have beneficial outcomes. EOHHS will develop a multi-phased comprehensive research and evaluation plan to help determine whether the Demonstration successfully diverts/delays individuals from nursing facility admission and facilitates appropriate nursing facility discharges and achieves the outcomes outlined above. The research design likely will include “modules” where specific research themes can be grouped and closely examined. Evaluation modules will serve to address three key questions:

1. Did the Commonwealth enroll in the Community First 1115 Demonstration those people who would have entered, or remained in, a Medicaid-paid nursing facility stay in absence of the Demonstration? If not, what (if any) changes can be made to improve identification of such individuals?
2. Did the Demonstration benefit package include services that enabled the targeted individuals to delay, avoid, or leave a nursing facility stay? If not, was the issue related to the services provided, the delivery system model, or both? What can be done to improve effectiveness?
3. How did the addition of the Independence Plus option help or hinder the Demonstration's effectiveness?

The following five modules should serve the global needs of the research and evaluation on these overarching questions.

Module 1: Effectiveness of Eligibility Criteria. The evaluation will measure the efficacy of targeting and identifying elders and individuals with disabilities who participate in the Demonstration. EOHHS will examine the financial and clinical eligibility criteria for each eligibility group. EOHHS hypothesizes that the criteria selected for use will effectively identify those individuals who most likely would have entered, or stayed in, a nursing facility in the absence of Demonstration participation.

Module II: Person Level Information. To better understand the individuals served in the Demonstration, a wide array of data will be collected on each individual, including (where available) demographic profiles, identification of formal and informal supports, housing status, and an ongoing assessment of health status.

Module III: Impact of Community-Based Supports. The service packages provided to Demonstration participants will be examined with regard to their ability to prevent, divert, or delay nursing facility care. Assessment of the supports will differentiate between those who choose Independence Plus and those who do not. The effectiveness of any unique supports used, or purchases made, by participants as part of Independence Plus will be evaluated. The scope and duration of the transition services benefit will be evaluated for efficacy in supporting transition to the community.

Module IV: Cost-Benefit Analysis and Necessity for Caps. The evaluation will include examination of the accuracy of assumptions made about the eligibility groups' service costs and utilization (including for nursing facility services) for the "without waiver" and "with-waiver" budget neutrality scenarios. This analysis will provide information regarding the utility and appropriate size of enrollment caps.

Module V: Quality Outcomes. The evaluation will seek to determine whether the Community First 1115 Demonstration effectively achieved its quality outcome measures, as outlined in Section VII.

B. Submission of Evaluation Design Plan

The Commonwealth will submit to CMS a detailed draft evaluation design for measuring the above. The design will describe: 1) the research questions to be evaluated, 2) the baseline measures and indicators for answering the research questions and measuring Demonstration outcomes over the five-year Demonstration period, 3) any other indicators appropriate to demonstrate effectiveness of the

interventions, 4) how the effects of the demonstration will be isolated from those of other initiatives in the Commonwealth, 5) methodologies for data collection and analysis, 6) evaluation tools, and 7) any research support needed to successfully complete the evaluation.

X. Administration of the Community First 1115 Demonstration

A. Infrastructure

EOHHS serves as the single State agency responsible for administering MassHealth and any MassHealth Demonstrations or waivers. Three Offices within EOHHS – the Office of Medicaid, the Executive Office of Elder Affairs, and the Office of Disabilities and Community Services – will implement and oversee the Community First 1115 Demonstration. Descriptions of these Offices are contained in Appendix I. These three Offices share oversight responsibility for the MassHealth Office of Long-Term Care, which serves senior and disabled MassHealth members. These Offices also oversee the Commonwealth's three 1915(c) waivers, and work directly with various public and private programs that serve persons who may become eligible for MassHealth as part of the Community First 1115 Demonstration.

The three Offices administering the Community First 1115 Demonstration will oversee its implementation, ensure that enrollment occurs smoothly and successfully, and ensure effectiveness of the clinical assessment, care plan development, and case management processes. They will ensure compliance with federal reporting rules, that the quality management processes are effectively implemented, and that the

Demonstration evaluation activities occur as planned. This will include oversight of the enrollment process, including enrollment cap and/or waiting list management if necessary, and tracking of expenditures to ensure that any steps necessary to maintain budget neutrality will be taken.

B. Administrative Activities

Administration of the Demonstration will include oversight of the clinical assessment, care plan development, case management, provider network management, quality management and evaluation activities. The proposed clinical assessment, care plan development and case management processes are described in more detail below.

1. Clinical Assessment

As described in Section II, various entities, including ASAPs and MRC, will conduct the clinical assessment for Community First 1115 Demonstration eligibility.

2. Care Plan Development

Following determination of eligibility for the Community First 1115 Demonstration, the next step will be Demonstration care plan development. The Commonwealth will build on existing approaches in creating the process for developing care plans and subsequent case management for Demonstration participants. (The following subsection provides further details on case management.)

Currently, comprehensive care plans for the Frail Elder 1915(c) waiver are developed by ASAP case managers (at least bachelor's level clinicians, including social workers) with consumers and their families, and with the assistance of ASAP interdisciplinary care teams that include a nurse. In the case of an elder Community First 1115 Demonstration participant, if the entity that conducted the clinical assessment is an ASAP, then the Demonstration participant will work with the staff of that organization to develop their Demonstration care plan and receive case management. The Commonwealth anticipates that ASAPs will establish relationships with Independent Living Centers (ILCs) and will draw on medical and self-advocacy models, as well as the expertise of those more familiar with assisting persons with disabilities, to access and utilize community-based supports.

In the case of the TBI 1915(c) waiver, the clinical assessment for waiver eligibility and the determination of whether someone has TBI and is at NF LOC is currently conducted by MRC's Statewide Head Injury Program (SHIP) staff (with at least a bachelor's degree and access to assistance from a neuropsychologist). The assessments are conducted via face-to-face visits where the participant is located. The same team that conducts the clinical assessment develops the participant's care plan. In the case of Demonstration participants with brain injuries, MRC's SHIP staff may conduct the clinical assessment, and the same staff will work with the participant to develop the care plan and provide case management.

For non-elderly persons with disabilities who apply for the Community First 1115 Demonstration and whose clinical assessment is not conducted by the ASAP staff or

MRC's SHIP staff, the Commonwealth intends to contract with entities or work with State staff to ensure the clinical assessment, care plan development, and case management occurs for these participants. The entities, which may be ASAPs and/or MRC staff (this will be determined for the operational protocol) will be required to determine whether the individuals already have a case manager or other care support provider within the Commonwealth (including DMR service coordinators, DMH case managers, and/or MRC supported living case workers). If so, the contracting entity will be obligated to coordinate with the existing case manager to develop and monitor implementation of a Demonstration care plan, ensuring coordination with the delivery of other State agency-administered, state-funded services. If there is no existing case manager, the contracting entity will be responsible for developing the care plan with the participant and providing for case management.

3. Case Management

As noted earlier, the Commonwealth will build on existing approaches to provide case management for all Community First 1115 Demonstration participants. Case management for Frail Elder waiver enrollees is currently conducted by ASAP case managers (with access to the ASAP interdisciplinary team if necessary). This approach will be utilized for Community First 1115 Demonstration participants ages 60 and older.

Case management for Community First 1115 Demonstration participants with TBI will be conducted by the same SHIP staff that develops the care plan. Alternately, as in the case of other disabled participants, they may access the Community First 1115

Demonstration through other entity(s). Any case management entity will be required to determine whether a participant already has a case manager elsewhere in the State.

Specifics regarding contractual requirements for clinical assessment, care plan development, and case management for any new entity(s) that will perform these functions for non-elder Community First 1115 Demonstration participants are under development. Such entities may be contractors, State agencies, or a combination of both.

EOHHS anticipates that all entity(s) performing case management for Community First 1115 Demonstration participants will establish relationships with ILCs and behavioral health providers, and to identify mechanisms for including these entities in case management activities, as appropriate.

XI. Public Process and Community Support for the Community First Policy

A. Stakeholder Involvement Background

The goals of Community First have been shaped by recommendations from many interested parties gathered over time since the Community First policy was established in 2003. This proposal incorporates a broad range of diverse ideas provided by consumers, providers, and other stakeholders during this process.

Stakeholders have provided input to shape Demonstration design through a variety of forums, including:

- The December 2003 State report titled “Transforming Long-Term Supports in Massachusetts”;

- Community forums under Massachusetts' Systems Change grants;
- Stakeholder meetings held by the Executive Office of Elder Affairs in Fall of 2003;
- Massachusetts' participation in the National Governors Association policy academy on long-term care and its follow-up meetings;
- A stakeholder meeting held on June 20, 2005 to receive input on Community First;
- Regional stakeholder meetings held by ODCS in December 2005 and January 2006 to review the Community First 1115 Demonstration concept paper;
- Six meetings with stakeholders since completing the Community First 1115 Demonstration concept paper; and
- Written comments from interested parties provided via Email.

B. Stakeholder Involvement Process

EOHHS, with the support from the University of Massachusetts Medical School, currently manages an Email distribution list of over 700 stakeholders serving both the senior and disabled communities, including consumers, providers, advocates, and legislative representatives. Many of the individuals on this list serve as resource specialists and/or leaders of advocacy organizations, who then forward messages onto their constituents. The Executive Office of Elder Affairs and partners have used this Email distribution to provide ongoing updates on the Demonstration process, and to solicit feedback and participation in stakeholder meetings.

The State and its partners also maintain a website (www.communityfirstgrant.org) that contains information on the Community First initiative and the State's Systems Transformation Grant.

Two regional stakeholder meetings in December 2005 and January 2006 marked the official start of the public stakeholder input process for the Community First 1115 Demonstration. Participation was solicited via the above mentioned Email distribution and through targeted invitations. These public forums were held in accessible locations in the eastern and western parts of the State, with accommodations to assure accessibility for participants. The concept paper was distributed to all attendees before and during the forums. At the forum, an overview of the waiver and concept paper were presented and participants engaged in a structured question and answer session. Participants were able to ask additional questions by submitting questions in writing on index cards provided at the meeting. These questions were used to produce a formal response to stakeholders and an updated draft of the concept paper. The State distributed a final version of the concept paper to stakeholders along with its submission to CMS. The concept paper and formal response document were posted simultaneously on the official State website and the Community First website.

In addition to public outreach about the Community First 1115 Demonstration concept, the project has been a topic of discussion among the stakeholders involved with the State's Systems Transformation Grant, which was awarded by CMS in October 2005 and will continue into 2010. The Systems Transformation Grant currently engages over 120 stakeholders on a regular basis who represent consumers, providers,

legislators, advocates, and State agency staff. This grant focuses on the areas of affordable and accessible housing; quality management systems; and alternative financing and nursing facility care diversion. The Community First 1115 Demonstration aligns with the objectives of the “diversion” goal of the Systems Transformation grant. The grant stakeholders who are currently focused on this goal were asked to participate in further stakeholder feedback efforts on the Community First 1115 Demonstration. Formal solicitation of stakeholder input into the development of this Demonstration application has occurred much as it did prior to submission of the concept paper. EOHHS held several stakeholder meetings, in two cases with groups of stakeholders comprised of Systems Transformation Grant Diversion subcommittee members and additional members of the consumer, advocate, and provider community who had expressed interest in attending (this group currently consists of 38 members and will continue to meet to contribute design recommendations through the implementation planning phase of this Demonstration project), as well as separate meetings with representatives of particular stakeholder groups, such as the directors of independent living centers. EOHHS also solicited feedback on various aspects of the Demonstration design via Email.

Additional stakeholder involvement in this process includes outreach to State legislators on the Community First 1115 Demonstration concept and the Systems Transformation Grant efforts, which are ongoing within the Commonwealth. The State’s Executive leadership has met with provider stakeholder groups to address concerns

and to discuss how to collaborate effectively moving forward. EOHHS incorporated stakeholder suggestions into the completion of this Demonstration application.

Massachusetts is committed to involving the community in the development of current and future long-term care policies. The efforts outlined above demonstrate this commitment and lay the groundwork for a continued collaborative process with the public on future change efforts within the State.

XII. Waivers Requested/Expenditure Authority

A. Waivers Requested

The following waivers are requested pursuant to the authority of Section 1115(a)(1) of the Social Security Act:

- §1902(a)(1) (Statewideness) - To enable the State to offer different types of benefits under the Demonstration in different geographic regions of the State.
- §1902(a)(4)(A) (Medicaid Eligibility and Quality Control) - To enable the State to employ a Medicaid Eligibility and Quality Control System which varies from requirements under federal law and regulation.
- §1902(a)(8) (Opportunity to Apply\Reasonable Promptness) - To enable the State to place caps upon enrollment of participants in the Demonstration, to freeze Demonstration Enrollment or to place a moratorium on new entrants to the Demonstration and to place caps upon the number of participants served at any point in time under the Demonstration.

- §§1902(a)(10)(A) and 1902(a)(10)(C)(I)- (III) (Eligibility Procedures) - To enable the State to use streamlined eligibility procedures and include eligibility standards and requirements that differ from those required by law.
- §1902(a)(10)(A) (Mandatory Benefits) - To enable the State to offer a limited benefit package of nursing home transition services, which does not include all mandatory benefits, to certain institutionalized Demonstration participants whose income and resources exceed the established limits for Medicaid beneficiaries.
- §1902(a)(10)(B) (Amount, Duration and Scope) - To enable the State to offer benefits to Demonstration participants that are not equal in amount, duration, and scope to those offered to other Demonstration participants or other Medicaid beneficiaries.
- §1902(a)(10)(C)(i) (Income and Resource Rule) - To permit the exclusion of payments made to or on behalf of participants under the Demonstration from the income and resource limits established under State and Federal law for Medicaid eligibility. Participants will also be permitted to accumulate financial resources in a separate account for special (approved) purchases.
- §§1902(a)(23) , 1915(g) (Freedom of Choice) - To enable the State to assign a Demonstration participant to obtain assistance from a care manager, case manager, agency, community provider, or person, qualified to perform the Demonstration service or services required (including an organization that provides such services, or arranges for their availability, on a prepayment basis).

- §§1902(a)(4), 1902(a)(27), 1902(a)57, 1902(a)(58) (Provider Agreements) - To enable the State to administer the Demonstration in a manner that would permit the provision of personal care services or other direct care under the Demonstration by individuals who have not executed a Provider Agreement with the State Medicaid agency.
- §1902(a)(30)(A) (Payments to Providers) - To enable the State to provide for different methods and procedures relating to the utilization of, and the payment for, care and services available under the Demonstration, including permitting payments to be made directly to or on behalf of beneficiaries or their representatives.
- §1902(a)(34) (Retroactive Coverage) - To enable Massachusetts to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made.
- §1902(a)(37)(B) (Payment Review) - To the extent that prepayment review may not be available for disbursements by individual Demonstration participants to their caregivers/providers.
- §1916 (Cost Sharing) - To enable the State to establish cost sharing requirements in a manner that differs from Title XIX cost sharing requirements.

B. Expenditure Authority

Section 1115(a)(2) authority of the Social Security Act is requested, for the following expenditures to be made by the State under the Demonstration, (which are not

otherwise included as expenditures under Section 1903) for the period of the Demonstration to be regarded as expenditures under the State's Title XIX plan:

- Expenditures to provide community-based supports and nursing home transition services as Demonstration services that are not covered as medical assistance under the State's Title XIX plan.
- Expenditures to perform Independence Plus activities that are not covered under the State Plan as Demonstration services (i.e., to provide for training and fiscal/employer agent activities as a part of the Demonstration design).
- Expenditures for prepayment to or on behalf of Demonstration participants for Demonstration services prior to the delivery of those services.
- Expenditures for Demonstration caregiver services provided by members of the Demonstration participant's family to the participant.
- Expenditures for Demonstration services to Demonstration participants who meet eligibility requirements under the Demonstration, but who would not be eligible for MassHealth Standard or CommonHealth benefits under the Commonwealth's Title XIX State plan, its existing 1115 Demonstration, or its existing 1915c waivers for frail elders or adults with traumatic brain injuries.

XIII. Implementation Plan and Timeline

EOHHS, through the Office of Medicaid, Executive Office of Elder Affairs, and the Office of Disabilities and Community Services, will implement the Demonstration project once it is approved by CMS and the program specifications are developed. Key staff

from these three Offices will work together to prepare for implementation of the Demonstration. They will also work with stakeholder groups and additional State agencies to ensure smooth implementation.

Implementation activities are divided into Phase I (pre-implementation) and Phase II (post-implementation). Phase I represents the activities that must be accomplished for successful roll-out of the Demonstration before participants are enrolled. These activities include preparing eligibility and claims systems to identify and track participants; outreach and education, identifying internal resources for managing Demonstration activities, reporting, and tracking; and amending and adopting new State Medicaid regulations. Phase II activities include continued outreach and education to potential Demonstration participants, enrollment, tracking of expenditures, and managing data to support the research questions. An Implementation Timeline is contained in Appendix J.

XIV. Conclusion

The Community First 1115 Demonstration waiver represents a major step forward in the Commonwealth's Community First agenda. Through this Demonstration, the Commonwealth will be able to explore the benefits of broader and earlier access to community-based supports for more seniors and adults with disabilities, as well as test the effectiveness of a self-directed delivery approach. The Commonwealth looks forward to the opportunities this Demonstration will provide to reform the long term care system in Massachusetts in a way that benefits consumers and their families.

XV. Appendices

A. Chapter 211 of the Acts of 2006 – "AN ACT RELATIVE TO CHOICE OF LONG TERM CARE"

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 9 of chapter 118E of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out, in lines 14 to 18, inclusive, the words "provided, further, that said benefits shall be available to otherwise eligible persons seeking admission to and residents of long-term care facilities whose income and resources are insufficient to meet the cost of their medical care as determined by the financial eligibility requirements of the program" and inserting in place thereof the following words:- provided further, that long-term care services shall be available to otherwise eligible persons whose income and resources are insufficient to meet the costs of their medical care as determined by the financial eligibility requirements of the program. For the purposes of this section, the division shall establish clinical eligibility for a long-term care services. A person determined by the division to be clinically eligible for long-term care services shall be given the choice of care setting that is the least restrictive and most appropriate to meet his needs as determined by the division. The value of such long-term care services shall be determined based on the medically necessary long-term care needs of the individual.

SECTION 2. Said section 9 of said chapter 118E, as so appearing, is hereby further amended by adding the following paragraph:-

A person seeking admission to a long-term care facility paid for by MassHealth shall receive pre-admission counseling for long-term care services, which shall include an assessment of community-based service options. A person seeking care in a long-term care facility on a private pay basis shall be offered pre-admission counseling. For the purposes of this section, pre-admission counseling shall be conducted by the executive office of health and human services or the executive office of elder affairs or their subcontractors. The executive office of elder affairs shall, in consultation with the office of acute and ambulatory care in the executive office of health and human services, study the advisability and feasibility of using certain Medicaid providers to provide pre-admission counseling. The division shall report to the general court on an annual basis the number of individuals who received pre-admission counseling under this section and

the number of diversions to the community generated by the pre-admission counseling program.

SECTION 3. The division of medical assistance shall adopt regulations to implement section 1 and shall submit a research and demonstration waiver pursuant to section 1115(a) of the Social Security Act not later than October 1, 2006 to implement said section 1. The waiver shall establish an income eligibility up to 300 per cent of the federal benefit rate under the supplemental security income program and an asset test of not less than $10,000. The waiver shall be subject to the availability of federal financial participation for all enrollees and shall meet budget neutrality requirements established for such waivers.

B. MassHealth Regulations: 130 CMR 456.409 (Medical Eligibility for Nursing Facility Services)

456.409: Services Requirement for Medical Eligibility

To be considered medically eligible for nursing-facility services, the member or applicant must require one skilled service listed in 130 CMR 456.409(A) daily or the member must have a medical or mental condition requiring a combination of at least three services from 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C).
(A) Skilled Services. Skilled services must be performed by or under the supervision of a registered nurse or therapist. Skilled services consist of the following:
(1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding;
(2) nasogastric-tube, gastrostomy, or jejunostomy feeding;
(3) nasopharyngeal aspiration and tracheostomy care, however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services;
(4) treatment and/or application of dressings when the physician has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions);
(5) administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema);
(6) skilled-nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the 24 hours; for example, for arteriosclerotic heart disease with congestive heart failure);
(7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety;
(8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter (a urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled-nursing care). However, the insertion and maintenance

of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled-nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection);
(9) gait evaluation and training administered or supervised by a registered physical therapist at least five days a week for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame. The member must require these services in an institutional setting;
(10) certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical-therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record);
(11) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications; and
(12) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame.
(B) Assistance with Activities of Daily Living. Assistance with activities of daily living includes the following services:
(1) bathing when the member requires either direct care or attendance or constant supervision during the entire activity;
(2) dressing when the member requires either direct care or attendance or constant supervision during the entire activity;
(3) toileting, bladder or bowel, when the member is incontinent of bladder or bowel function day and night, or requires scheduled assistance or routine catheter or colostomy care;
(4) transfers when the member must be assisted or lifted to another position;
(5) mobility/ambulation when the member must be physically steadied, assisted, or guided in ambulation, or be unable to propel a wheelchair alone or appropriately and requires the assistance of another person; and
(6) eating when the member requires constant intervention, individual supervision, or direct physical assistance.

(C) Nursing Services. Nursing services, including any of the following procedures performed at least three times a week, may be counted in the determination of medical eligibility:
(1) any physician-ordered skilled service specified in 130 CMR 456.409(A);
(2) positioning while in bed or a chair as part of the written care plan;
(3) measurement of intake or output based on medical necessity;
(4) administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions;
(5) staff intervention required for selected types of behavior that are generally considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers; or requiring a consistent staff one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental-health professional;
(6) physician-ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals);
(7) physician-ordered licensed registered nursing observation and/or vital-signs monitoring, specifically related to the written care plan and the need for medical or nursing intervention; and
(8) treatments involving prescription medications for uninfected postoperative or chronic conditions according to physician orders, or routine changing of dressings that require nursing care and monitoring.

C. Aging Services Access Points (ASAPs) Law: MGL 19A §4B

Chapter 19A: Department of Elder Affairs

Chapter 19A: Section 4B. Aging services access points

Section 4B. The department shall manage the home care program established in section 4 with respect to clinical screening, service authorization activities and case management for Medicaid community-based long-term care made available to eligible elderly persons pursuant to chapter 118E and the regulations promulgated thereunder; provided, however, that the programs and activities authorized by this section shall be administered and coordinated in accordance with the single state agency requirement under 42 CFR Part 431 and other applicable requirements of Title XIX of the Social Security Act, or its successor title. The primary goal of the coordinated system of care shall be to assist elders in maintaining their residences in the community-consistent with their clinical and psychosocial needs in the most cost-effective manner possible. As used in this section, the word “Medicaid” shall mean medical care and assistance provided to eligible persons pursuant to said chapter 118E and said Title XIX or its successor title, the term “executive office” shall mean the executive office of health and human services and the term “community long-term care” shall mean those Medicaid services determined by the department in consultation with the secretary of health and human services.

The coordinated system of care shall be administered by agencies under contract with the department that shall be known as aging services access points, hereinafter referred to as ASAPs. ASAPs shall be designated by the department and may be operated nonprofit agencies, home care providers as defined in clause (c) of the third paragraph of section 4, a combination of home care corporations acting jointly or by state agencies. Pursuant to the terms of those contracts, ASAPs shall coordinate services on behalf of Medicaid eligible elders; provided, however, that the department shall maintain exclusive responsibility for determining the financial or categorical eligibility of elders for Medicaid and the secretary of health and human services shall establish rates and methods of payment for Medicaid services delivered pursuant to this section. Administrative payments to ASAPs for Medicaid-funded functions including, but not limited, to screenings, assessments, case management and coordination of care shall be established by the department in consultation with the secretary of health and human services. Administrative payments for home care-funded services under said section 4 shall be established by the department in consultation with the secretary of health and human services. The department, in consultation with the secretary of health and human services, may develop a capitation system of payment for services in which

ASAPs shall be at financial risk for any Medicaid services authorized and purchased on behalf of an eligible person that exceed the amount of said capitation payments.

The department shall establish performance and outcome goals for Medicaid and home care-related functions of ASAPs and may establish such goals for any other responsibilities contracted to ASAPs for managing the coordinated system. Continuation of the contracts authorized by this section shall be dependent on the achievement of the Medicaid-related performance and outcome goals, as determined by the department.

ASAPs shall be responsible for: (1) providing information and referral services to elders; provided, however, that referrals for terminally ill elders shall include referrals to licensed and certified hospices for determination of eligibility, appropriateness and consumer interest in services; (2) conducting intake, comprehensive needs assessments, preadmission screening and clinical eligibility determinations for elders seeking institutional and community care services from Medicaid or the home care program, which in the case of hospice clients, shall adhere to Medicare and Medicaid conditions of participation pursuant to 42 C.F.R. 418 and 114.3 C.M.R. 43.00; (3) developing a comprehensive service plan based on the needs of an elder, provided, however, that a medical plan of care for an elder shall be developed by a licensed or certified health care provider; (4) arranging, coordinating, authorizing and purchasing community long-term care services called for in the comprehensive service plan; and (5) monitoring the outcomes of and making periodic adjustments to a service plan in consultation with service and health care providers. The establishment of a comprehensive service plan for an elder shall not establish an entitlement to services for that eligible person for services beyond that established by law or beyond the amounts appropriated therefor.

ASAP responsibilities for Medicaid-related functions shall be those established by the department. When renewing the annual terms of a contract the subsequent fiscal year, the department shall seek to promote continuity in the the coordinated system of care consistent with this section; provided, however, that substantive changes to the terms and conditions of an annual agreement, including changes to the functional responsibilities of ASAP’s as defined in this section, shall be negotiated after the department’s written findings that such changes are necessary as a result of changes in federally reimbursable services, rates of federal reimbursement rates or state fiscal demands or that the division is prepared to implement a more comprehensive, cost-effective and coordinated system of long-term care than that established in this section. The written finding required by this paragraph shall be submitted to the executive office, the secretary of administration and finance and the legislature’s joint committee on human services and elderly affairs.

ASAPs shall not provide direct services except for case management; information and referral, and protective services as defined in regulations of the home care program

established pursuant to 651 C.M.R. 3.00 et seq. and nutrition services established pursuant to 651 CMR 4.00 et seq. and the Older Americans Act, as amended, 42 U.S.C. 3021 et seq. Except for the direct services provided by ASAPs pursuant to this section, no ASAP shall have a direct or indirect financial ownership interest in an entity that provides institutional or community long-term care services on a compensated basis. The department may grant a waiver of the restrictions in this paragraph upon a finding that public necessity and convenience require such a waiver.

Overall management, administration and oversight activities related to the screening and authorization of community long-term care services and related case management services shall be the responsibility of the department. The department shall actively explore with interested parties programmatic options that would decrease the reliance of nursing facilities on Medicaid funding and shall promote increased residential and community long-term care program options for elders needing long-term care services. The department shall also explore future coordinated systems of service delivery options as identified in the coordinated aging, rehabilitation and disability services project.

D. MassHealth SCO Regulations: 130 CMR 508.008

508.008: Voluntary Enrollment in Senior Care Organizations

(A) Enrollment Requirements. In order to voluntarily enroll in a senior care organization, a MassHealth Standard member must meet all of the following criteria:

(1) be aged 65 or older;

(2) live in a designated service area of a senior care organization;

(3) not be diagnosed as having end-stage renal disease;

(4) not be subject to a six-month deductible period under 130 CMR 520.028;

(5) not be a resident of an intermediate care facility for the mentally retarded (ICF/MR); and

(6) not be an inpatient in a chronic or rehabilitation hospital.

(B) Selection of a Senior Care Organization. The MassHealth agency will notify members of the availability of a senior care organization in their service area and of the procedures for enrollment. An eligible member may voluntarily enroll in any senior care organization in the member's service area. A service area is the specific geographical area of Massachusetts in which a senior care organization agrees to serve its contract with the MassHealth agency and the Centers for Medicare and Medicaid Services. Service area listings may be obtained from the MassHealth agency or its designee.

(C) Obtaining Services. When a member chooses to enroll in a senior care organization in accordance with the requirements under 130 CMR 508.008, the senior care organization will deliver the member's primary care and will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, each senior care organization is required to provide evidence of its coverage, including a complete list of participating providers, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to covered services such as specialty, behavioral health, and long-term-care services.

(D) Disenrollment from a Senior Care Organization. A member may disenroll from a senior care organization at any time by submitting a notice of disenrollment to the MassHealth agency or its designee. Disenrollment notices received by the MassHealth agency or its designee by the 20th day of the month will be effective the first day of the following month.

(E) Discharge or Transfer. The MassHealth agency may discharge or transfer a member from a senior care organization where the senior care organization demonstrates to the MassHealth agency's satisfaction a pattern of noncompliant or disruptive behavior by the member or for other good cause. In each case, the MassHealth agency will state the good cause basis for discharge or transfer in a notice to the member.

(F) Other Programs. While voluntarily enrolled in a senior care organization under 130 CMR 508.008, a member may not concurrently participate in any of the following programs:

(1) the Home and Community-Based Services Waiver described in 130 CMR 519.007(B);

(2) the Section 1915 Home and Community-Based Services Waiver for the Mentally Retarded administered by the Department of Mental Retardation;

(3) the Program of All-Inclusive Care for the Elderly (PACE) described in 130 CMR 519.007(C); and

(4) any Medicare+Choice plan or Medicare demonstration program.

E. MassHealth PACE Regulations: 130 CMR 519.007(C)(2)

519.007: Individuals Who Would Be Institutionalized

130 CMR 519.007 describes the eligibility requirements for MassHealth Standard coverage for individuals who would be institutionalized if they were not receiving home- and community-based services.

…

(C) Program of All-Inclusive Care for the Elderly (PACE).

(1) Overview. The PACE program is a comprehensive health program that is designed to keep frail, older individuals who are certified eligible for nursing-facility services living in the community.

(a) A complete range of health-care services is provided by one designated community-based program with all medical and social services coordinated by a team of health professionals.

(b) the MassHealth agency administers the program in Massachusetts as the Elder Service Plan (ESP).

(c) Persons enrolled in PACE have services delivered through managed care:

(i) in day-health centers;

(ii) at home; and

(iii) in specialty or inpatient settings, if needed.

(2) Eligibility Requirements. In determining PACE eligibility, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must meet all of the following criteria:

(a) be aged 55 or older;

(b) meet Title XVI disability standards if aged 55 through 64;

(c) be certified by the MassHealth agency or its agents to be in need of nursing-facility services;

(d) live in a designated service area;

(e) have medical services provided in a specified community-based PACE program;

(f) have countable assets whose total value does not exceed $2,000 or, if assets exceed these standards, reduce assets in accordance with 130 CMR 520.004; and

(g) have a countable-income amount less than or equal to 300 percent of the federal benefit rate (FBR) for an individual.

(3) Income Standards Not Met. Individuals whose income exceeds the standards set forth in 130 CMR 519.007(C)(2) may establish eligibility for MassHealth Standard by meeting a deductible as described at 130 CMR 520.028 et seq.

F. Budget Neutrality: Summary Budget Neutrality Worksheet Comparing With and Without Demonstration Costs

See Attachment – Tab 1

G. Budget Neutrality: Historical Caseload and Cost Data, and Projected Caseload and Costs for the Demonstration Population in the Absence of the Demonstration

See Attachment – Tab 2

H. Budget Neutrality: Projected Caseload and Costs for the Demonstration Population With the Demonstration

See Attachment – Tab 3

I. Descriptions of the Office of Medicaid, Executive Office of Elder Affairs, and Office of Disabilities and Community Services

Three Offices within EOHHS – the Office of Medicaid, the Executive Office of Elder Affairs, and the Office of Disabilities and Community Services – will implement and oversee the Community First 1115 Demonstration.

Office of Medicaid

The Office of Medicaid serves as the medical assistance unit with primary oversight of the MassHealth program. MassHealth includes the Massachusetts Medicaid program and State Children's Health Insurance Program (SCHIP) in accordance with Titles XIX and XXI of the Social Security Act, and under the MassHealth 1115 Demonstration respectively. MassHealth includes the CommonHealth program, which provides full Medicaid coverage for disabled children and disabled adults at any income level. MassHealth offers health care coverage for children under 19, low-income parents with children under age 19, pregnant women, working and non-working disabled adults, long-term unemployed adults, certain individuals with HIV disease or diagnosed with breast or cervical cancer, and low-income seniors. MassHealth also provides a subsidy to qualified small businesses (fewer than 50 employees) through the Insurance Partnership program. MassHealth serves over one million people, nearly one out of six Massachusetts residents.

Executive Office of Elder Affairs

The Executive Office of Elder Affairs (EOEA), as the State Unit on Aging, provides services to seniors through a significant network which includes Aging Services Access Points (ASAP), Area Agencies on Aging, Councils on Aging (COA), and senior centers in communities across the Commonwealth. This network reaches out to elders in need of services such as home care and caregiver support, nutrition programs, protective services, health and wellness services, housing options, and health insurance counseling. EOEA directly administers the Frail Elder 1915(c) waiver, which will be replaced by the Community First 1115 Demonstration. Additionally, EOEA's Office of Long-Term Care manages MassHealth long-term care services and service providers in three areas: Community Services; Coordinated Care Systems; and Institutional, Residential, and Day Services.

Office of Disabilities and Community Services (ODCS)

The Office of Disabilities and Community Services (ODCS) has oversight responsibility for the Department of Mental Retardation, the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, the Massachusetts Commission for the Deaf and Hard of Hearing, the MassHealth Office of Long-Term Care, and the Chelsea and Holyoke Soldier's Homes. The mission of the ODCS cluster of agencies is to promote initiatives that enable individuals to live as independently as possible in the setting of their choice. The Massachusetts Rehabilitation Commission administers the TBI 1915(c) waiver, which will be replaced by the Community First 1115 Demonstration.

J. Proposed Implementation Timeline

The following timeline assumes an implementation date of July 1, 2008.

Phase I: Pre-Implementation (1/1/07 – 7/1/08)

Demonstration Administration

- Develop Demonstration administration process
- Define Demonstration administration staff resource needs and positions
- Assign/allocate staff time to Demonstration administration
- Develop reporting and participant tracking procedures
- Develop appropriate database and/or technology requirements related to administration
- Establish methods to track research questions and test with sample data
- Establish contracts with any new contractors via RFR processes, and develop other contracting processes
- Continue to work with stakeholders on development of Demonstration
- Establish case management activity guidelines
- Coordinate case management activities and establish roles and responsibilities

Regulations

- Identify necessary regulation changes
- Amend current regulations
- Draft and adopt new regulations where necessary

Systems Changes

- Make changes to MMIS system to accommodate new eligibility and claim regulations
- Establish eligibility rules & groups
- Establish appeals process
- Establish waiting list procedures & management functions

Service Package/Case Management

- Draft and execute contracts, memoranda of understanding, and contract amendments
- Expand/create service networks

Outreach/Education

- Develop initial outreach and education plan
- Develop initial outreach and education materials
- Notify frail elder and TBI 1915(c) waiver enrollees of plan to enroll in the Demonstration
- Outreach activities will begin to new eligibility groups

Quality

- Establish quality management processes
- Ensure that the quality effort is integrated with other quality initiatives within the Commonwealth

Phase II: Post-Implementation (after 7/1/08)

Outreach and Enrollment

- Continue to develop education campaign and begin with care providers in community and at facility based settings
- Continue outreach and education to potential enrollees
- Provide training and information updates to stakeholders and providers

Tracking and Research

- Begin to track utilization and expenditures of Demonstration participants
- Monitor enrollment caps and wait list management
- Engage in continuous evaluation of Demonstration project and outcomes

Glossary

Care plan – see *Demonstration care plan*

Case management – an administrative activity designed to promote efficient administration of services under the Community First 1115 Demonstration

Case manager - an individual who performs case management

Community First 1115 Demonstration – Research and Demonstration project proposed by the Commonwealth of Massachusetts under Section 1115 of the Social Security Act designed to prevent and/or delay admission to, or facilitate discharge from, nursing facilities for certain targeted elders and adults with disabilities in Massachusetts, by waiving certain Title XIX rules and enabling the State to obtain federal financial participation for Demonstration expenditures that otherwise would not be eligible for federal match

Community-based supports – services provided to Demonstration participants under the Community First 1115 Demonstration that are provided in the home or another community (non-institutional) setting

Demonstration care plan – a plan that is developed and approved by a Demonstration participant and his or her case manager, which contains the list of Demonstration services and supports that are determined to meet the participant's identified community-based supports needs under the Community First 1115 Demonstration

Disabled individual - for the purpose of the Community First 1115 Demonstration, an individual under age 65 who has been determined disabled in accordance with current MassHealth rules, which incorporate the rules that apply for Social Security purposes (as provided in §1614(a)(3) of the Social Security Act).

Elder - for the purpose of the Community First 1115 Demonstration, an individual age 65 and over

Executive Office of Health and Human Services (EOHHS) – the Massachusetts Office that serves as the single State agency responsible for administering MassHealth and any MassHealth 1115 Demonstrations and waivers, and which oversees the three Offices (the Office of Medicaid, the Executive Office of Elder Affairs, and the Office of Disabilities and Community Services) that will implement and administer the Community First 1115 Demonstration

Fiscal agent (also known as financial management services) – An administrative activity that provides support to Demonstration participants who direct certain Demonstration services, which may include (but is not necessarily limited to): (i) operating a payroll service for participant employed workers and making required payroll withholdings and (ii) paying invoices for Demonstration goods and services and tracking expenditures against the participant-directed budget

Imminent Risk group – one of three eligibility groups of adults (ages 21 and older) covered under the Community First 1115 Demonstration that consists of elderly and disabled individuals at nursing facility level of care (NF LOC) who are residing in the community

Independence Plus – a designation by CMS for a particular 1115 Demonstration project in which Demonstration participants (or the participants' representatives) may direct and manage some or all of their Demonstration services

MassHealth 1115 Demonstration – Massachusetts' existing Health Care Reform 1115 Demonstration project

Nursing facility level of care (NF LOC) criteria – the MassHealth medical eligibility criteria for payment for nursing facility care (contained in MassHealth regulations at 130 CMR 456.409)

Phase I (pre-implementation) – timeframe during which Massachusetts will perform activities that must be accomplished for successful roll-out of the Community First 1115 Demonstration before participants are enrolled.

Phase II (post-implementation) – timeframe during which Massachusetts will perform activities once the Demonstration is implemented

Prevention group – one of three eligibility groups of adults (ages 21 and older) covered under the Community First 1115 Demonstration that consists of elderly and disabled individuals residing in the community who do not currently meet NF LOC, but have clinical and functional profiles that deem them likely to enter a nursing facility in 9-12 months

Program of All-Inclusive Care for the Elderly (PACE) – a program of all-inclusive care for the elderly that is jointly administered by CMS and Massachusetts in accordance with Sections 1894, 1905(a) and 1934 of the Social Security Act.

Risk score (or Diagnosis-based clinical risk score) – a numerical rating based on medical diagnoses of an applicant seeking to enroll in the Community First 1115

Demonstration that is used for purposes of determining clinical eligibility for enrollment in the Prevention group

Risk score threshhold – a minimum risk score set by EOHHS that is one of the criteria for enrollment in the Prevention group in the Community First 1115 Demonstration

Senior Care Options (SCO) - a program implemented by CMS and Massachusetts in partnership for the purpose of delivering and coordinating all Medicare- and Medicaid-covered benefits for eligible Massachusetts seniors managed by a Senior Care Organization using a geriatric model of care

Support broker – A person or entity that undertakes activities to assist a Demonstration participant to direct and manage his/her Demonstration services. Such activities might include assisting a participant in locating sources of Demonstration goods and services and managing the participant-directed budget

Support brokerage services - Activities that are undertaken to assist a Demonstration participant to direct and manage his/her Demonstration services, which may include assisting a participant in locating sources of Demonstration goods and services and managing the participant-directed budget

Surrogate – a person or entity with legal authority to act on behalf of a Community First 1115 participant who requires support in decision-making

Transition group – one of three eligibility groups of adults (ages 21 and older) covered under the Community First 1115 Demonstration that consists of certain elderly and disabled individuals who have been in a nursing facility for at least three months and seek to transition to the community

Transition services – the Demonstration benefit provided to Transition group Demonstration participants