

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

I. Request Information

- A. The State of requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. Waiver Title (optional):
- C. CMS Waiver Number:
- D. Amendment Number (Assigned by CMS):
- E.1 Proposed Effective Date:
- E.2 Approved Effective Date (CMS Use):

II. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

This amendment makes technical revisions to the target group criteria to reflect the phase-out of the Money Follows the Person Demonstration, adds Transitional Assistance (TA) and Orientation and Mobility Services as participant services, and updates the unit type for Day Services. The cost neutrality demonstration is updated accordingly. In addition, this amendment addresses Fair Labor Standards Act (FLSA) requirements applicable to self-directed services.

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III. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

	Component of the Approved Waiver	Subsection(s)
<input checked="" type="checkbox"/>	Waiver Application	Public Input, Attachment #2
<input type="checkbox"/>	Appendix A – Waiver Administration and Operation	
<input checked="" type="checkbox"/>	Appendix B – Participant Access and Eligibility	B-1-b, B-3-c
<input checked="" type="checkbox"/>	Appendix C – Participant Services	C-1-a, C-1/C-3, Appendix C-5
<input type="checkbox"/>	Appendix D – Participant Centered Service Planning and Delivery	
<input checked="" type="checkbox"/>	Appendix E – Participant Direction of Services	E-1-a
<input type="checkbox"/>	Appendix F – Participant Rights	
<input type="checkbox"/>	Appendix G – Participant Safeguards	
<input checked="" type="checkbox"/>	Appendix I – Financial Accountability	I-2-a
<input checked="" type="checkbox"/>	Appendix J – Cost-Neutrality Demonstration	J-1, J-2-c, J-2-d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

<input checked="" type="checkbox"/>	Modify target group(s)
<input type="checkbox"/>	Modify Medicaid eligibility
<input checked="" type="checkbox"/>	Add/delete services
<input checked="" type="checkbox"/>	Revise service specifications
<input type="checkbox"/>	Revise provider qualifications
<input type="checkbox"/>	Increase/decrease number of participants
<input checked="" type="checkbox"/>	Revise cost neutrality demonstration
<input type="checkbox"/>	Add participant-direction of services
<input type="checkbox"/>	Other (specify):
<input type="checkbox"/>	

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IV. Contact Person(s)

- A. The Medicaid agency representative with whom CMS should communicate regarding this amendment is:

First Name:	Amy
Last Name	Bernstein
Title:	Director, Community Based Waivers
Agency:	MassHealth
Address 1:	One Ashburton Place
Address 2:	11 th Floor
City	Boston
State	MA
Zip Code	02108
Telephone:	(617) 573-1751
E-mail	Amy.Bernstein@state.ma.us
Fax Number	(617) 573-1894

- B. If applicable, the operating agency representative with whom CMS should communicate regarding this amendment is:

First Name:	Helen
Last Name	Quinn
Title:	Director, Waiver Management Unit
Agency:	Department of Developmental Services
Address 1:	500 Harrison Ave.
Address 2:	
City	Boston
State	MA
Zip Code	02118
Telephone:	(617) 624-7554
E-mail	Helen.Quinn@MassMail.State.MA.US
Fax Number	(617) 624-7578

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V. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: _____ **Date:** _____
 State Medicaid Director or Designee

First Name:	Daniel
Last Name	Tsai
Title:	Assistant Secretary and Director of MassHealth
Agency:	Executive Office of Health and Human Services
Address 1:	One Ashburton Place
Address 2:	11 th Floor
City	Boston
State	MA
Zip Code	02108
Telephone:	
E-mail	
Fax Number	(617) 573-1894



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6. Additional Requirements

I. Public Input. Describe how the State secures public input into the development of the waiver:

~~Massachusetts submitted a Statewide HCBS Transition Plan on February 27, 2015 in response to the Centers for Medicare and Medicaid Services (CMS) March 17, 2014 final rule related to Medicaid long term services and supports provided in home and community based settings. The state engaged in an extensive process to obtain public review and input of this plan, including: formation of stakeholder groups; convening an interagency workgroup to address the new federal HCB settings requirements; posting the state's draft Statewide HCBS Transition Plan on the MassHealth website; publication in multiple newspapers of the public input period and publication of an email and regular mail address for submission of comments; emailing a notice to several hundred people, including key advocacy organizations and the Native American tribal contacts, and conducting two public forums. The draft Statewide HCBS Transition Plan as well as these HCBS waiver amendments have been and continue to be discussed during the quarterly conference calls with the tribal representatives.~~

2015 Amendment:

Massachusetts outreached broadly to the public and to interested stakeholders to solicit input on this MFP-RS waiver amendment. The waiver was posted to MassHealth's website, and public notices were issued in multiple newspapers, including: the Boston Globe, Worcester Telegram and Gazette, and the Springfield Republican. In addition, emails were sent to several hundred recipients, which included key advocacy organizations as well as the Native American tribal contacts. The newspaper notices and email provided the link to the MassHealth website that includes the draft MFP-RS amendment, the public comment period, and, for anyone wishing to send comments, both email and mailing addresses. No written comments were received either through email or mail. In addition, feedback on this waiver amendment was solicited at the ABI/MFP/TBI Stakeholder Advisory Committee meeting, a community meeting involving waiver participants and from a group of waiver service providers. Overall feedback at these meetings was positive, no specific changes to the amendments were suggested.

2016 Amendment:

~~Massachusetts outreached broadly to the public and to interested stakeholders to solicit input on this MFP-RS waiver amendment. The waiver was posted to MassHealth's website, and public notices were issued in multiple newspapers, including: the Boston Globe, Worcester Telegram and Gazette, and the Springfield Republican. In addition, emails were sent to several hundred recipients, which included key advocacy organizations as well as the Native American tribal contacts. The newspaper notices and email provided the link to the MassHealth website that includes the draft MFP-RS amendment, the public comment period, and, for anyone wishing to send comments, both email and mailing addresses.~~

Massachusetts engaged in an extensive public input process in order to develop its Money Follow the Person demonstration grant application and continues to engage with stakeholders as it implements the demonstration. The MFP-RS waiver is a key component of the state's implementation of its MFP demonstration. Outreach by the Office of Medicaid (OOM), and the Massachusetts Rehabilitation Commission (MRC) began in 2010. Ongoing outreach continues through semi-annual MFP Stakeholder Meetings and on-going meeting with MFP contractors serving as MFP Transition Entities, demonstration service providers, and/or waiver service providers. The MFP Demonstration staff and staff associated with related waivers maintain a mailing list of over 200 interested persons and organizations. The list includes Native American Tribal contacts, and representatives from

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Advocacy Agencies, Human Service Provider Agencies, Community Support Providers, Aging and Disability Resource Consortia (ADRC) partners (which include Independent Living Centers, Area Agencies on Aging/Aging Services Access Points), multiple State Human Service Agencies, and individuals with disabilities. The stakeholder meetings are well attended and provide positive feedback about the MFP waivers. Through the MFP Demonstration, EOHHS is now working with Transition Entity contractors to promote transition of MFP qualified individuals. These stakeholders have created a grass roots effort to outreach to potential MFP qualified individuals, and therefore to potential MFP waiver participants. Communication with and training opportunities for these entities, is on-going and includes extensive information about the MFP-RS and other waivers.

Since January 2011, MassHealth has outreached to and communicated with the Tribal governments about both the Money Follows the Person (MFP) Demonstration and related Waivers, including this MFP-RS waiver at each of their regularly scheduled tribal consultation quarterly meetings. The tribal consultation quarterly meetings have afforded direct discussions with Tribal government contacts about this amendment. The Tribal government contacts were also added to the MFP interested stakeholders e-mail distribution list so they receive regular notifications of all MFP stakeholder meetings. The tribal governments have not offered any comments or advice on the MFP Demonstration, or this waiver to MassHealth staff.

The state will continue to work with stakeholders and to obtain ongoing input from public forums about the MFP-RS waiver.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for

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this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Massachusetts Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency (MassHealth) convened an interagency workgroup to address how best to comply with the requirements of the federal Home and Community Based settings at 42 CFR 441.301 (c)(4)-(5). The Department of Developmental Services (DDS), an agency within EOHHS that has primary responsibility for day-to-day operation of the MFP-RS waiver, participated in the workgroup. All regulations, policies, standards, certifications and procedures have been reviewed against the Community Rule HCBS Regulations and necessary changes identified. ~~Details are provided in the Systemic Assessment section of the STP.~~

~~Participants in the MFP-RS Waiver live in 24-hour residential settings, including Residential Habilitation group homes, Assisted Living Residences (ALRs) or homes or apartments with a Shared Living caregiver. DDS conducted a review of existing residential settings in the MFP-RS and ABI-RH waivers to determine those settings that had a license and certification in good standing. For Assisted Living sites, where licensure is not applicable, the review determined whether they were credentialed in good standing. This review included development of a review tool that borrowed extensively from the CMS exploratory questions and review of settings by DDS Central Office, Regional and Area Office staff to categorize settings as compliant, requiring minor changes to comply, requiring more extensive changes to comply, or unable to comply. Based upon the DDS review and assessment, all the 24-hour residential settings serving participants in the MFP-RS and the ABI-RH waivers were determined to be in compliance with federal HCB settings requirements with the exception of consistently having locks on all individual participant's bedroom doors and legally enforceable leases. As the state is staking a system-wide approach to transitioning residential settings to compliance in these areas, details on remedial actions are provided in the Systemic Assessment section of the STP, and transition milestones are summarized in Table 3 of the STP.~~

~~In order to qualify as a provider of Assisted Living services ALRs must be certified in compliance with the Commonwealth's ALR rules at 651-CMR-12.00. These regulations establish ALRs as residential environments with supportive services and not as medical or nursing facilities. They require Residency Agreements which provide protections from eviction, and include resident rights including the right to privacy, the right to visit with any person of her or his choice and "freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community." In addition the setting must meet the requirements as a Money Follows the Person qualified residence. As such, all ALRs meet the requirements in the HCBS Regulations.~~

~~Participants receiving Shared Living services may either live in their own homes or apartments, or in the home or apartment of the Shared Living caregiver. Homes or apartments owned or rented by waiver participants are considered to fully comply with the HCBS Regulations.~~

~~Transportation services by definition assist the participant in engaging in waiver or other services in the community and in other community activities. As such this service is considered to be fully compliant with the HCBS Regulations.~~

~~Further review and assessment of the settings in which the following waiver services are provided is currently underway: Day Services, Prevocational Services and Supported Employment Services. Additional details regarding the process used to review HCBS Settings types and whether they comply with the HCBS Regulations may be found in the Statewide Transition Plan submitted to CMS on February 27, 2015 and the Addendum to the Statewide Transition Plan currently under review and anticipated to be submitted to~~

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~~CMS shortly:~~

~~As indicated in Appendix C 5, concurrent with the systemic review of regulations, policies and procedures and provider qualification processes related to residential settings, the state embarked on a review, in conjunction with its providers, to assess whether 24 hour residential settings are in compliance with the Community Rule. This review included development of a review tool that borrowed extensively from the CMS exploratory questions and review of settings by DDS Central Office, Regional and Area Office staff to categorize settings as requiring minor changes to comply, more extensive changes to comply or unable to comply.~~

~~Based upon the DDS review and assessment, all the 24 hour residential settings serving participants in the MFP RS and the ABI RH waivers were determined to be in compliance with federal HCB settings requirements with the exception of consistently having locks on all individual participant's bedroom doors, legally enforceable leases, and certain policy areas that required revision to comply with the federal HCB settings requirements. These identified policy areas include: residential guidelines regarding visits by family members, significant others, friends and legal guardians; alcohol and drug abstinence policy; smoking policy; leave of absence policy; and telephone, cable and internet usage policy. DDS will phase in full compliance with these areas over a period of one year, and therefore anticipates full compliance by April 2016.~~

~~As described in detail in the Statewide Transition Plan, DDS developed and distributed a survey to providers of day services in collaboration with the Massachusetts Rehabilitation Commission (MRC). DDS staff reviewed survey results along with site-specific program data for providers that contract with both DDS and MRC. Based on this review, it was determined that all of the day services providers that contract with both DDS and MRC require some level of modification to come into full compliance with the Community Rule. Details on remedial actions are provided in the Site-Specific Assessment section of the STP, and transition milestones are summarized in Table 3 of the STP.~~

~~As described extensively in the STP, the assessment process for group supported employment settings occurred against the backdrop of the state's existing Blueprint for Success, including Next Steps and Progress Reports associated with that document. DDS reviewed site-specific data across a range of group employment settings and determined that state-wide, all group employment settings that are licensed or certified by DDS require some level of modification to achieve full compliance with the Community Rule, particularly regarding policies or practices in one or more of the following domains: meaningful integration into the workplace; access to workplace amenities to the same degree as non-disabled workers; and assurance that individuals are earning at least the minimum wage. Details on remedial actions are provided in the Site-Specific Assessment section of the STP, and transition milestones are summarized in Table 3 of the STP.~~

~~The 24 hour residential setting provider qualifications are reviewed through the DDS licensure and certification process on an on-going basis. All waiver providers will be subject to ongoing review on the schedule outlined in Appendix C of the waiver application.~~

~~Concurrent with the systemic review of regulations, policies and procedures and provider qualification processes, all providers of community based day support services have been sent a survey that incorporates questions that enable a provider to assess where they are in the continuum of outcomes necessary to meet the requirements of the Community Rule.~~

~~Survey data has not as yet been received. Once received, it will be aggregated, reviewed, and analyzed to determine any changes needed to fully comply with the requirements of the Community Rule. Data gleaned from the surveys will inform the existing Employment Work Group as well as a recently formed group of advocates, participants/family members, and other stakeholders regarding:~~

~~a. The development of definitions and standards for what constitutes a meaningful day service;~~

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- ~~b. The incorporation of both qualitative and quantitative measures into the DDS licensure and certification process to ensure providers fully comply with the HCBS Regulations;~~
- ~~e. The modification of the MRC monitoring tool to reflect changes in program expectations and standards to ensure providers fully comply with the HCBS Regulations;~~
- ~~d. Systemic strategies to assist all community based day service providers to achieve the outcomes of the Community Rule including but not limited to technical assistance and staff development and training.~~

~~Findings will be validated through ongoing Licensure and Certification processes or, for those providers not subject to Licensure and Certification, through responses to a Request for Response (RFR) and ongoing program monitoring.~~ All waiver providers will be subject to ongoing review on the schedule outlined in Appendix C of the waiver application.

~~The state anticipates development of clear guidelines and standards that define day services, including what constitutes meaningful day activities, and how services and supports can be integrated into the community more fully. Technical assistance, training and staff development will be provided to assist providers in complying with the HCBS Regulations.~~

Individuals receiving services in settings that cannot meet requirements will be notified by the state agency providing case management. The case manager will review with the participant the services available and the list of qualified and fully compliant providers, and will assist the participant in choosing the services and providers, from such list, that best meet the participant's needs and goals.

For all settings in which changes will be required, DDS has instituted an on-going compliance review process to assure that the changes are monitored and occur timely and appropriately. This process will include consultation and support to providers to enable them to successfully transition, quarterly reporting by providers to update DDS on progress towards compliance, and reviews by designated Area, Regional and Central Office DDS staff to assure adherence to transition plans and processes.

All settings in which waiver services are delivered will be fully compliant with the HCBS Regulations no later than March 16, 2019. ~~Additional information on transition milestones is provided in Table 3 of the STP.~~

~~Massachusetts outreached to the public to solicit input on this MFP RS waiver amendment through multiple formats. The waiver was posted to MassHealth's website and newspaper public notices were issued in the Boston Globe (March 14, 2015), Worcester Telegram and Gazette (March 17, 2015), and the Springfield Republican (March 17, 2015). In addition, emails were sent on March 13, 2015 to several hundred recipients, which included key advocacy organizations as well as the Native American tribal contacts. The newspaper notices and email provided the link to the MassHealth website that includes the draft MFP RS amendment, the public comment period, and, for anyone wishing to send comments, both email and mailing addresses. The waiver amendment was also discussed in the quarterly conference call with tribal representatives held on February 5, 2015.~~

Massachusetts ~~also has~~ engaged in an extensive process to obtain public review and input of ~~their HCBS~~the Massachusetts Statewide Transition Plan, as described in detail in the STP submitted to CMS in September 2016., including: formation of stakeholder groups; convening an interagency workgroup to address the new federal HCB settings requirements; posting the state's draft Statewide HCBS Transition Plan on the MassHealth website from October 15, 2014 through the close of the public comment period on November 15, 2014; publication in multiple newspapers of the public input period and publication of an email and

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~~regular mail address for submission of comments (published in the Boston Globe, Worcester Telegram and Gazette and Springfield Republican on October 15, 2014); emailing a notice to several hundred people (October 16, 2014), including key advocacy organizations and the Native American tribal contacts, and conducting two public forums (November 6, 2014 and November 12, 2014) at which oral comments were heard and noted.~~

~~The Addendum to the Statewide Transition Plan has been publicized in the same fashion: posted on the MassHealth website from May 15, 2015 through the close of the public comment period on June 18, 2015; publication in multiple newspapers of the public input period and publication of an email and regular mail address for submission of comments (published in the Boston Globe, Worcester Telegram and Gazette and Springfield Republican on May 18, 2015); emailing a notice to several hundred people (May 15, 2015 with a reminder email sent on June 8, 2015), including key advocacy organizations and the Native American tribal contacts, and conducting a public forum (June 1, 2015).~~

~~If a substantive change in the transition plan is indicated during the ongoing monitoring process, DDS along with MassHealth will revise the transition plan, provide public input opportunities and resubmit the Transition Plan for CMS approval.~~ The State is committed to transparency during both the STP planning and phase and the implementation phases to comply with the HCB settings requirements. If, in the course of monitoring activities, DDS determines that **additional** substantive changes to the Transition Plan are necessary, MassHealth and DDS will engage in activities that include: publication of draft plan for 30 days with the opportunity for public comments to be submitted to the agencies, as well as review/comment by the agencies on all input received.

The State assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to the waiver when the next amendment or renewal is submitted.

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Appendix B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

SELECT ONE WAIVER TARGET GROUP	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input checked="" type="checkbox"/>	Aged or Disabled, or Both - General			
	<input checked="" type="checkbox"/> Aged (age 65 and older)	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/> Disabled (Physical)	18	64	
	<input type="checkbox"/> Disabled (Other)			
<input type="checkbox"/>	Aged or Disabled, or Both - Specific Recognized Subgroups			
	<input type="checkbox"/> Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/> HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/> Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/> Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/>	Intellectual Disability or Developmental Disability, or Both			
	<input type="checkbox"/> Autism			<input type="checkbox"/>
	<input type="checkbox"/> Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/> Mental Retardation			<input type="checkbox"/>
<input checked="" type="checkbox"/>	Mental Illness (<i>check each that applies</i>)			
	<input checked="" type="checkbox"/> Mental Illness	18	64	<input type="checkbox"/>
	<input type="checkbox"/> Serious Emotional Disturbance			

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

The target group for this waiver includes adults, age 18 and over, with both physical disabilities and mental illness

Applicants to the MFP Residential Habilitation (MFP-RS) Waiver must also meet the following program criteria to participate in the waiver:

1. Reside (and have resided for a period of not less than 90 consecutive days, ~~excluding Medicare rehabilitation days~~) in an inpatient facility (~~specifically a nursing facility, chronic disease or rehabilitation hospital, or, for participants 18 through 21 years of age or 65 years of age and older, a psychiatric hospital~~ **MFP-qualified facility**);
2. ~~Meet the requirements for participation in the MFP Demonstration;~~
3. Meet the level of care criteria as specified in Appendix B.6.d.;
4. Be able to be safely served in the community within the terms of the MFP-RS Waiver;
5. In transitioning to the community setting from a facility, move to a ~~home owned or leased by the applicant or family member, an apartment with an individual lease or a community-based residential setting in which no more than 4 unrelated individuals reside~~ **setting that meets the applicable requirements of the Community Rule (42 CFR 441.301(c)(4)).**

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~~The state has defined MFP Qualified Facilities for the MFP Demonstration as all Massachusetts Department of Public Health (DPH) licensed and Medicaid certified nursing facilities (NFs), chronic disease and rehabilitation hospitals, and Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID) as well as all Department of Public Health Hospitals in the Commonwealth, and for Enrollees 18-21 and 65 and older, Institutions for Mental Disease (IMDs). For purposes of this waiver these facilities would include nursing homes, chronic disease and rehabilitation hospitals, public health hospitals and IMDs (limited to enrollees 18-21 and 65 and older).~~

~~MFP Demonstration qualified participants receiving services from another 1915(c) waiver or receiving State Plan services~~The following individuals may request a transfer to the MFP-RS waiver: MFP-CL, ABI-RH, and ABI-N Waiver Participants;
~~This shall include participants who have completed their participation in the~~MFP Demonstration qualified participants within their MFP Demonstration period; and MFP Demonstration participants within 180 days of the conclusion of their MFP Demonstration period. These applicants will be considered to have met the criteria in items ~~1 and 2~~ above.

Appendix B-3: Number of Individuals Served

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

<input type="radio"/>	Not applicable. The state does not reserve capacity.
<input checked="" type="radio"/>	<p>The State reserves capacity for the following purpose(s). Purpose(s) the State reserves capacity for: Waiver Transfer</p>
Table B-3-c	
	Purpose (provide a title or short description to use for lookup):
	Waiver Transfer
	Purpose (describe):
	The state reserves capacity for individuals who have been receiving service from another 1915(c) waiver or receiving State Plan services who now require the services of the MFP-CL waiver to meet their needs. MFP-CL, ABI-RH, and ABI-N Waiver MFP Demonstration Participants, and MFP Demonstration Participants within their MFP Demonstration period or up to 180 days thereafter, who request a transfer to the MFP-RS Waiver will be considered to have met the additional targeting criteria outlined in Appendix B-1-b items #1 and #2. All such individual must meet the remaining eligibility criteria as outlined in Appendix B-1-b.
	Describe how the amount of reserved capacity was determined:
Waiver Year	The reserved capacity is an estimate of anticipated need for waiver transfers and will be adjusted if necessary based on actual experience.

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		Capacity Reserved
	Year 1	3
	Year 2	3
	Year 3	3
	Year 4 (only if applicable based on Item 1-C)	3
	Year 5 (only if applicable based on Item 1-C)	3

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Appendix C-1/C-3: Summary of Services Covered and Services Specifications

C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services (<i>check each that applies</i>)		
Service	Included	Alternate Service Title (if any)
Case Management	<input type="checkbox"/>	
Homemaker	<input type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input type="checkbox"/>	
Adult Day Health	<input type="checkbox"/>	
Habilitation	<input type="checkbox"/>	
Residential Habilitation	<input checked="" type="checkbox"/>	
Day Habilitation	<input type="checkbox"/>	
Prevocational Services	<input checked="" type="checkbox"/>	
Supported Employment	<input checked="" type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input type="checkbox"/>	
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input type="checkbox"/>	
Other Services (<i>select one</i>)		
<input type="radio"/>	Not applicable	
<input checked="" type="radio"/>	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (<i>list each service by title</i>):	
a.	Addiction Services	
b.	Assisted Living Services	
c.	Community Crisis Stabilization	
d.	Community Psychiatric Support and Treatment (CPST)	

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e.	Day Services
f.	Home Accessibility Adaptations
g.	Individual Support and Community Habilitation
h.	Medication Administration
i.	Occupational Therapy
j.	Orientation and Mobility Services
jk.	Peer Support
kl.	Physical Therapy
lm.	Residential Family Training
mn.	Shared Living – 24 Hour Supports
no.	Skilled Nursing
op.	Specialized Medical Equipment
pq.	Speech Therapy
r.	Transitional Assistance Services
qs.	Transportation

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C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Definition (Scope): Orientation and Mobility Services			
Orientation and Mobility (O&M) services teach an individual with vision impairment or legal blindness how to move or travel safely and independently in his/her home and community and include (a) O&M assessment; (b) training and education provided to Participants; (c) environmental evaluations; (d) caregiver/direct care staff training on sensitivity to blindness/low vision; and (e) information and resources on community living for persons with vision impairment or legal blindness. O&M Services are tailored to the individual's need and may extend beyond residential settings to other community settings as well as public transportation systems.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/> Relative
	<input type="checkbox"/>		<input type="checkbox"/> Legal Guardian
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Certified Orientation and Mobility Specialists (COMS)	Human Service Agencies
Provider Qualifications			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Certified Orientation and Mobility Specialists (COMS)		Individuals providers of Orientation and Mobility Services must have a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from an ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals) -certified university program.	Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual's customary environment. - Knowledge and/or experience in educating caregivers or direct care staff, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with vision impairment or legal blindness, in sensitivity to low vision/blindness.
Human Services Agencies		Individuals providers and individuals employed by the agency providing Orientation	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider

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		<p>and Mobility Services must have a master’s degree in special education with a specialty in orientation and mobility or a bachelor’s degree with a certificate in orientation and mobility from an ACVREP-certified university program.</p>	<p>enrollment process and as such, has successfully demonstrated, at a minimum, the following:</p> <ul style="list-style-type: none"> - Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities. <p>Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies.</p> <p>Staff providing services must have:</p> <ul style="list-style-type: none"> - Master’s degree in special education with a specialty in orientation and mobility; or - Bachelor’s degree with a certificate in orientation and mobility from an ACVREP-certified university program <p>Individuals providing services must also have:</p> <ul style="list-style-type: none"> - Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual’s customary environment.
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Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Orientation and Mobility Specialists (COMS)	Administrative Service Organization	Annually
Human Service Agencies	Administrative Service Organization	Annually

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Service Specification

Service Definition (Scope): Transitional Assistance

Transitional Assistance services are non-recurring personal household set-up expenses for individuals who are transitioning from a nursing facility or hospital or another provider-operated living arrangement to a community living arrangement where the person is directly responsible for his or her own set-up expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) assistance arranging for and supporting the details of the move; (b) essential personal household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone service; (d) moving expenses; and, (e) activities to assess need, arrange for and procure needed resources related to personal household expenses, specialized medical equipment, or community services. Transitional Assistance services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Transitional Assistance services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transitional Assistance – RS services include only those non-recurring set up expenses incurred during the 180 days prior to discharge from a nursing facility or hospital or another provider-operated living arrangement to a community living arrangement or during the period following such a transition during which the participant is establishing his or her living arrangement. Home accessibility adaptations are limited to those which are initiated during the 180 days prior to discharge.

Transitional Assistance – RS services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:	
			Certified Business		

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Certified Business		Certified Business	Will meet applicable State regulations and industry standards for type of goods/services provided.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Business	Massachusetts Rehabilitation Commission	Annually or prior to utilization of service

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Appendix C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Massachusetts Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency, convened an interagency workgroup to address how best to comply with the requirements of the federal Home and Community Based (HCB) settings requirements at 42 CFR 441.301 (c)(4)-(5). The Department of Developmental Services (DDS), an agency within EOHHS that has primary responsibility for day-to-day operation of the MFP-RS waiver, was a member of the workgroup. ~~DDS undertook a review of all their regulations, standards, policies, licensing requirements, and other provider requirements to ensure compliance of settings with the new federal requirements, as they apply within this waiver. The MFP-RS waiver supports individuals in the community in 24-hour residential settings that include: Residential Habilitation, Assisted Living Services or Shared Living—24 Hour Supports.~~

The DDS review and assessment process included: a thorough review of regulations, policies and procedures, waiver service definitions, provider qualifications and quality management and oversight systems to determine whether the systemic infrastructure was consistent with the principles of community integration; development of an assessment tool that borrowed substantially from the exploratory questions that CMS published; ~~and review of existing 24-hour residential and non-residential settings to determine if those settings met standards consistent with the federal HCB settings requirements; and an assessment of specific 24-hour residential settings that staff identified as potentially presumed to have the qualities of an institution.~~

Based upon the DDS review and assessment, all the 24-hour residential settings serving participants in the MFP-RS and the ABI-RH waivers were determined to be in compliance with federal HCB settings requirements with the exception of consistently having locks on all individual participant's bedroom doors and legally enforceable leases. ~~The State identified other policy areas that must be revised to ensure compliance with the federal HCB settings requirements, including: residential guidelines regarding visits by family members, significant others, friends and legal guardians; alcohol and drug abstinence policy; smoking policy; leave of absence policy; and telephone, cable and internet usage policy. DDS will phase in full compliance with these areas over a period of one year. Any modification of these requirements will be determined on an individual participant's needs and situation, and will be incorporated into that participant's Person-Centered Plan as outlined in Appendix D.~~

~~The quality management systems described in the Systemic Assessment section of the STP are the mechanisms through which DDS will monitor providers' and settings' compliance with the HCBS settings rule. While providers are expected to have robust internal quality management and improvement processes, DDS staff—including licensure and certification surveyors, program monitors, and Area and Regional staff—conduct all reviews and monitoring. Should any of the ongoing monitoring indicate a need for a substantive change in the STP, DDS along with MassHealth will revise the STP, complete public input~~

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~~activities, and resubmit the STP for CMS approval. The 24-hour residential setting provider qualifications are reviewed through the DDS licensure and certification process on an on-going basis. All waiver residential providers serving participants in this waiver, that DDS has fully licensed and certified, largely meet the standards established in the HCB settings requirements and, as noted above, will be fully compliant within one year. DDS will be working collaboratively with stakeholders to offer workshops and conferences to highlight practices to further enhance the individual participant's full access to community living and opportunities to receive services in the most integrated setting possible.~~

~~The outcomes identified in the federal HCB settings requirements apply to the following MFP RS non-residential waiver services: day services, supported employment and pre-vocational services. The State continues to assess these settings and establish a timeline for full compliance (see Main Module Attachment #2).~~

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Applicability (from Application Section 3, Components of the Waiver Request):

<input checked="" type="radio"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input type="radio"/>	No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

<input type="radio"/>	Yes. The State requests that this waiver be considered for Independence Plus designation.
<input checked="" type="radio"/>	No. Independence Plus designation is not requested.

Appendix E-1: Overview

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver’s approach to participant direction.

Subject to the limits to be described in the waiver application, participants in this waiver may lead the design of their service delivery through participant direction. The Case Manager will provide consumer-directed options for participants who choose to self-direct one or more services within their Plan of Care (POC) and to have choice and control over the selection and management of waiver services and providers. Participants may choose employer authority which will provide participants the opportunity to hire, manage and dismiss their own workers. Once eligibility has been established, and as part of the initial and on-going planning process of assessment and enrollment into the waiver, the individual is provided information by the Case Manager about the opportunity to self-direct. The Case Manager will describe the responsibilities of employer authority, the role of representatives and the availability of skills training and support for those choosing a participant-directed model of care.

Each year at the time of the POC development process, participants will be given the opportunity to self-direct certain services as specified in this application. The Case Manager will assess, based on established criteria, the participant’s ability to self-direct and what supports may be needed to ensure success.

Each individual who self-directs will have a Case Manager to assist him/her to develop the waiver plan of care, and assist him/her to direct and manage that part of their plan of care that will be self-directed. The Case Manager will assist individuals to access community and natural supports and advocate for the development of new community supports as needed. The Case Manager will ensure that the participant receives necessary support and training on how to hire, manage and train staff and to negotiate with service providers.

A variety of supports are available to assist participants who choose this model. The Case Manager determines whether the participant is able to carry out the responsibilities of an employer without assistance. Participants who require assistance must appoint a representative. Any participant may elect someone to act as his or her representative and assume responsibility for employer functions that

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the participant cannot or chooses not to perform. The Case Manager assists the participant and/or representative in POC development, identification of worker tasks and completion of required forms. In addition the Case Manager will provide or arrange for skills training to the participant and/or representative on employer functions and will link them to other needed resources such as worker training.

Individuals who self-direct and hire their own workers will sign an Agreement for Self Directed Supports and have the authority and responsibility as follows: recruit and hire workers, verify qualifications, determine workers duties, submit time sheets, provide training and supervision, evaluate staff, maintain time sheets, submit employee data to the Fiscal Management Service Agency (FMS) as required, and, if necessary, terminate a worker's employment. Once the POC is complete, information regarding the authorized frequency and duration of the participant-directed services in the POC is forwarded to a FMS.

The FMS performs the payment tasks associated with the employment of a participant's waiver service worker. The participant functions as the common law employer, while the FMS provides fiscal services related to income and social security tax withholding and state worker compensation taxes. The FMS assists participants in verifying worker citizenship status and conducts the Criminal Offender Record Information (CORI) check. The FMS collects and processes the participant's time-sheets.

The FMS will issue appropriate checks in the name of the worker and will mail the check to the MFP waiver participant who will distribute check to the worker. The worker may elect to have the FMS direct deposit payment into the worker's bank account in which case, the participant will notify the FMS to do so.

The FMS is responsible for tracking time worked to enable MassHealth to calculate payments to be made in accordance with FLSA requirements, including but not limited to payments for overtime.

The FMS is required to be utilized by participants and families who choose to hire their own staff and self-direct some or all of their waiver services in their POC. Each calendar year, there must be one FMS entity that is related to each worker in order to comply with IRS tax code requirements. The FMS functions will be recognized as administrative costs.

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APPENDIX I-2: Rates, Billing and Claims

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The rates for all MFP waiver services except the capitated Behavioral Health Diversionary Services (Addiction Services, Community Crisis Stabilization, Community Psychiatric Support and Treatment and Medication Administration) have been established by the Executive Office of Health and Human Services (EOHHS) with the assistance of rate analysis from Center for Health Information and Analysis (CHIA). The rate development process starts with an analysis of available data that may include but not be limited to provider cost, labor and other economic market information, utilization and public agency spending data. A cost adjustment factor is added to account for projected inflation anticipated during the prospective rate period. If appropriate, the data is adjusted to reflect desired economic efficiencies, such as productivity expectations and administrative ceilings. The process includes at least one consultative session to receive input from service providers. In addition, EOHHS has a public hearing for all rate regulations it proposes. Before the public hearing date, there is a public notice that includes the hearing date, time, location and the proposed rates. The public is welcomed to comment in person and/or in writing.

EOHHS is in the process of reviewing the MFP waiver rates according to the process described above. As part of this process, EOHHS is considering consolidation of the ABI and MFP rate regulations into one HCBS rate regulation.

The MFP waiver rates can be found in EOHHS MFP waiver services regulations 101 CMR 357.00. The regulation can be found on the MassHealth website:
www.mass.gov/eohhs/gov/departments/masshealth/.

For Homemaker, Personal Care, Respite, Supported Employment, Adult Companion, Chore Service, Day Services, Home Accessibility Adaptations, Individual Support and Community Habilitation, Specialized Medical Equipment, and Transportation services the existing rates for ABI Waiver services established in the EOHHS regulation at 114.3 CMR 54.00 was utilized. Skilled Nursing services, Occupational, Physical and Speech Therapy services, self-directed Personal Care services and Home Health Aide rates are established based on the comparable state plan Medicaid service rates as established by EOHHS. For other services, such as Prevocational Services, Community Family Training, Independent Living Supports, Peer Support, Shared Home Supports, Supportive Home Care Aide and Vehicle Modification, CHIA developed new rates, as outlined above including utilizing an amalgamation of existing rates for comparable service components based on projected units per week, and analysis of provider cost data to establish the rate. Rates for Transitional Assistance services are based on the reasonable, allowable costs of goods and services provided. Rates for Orientation and Mobility services are based on the rates established for Money Follows the Person Demonstration Services in 101 CMR 356.00.

All costs that are not eligible for federal financial participation, such as room and board, are excluded from the rate computation.

For the capitated Behavioral Health Diversionary Services, the state's actuary, Mercer, estimated expenditures based on recent experience of similar populations. Mercer estimated program

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expenditures for non-dual disabled clients between 19 and 64 years old and adjusted these expenditures, to account for the minimal expected cost impact of Medicare coverage.

The MFP case manager will inform the participant of the availability of information about waiver services payment rates and the EOHHS MFP waiver service regulations.

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Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care (<i>specify</i>):			Hospital, Nursing Facility				
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Column 7 less Column 4)
1	62219.27	9104.01	71323.28	72738.74	3684.62	76423.36	5100.08
2	95819.38	14168.90	109988.28	113149.63	5731.66	118881.29	8893.01
3	110221.98	16289.63	126511.61	130019.61	6586.21	136605.82	10094.21
4	119440.83 120539.47	17705.87	137146.70 138245.34	141251.09	7155.15	148406.24	11259.54 10160.90
5	127242.58 127897.69	18843.06	146085.64 146740.75	150244.87	7610.73	157855.60	11769.96 11114.85

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Appendix J-2: Derivation of Estimates

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	65	28	37
Year 2	120	64	56
Year 3	181	103	78
Year 4 (only appears if applicable based on Item 1-C)	249	147 101	102 148
Year 5 (only appears if applicable based on Item 1-C)	304	183 124	121 180

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.
- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D costs are based on the following:

- Number of Users: The estimated number of users for each waiver service is based on experience with other Massachusetts 1915(c) home and community-based service waivers that serve a similar target group with similar services, where applicable. For services that do not have a comparable waiver service, the estimated number of users is based on state agency experience with similar types of services for similar populations. We estimate that 90% of the 1915(c) waiver population will access a capitated behavioral health service via this concurrent 1915(b)/(c) waiver. This is based on percentages of MassHealth populations that currently do not have access to managed behavioral health care, applied to our total waiver participant projections.
- Average Units per User: The average number of units per user for each service is based on the number of units per user for services included on other Massachusetts 1915(c) home and community based waivers that serve a similar target group with similar services, where applicable. **The average units per user for Day services is based on the actual average units per person for this waiver reported in the most recent CMS-372 Report (Waiver Year 4) with conversion from per diem to 15 minute units.** For services that do not have a comparable waiver service, the estimated average units per user is based on state agency experience with similar

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types of services for similar populations. The enrollee expected utilization of the capitated services are based on utilization of a similar target group. As with all waiver services, this service is adjusted for the estimated average length of stay in each waiver year.

- Average Cost per Unit: The Division of Health Care Finance & Policy (DHCFP) established rates for waiver services are used where applicable. The following services are based on Rates for Acquired Brain Injury Waiver and Related Services 114.3 CMR 54.00: Residential Habilitation, Individual Support and Community Habilitation, Day Services, Occupational Therapy, Physical Therapy, Speech Therapy, Skilled Nursing, ~~Community Based Substance Abuse Services~~, and Supported Employment. **As part of the rate review process for this waiver, EOHHS anticipates transitioning from per diem rates to 15-minute units in Prevocational and Day Services.** The average cost per unit For Residential Habilitation reflects a weighted average of Level 1 and Level 2 rates based on experience to date with waiver the Acquired Brain Injury with Residential Habilitation (ABI-RH) MA.40701. The Skilled Nursing average cost per unit reflects a weighted average of the rate for 1-60 days and the rate for 61 days or more. ~~The Community Based Substance Abuse Services average cost per unit reflects an average of rates for applicable programs for the target population.~~ The average cost per unit for Family Training and Peer Support is based on the DHCFP approved SFY 2011 provisional rates for the Department of Developmental Services Waivers MA.0826 and MA.0827. The Home Health Aide average cost per unit is based on the DHCFP established rate in 114.3 CMR 50.00. **The Orientation and Mobility average cost per unit is based on the rates established for Money Follows the Person Demonstration Services in 101 CMR 356.00. Transitional Assistance cost per unit reflects the average costs reported for Acquired Brain Injury waiver participants during the most recent CMS-372 Report reporting period (ABI Waiver Year 4).** For services that do not currently have a similar waiver service rate, or that are not rate based, average costs per unit were based on expenditures for similar services in state-funded programs in SFY 2011 or SFY 2012. The average cost per unit of the capitated units is based on our actuary Mercer’s estimate of each individual service that will be delivered in a community setting to the target population.

- Trend: Rates described above, except for Behavioral Health Diversionary Services, are trended annually by 3.5%, the Consumer Price Index (CPI) rate, beginning in Waiver Year 2 and forward. There is no trend applied to base year waiver service rates forward to Waiver Year 1, as we do not expect the waiver service rates to increase during this time period. The capitated service cost is trended forward by 4.9% per year, based on Mercer’s calculation of annual trend for these services. Mercer also applied a managed care savings adjustment of -2.4% to the base year SFY 2011.

The cost of services included in the capitation is calculated for each year by determining the aggregate cost of each service included in the capitation by the number of members we project will receive each service in the waiver. The cost of services not included in the capitation is calculated for each year by dividing the total amount for services not included in the capitation (all waiver services except the capitated services) by the number of members we project will enroll in the waiver.

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d. Estimate of Factor D. *Select one:* Note: Selection below is new.

<input type="radio"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input checked="" type="radio"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 (only appears if applicable based on Item 1-C)							
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total							109507.90 187,420.80
Prevocational Services – per diem	<input type="checkbox"/>	Per diem	5	84.00	114.09	47917.80	
Prevocational Services – 15 min	<input type="checkbox"/>	15 min.	5 25	1298.00 588	9.49	61590.10 139,503.00	
Residential Habilitation	<input type="checkbox"/>	Per diem	224	296.00	387.71	25706723.84	25706723.84
Supported Employment	<input type="checkbox"/>	15 min.	7	676.00	9.49	44906.68	44906.68
Addiction Services	<input checked="" type="checkbox"/>	15 min.	40	34.06	17.41	23719.38	23719.38
Assisted Living Services	<input type="checkbox"/>	Per diem	12	296.00	115.90	411676.80	411676.80
Community Crisis Stabilization	<input checked="" type="checkbox"/>	15 min.	78	9.10	37.67	26738.17	26738.17
Community Psychiatric Support and Treatment (CPST)	<input checked="" type="checkbox"/>	15 min.	180	16.52	32.11	95482.30	95482.30
Day Services - Total							1,475,296.77

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Waiver Year: Year 4 (only appears if applicable based on Item 1-C)							
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Services – Per diem	<input type="checkbox"/>	Per diem	100	127.00 95.25	114.09	1448943.00 1,086,707.25	
Day Services – 15 min.	<input type="checkbox"/>	15 min.	122	762.00	4.18	388,589.52	
Home Accessibility Adaptations	<input type="checkbox"/>	Item	2	1.00	16630.77	33261.54	33261.54
Individual Support and Community Habilitation	<input type="checkbox"/>	15 min.	5	973.00	11.42	55558.30	55558.30
Medication Administration	<input checked="" type="checkbox"/>	15 min.	22	2.02	3.44	152.87	152.87
Occupational Therapy	<input type="checkbox"/>	Visit	25	42.00	78.94	82887.00	82887.00
Orientation and Mobility Services	<input type="checkbox"/>	15 min.	1	16.00	31.02	496.32	496.32
Peer Support	<input type="checkbox"/>	15 min.	50	973.00	3.46	168329.00	168329.00
Physical Therapy	<input type="checkbox"/>	Visit	62	42.00	75.72	197174.88	197174.88
Residential Family Training	<input type="checkbox"/>	15 min.	5	191.00	3.46	3304.30	3304.30
Shared Living – 24 Hour Supports	<input type="checkbox"/>	Per diem	12	296.00	171.86	610446.72	610446.72
Skilled Nursing	<input type="checkbox"/>	Visit	12	42.00	80.38	40511.52	40511.52
Specialized Medical Equipment	<input type="checkbox"/>	Item	62	1.00	2523.61	156463.82	156463.82
Speech Therapy	<input type="checkbox"/>	Visit	25	42.00	80.80	84840.00	84840.00
Transitional Assistance	<input type="checkbox"/>	Per episode	34	2.00	2,482.36	135,978.11 168,880.48	168,880.48
Transportation	<input type="checkbox"/>	1-way trip	125	165.00	21.34	440137.50	440137.50
GRAND TOTAL:							29740765.52 30,014,328.99

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Waiver Year: Year 4 (only appears if applicable based on Item 1-C)							
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5		Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total: Services included in capitation							146092.72
Total: Services not included in capitation							29594672.80 29,835,413.90
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							249
FACTOR D (Divide grand total by number of participants)							119440.83 120,539.47
Services included in capitation							586.72
Services not included in capitation							118854.11 119,952.76
AVERAGE LENGTH OF STAY ON THE WAIVER							296

ii. **Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 (only appears if applicable based on Item 1-C)							
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5		Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total							140178.12 173,224.80
Prevocational Services – per diem	<input type="checkbox"/>	Per diem	6 0	87.00 N/A	118.08 N/A	61637.76 N/A	
Prevocational Services – 15 min	<input type="checkbox"/>	15 min.	6 30	1333.00 588.00	9.82	78540.36 173,224.80	
Residential Habilitation	<input type="checkbox"/>	Per diem	274	304.00	401.28	33425018.88	33425018.88
Supported Employment	<input type="checkbox"/>	15 min.	9	694.00	9.82	61335.72	61335.72

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Waiver Year: Year 5 (only appears if applicable based on Item 1-C)							
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5		Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Addiction Services	<input checked="" type="checkbox"/>	15 min.	49	34.87	17.76	30345.27	30345.27
Assisted Living Services	<input type="checkbox"/>	Per diem	15	304.00	119.96	547017.60	547017.60
Community Crisis Stabilization	<input checked="" type="checkbox"/>	15 min.	95	9.37	38.42	34199.56	34199.56
Community Psychiatric Support and Treatment (CPST)	<input checked="" type="checkbox"/>	15 min.	219	17.02	32.75	122071.70	122071.70
Day Services - Total							1,898,355.36
Day Services – Per diem	<input type="checkbox"/>	Per diem	122 0	130.00 N/A	118.08 N/A	1872748.80 N/A	
Day Services – 15 min.	<input type="checkbox"/>	15 min.	149	3,048.00	4.18	1,898,355.36	
Home Accessibility Adaptations	<input type="checkbox"/>	Item	3	1.00	17212.85	54638.55	51638.55
Individual Support and Community Habilitation	<input type="checkbox"/>	15 min.	6	1000.00	11.82	70920.00	70920.00
Medication Administration	<input checked="" type="checkbox"/>	15 min.	27	1.75	3.51	165.85	165.85
Occupational Therapy	<input type="checkbox"/>	Visit	30	43.00	81.70	105393.00	105393.00
Orientation and Mobility Services	<input type="checkbox"/>	15 min.	3	16.00	31.02	1,488.96	1,488.96
Peer Support	<input type="checkbox"/>	15 min.	61	1000.00	3.58	218380.00	218380.00
Physical Therapy	<input type="checkbox"/>	Visit	76	43.00	78.37	256113.16	256113.16
Residential Family Training	<input type="checkbox"/>	15 min.	6	197.00	3.58	4231.56	4231.56

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Waiver Year: Year 5 (only appears if applicable based on Item 1-C)							
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Shared Living – 24 Hour Supports	<input type="checkbox"/>	Per diem	15	304.00	177.88	811132.80	811132.80
Skilled Nursing	<input type="checkbox"/>	Visit	15	43.00	83.19	53657.55	53657.55
Specialized Medical Equipment	<input type="checkbox"/>	Item	76	1.00	2611.94	198507.44	198507.44
Speech Therapy	<input type="checkbox"/>	Visit	30	43.00	83.63	107882.70	107882.70
Transitional Assistance	<input type="checkbox"/>	Per Episode	28	2.00	2,482.36	139,012.16	139,012.16
Transportation	<input type="checkbox"/>	1-way trip	152	170.00	22.09	570805.60	570805.60
GRAND TOTAL:							38681743.85
Total: Services included in capitation							186,782.37
Total: Services not included in capitation							38494961.48 38,694,115.84
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							304
FACTOR D (Divide grand total by number of participants)							127242.58 127,897.69
Services included in capitation							614.42
Services not included in capitation							126628.16 127,283.28
AVERAGE LENGTH OF STAY ON THE WAIVER							304

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Effective Date	