

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

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

1. Request Information

A. The **State of Massachusetts** 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. Program Title:

MFP Residential Supports (MFP-RS)

C. Waiver Number: MA.1028

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)

09/01/16

Approved Effective Date of Waiver being Amended: 04/01/13

2. 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.

3. 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, Attachr
<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, C-5
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	

Component of the Approved Waiver	Subsection(s)
<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 type="checkbox"/> Appendix H	
<input checked="" type="checkbox"/> Appendix I – Financial Accountability	I-2-a
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	J-a, 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):

- Modify target group(s)**
- Modify Medicaid eligibility**
- Add/delete services**
- Revise service specifications**
- Revise provider qualifications**
- Increase/decrease number of participants**
- Revise cost neutrality demonstration**
- Add participant-direction of services**
- Other**

Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of **Massachusetts** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (optional - this title will be used to locate this waiver in the finder):

MFP Residential Supports (MFP-RS)

C. Type of Request: amendment

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

- 3 years 5 years

Draft ID: MA.016.00.03

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/13

Approved Effective Date of Waiver being Amended: 04/01/13

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

- Hospital**

Select applicable level of care

- Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

Chronic and Rehabilitation Hospital, Psychiatric Hospital for participants age 18 thru 21 or age 65 and older.

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR §§440.40 and 42 CFR §§440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Money Follows the Person Behavioral Health Waiver application. This waiver application has been submitted.

Specify the §1915(b) authorities under which this program operates (check each that applies):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Goals and Objectives:

The goal of the Massachusetts MFP Residential Supports Waiver (MFP-RS) is to transition qualified Massachusetts Medicaid-eligible persons from nursing facilities, chronic or rehabilitation hospitals and psychiatric hospitals (for participants 18 - 21 or age 65 and older) to qualified community settings providing 24 hour supports and to furnish home or community-based services to the waiver participants following their transition from the medical facility setting.

Organizational Structure:

The Department of Developmental Services (DDS), a state agency within the Executive Office of Health and Human Services (EOHHS), is the lead agency responsible for day-to-day operation of this waiver. The Executive Office of Health and Human Services, the Single State Medicaid Agency, oversees DDS's operation of the waiver. DDS and the Massachusetts Rehabilitation Commission (MRC), a state agency within the Executive Office of Health and Human Services, collaborate in the oversight of the contracted Level of Care Entity and Administrative Service Organization.

Case Management and Service Delivery:

Case Management for the MFP-RS waiver will be provided by DDS. DDS will be responsible for participant needs assessment, service plan development and service authorization activities. Clinical determination of eligibility and level of care redetermination is conducted by nurses at the contracted Level of Care Entity. DDS will collaborate with MRC, a state agency within EOHHS, for the oversight of waiver clinical eligibility functions.

MFP-RS waiver services will be provided pursuant to a Plan of Care(POC) that is developed with the Waiver participant through a person-centered planning process. The POC will be developed by an interdisciplinary team that is coordinated by the DDS Case Manager and includes the participant, his/her guardian if any, relevant waiver service providers, other persons as chosen by the applicant and other appropriate professionals. The POC planning process will determine what MFP-RS waiver services, including their need for Residential Habilitation, Assisted Living Services or Shared Living - 24 Hour Supports services within the terms of the MFP-RS Waiver, and other supports that the waiver participant will need to live safely in the community.

This waiver will be operated concurrently with a 1915(b) MFP Behavioral Health Waiver in order to provide access to managed behavioral health services to disabled or elderly waiver participants with concurrent behavioral health needs.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- | |
|--|
| <ul style="list-style-type: none"> <input checked="" type="radio"/> Yes. This waiver provides participant direction opportunities. <i>Appendix E is required.</i> <input type="radio"/> No. This waiver does not provide participant direction opportunities. <i>Appendix E is not required.</i> |
|--|

- F. Participant Rights.** **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** **Appendix H** contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
- As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
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 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.

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Massachusetts**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Massachusetts**

Zip:

Phone:(617) 624-7554 Ext: TTY**Fax:**

(617) 624-7578

E-mail:

Helen.Quinn@MassMail.State.MA.US

8. 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:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

Tsai

First Name:

Daniel

Title:

Assistant Secretary and Director of MassHealth

Agency:

Executive Office of Health and Human Services

Address:

One Ashburton Place

Address 2:

11th Floor

City:

Boston

State:

Massachusetts

Zip:

02108

Phone: Ext: TTY**Fax:**

(617) 573-1894

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.
- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the 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 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.

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.

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. All waiver providers will be subject to ongoing review on the schedule outlined in Appendix C of the waiver application.

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 has engaged in an extensive process to obtain public review and input of the Massachusetts Statewide Transition Plan, as described in detail in the STP submitted to CMS in September 2016.

The State is committed to transparency during both the STP planning and 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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

The Department of Developmental Services. While DDS is organized under EOHHS and subject to its oversight authority, it is a separate agency established by and subject to its own enabling legislation.

(Complete item A-2-a).

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

a) a) The Executive Office of Health and Human Services (EOHHS) contracts with a Level of Care entity which is responsible for determinations of clinical eligibility for the waiver and level of care redetermination.

EOHHS also contracts with an Administrative Service Organization (ASO) which is responsible for managing the expansion and oversight of the waiver service provider network of MassHealth providers.

As indicated in Appendix A-1 this waiver is operated by the Department of Developmental Services (DDS), a state agency within the single state agency, the Executive Office of Health and Human Services (EOHHS). Consistent with the concurrently operating MFP Community Living Waiver (MA.1027) the Massachusetts Rehabilitation Commission (MRC), another state agency within EOHHS has primary responsibility for oversight of the contracted Level of Care entity and Administrative Service Organization. MRC and DDS will collaborate in the oversight of these contracts as they relate to this waiver.

This oversight will include ensuring that the Level of Care entity adheres to the contractual obligations

imposed on them for performing clinical eligibility, provide any necessary training, and collect and report information on waiver enrollment.

MRC, with the collaboration of DDS, will work with the contractors to provide any necessary training, regarding their performance of waiver functions and will collect and report information on waiver enrollees' utilization and experience with waiver enrollment.

MRC and DDS will conduct annual on-site audits of the LOC and ASO entity. Summary reports from these audits are submitted to the Office of Medicaid for review. In addition, the LOC and ASO submit reports for specific performance management indicators to both DDS and OOM on at least a semi-annual basis.

b) DDS and MRC have entered into Interagency Services Agreements with Office of Medicaid (OOM) to document the responsibility for performing and reporting on these functions.

c) The Office of Medicaid (OOM), within the Executive Office of Health and Human Services (EOHHS) the single state agency, will administer and oversee performance of the waiver. Initially, OOM will meet with DDS staff on at least a monthly basis regarding the performance of these activities as well as to collect and report data and other information collected from DDS to CMS. OOM will also oversee MRC and DDS in their oversight of the contracted Level of Care and Administrative Service Organization contractors in the performance of their duties for this waiver. Once waiver operations have been established the frequency of oversight meetings will be re-evaluated. The Medicaid Director reviews and signs all waiver applications, amendments and waiver reports to CMS.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

- 3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The Medicaid agency contracts with a Level of Care entity to perform initial waiver eligibility assessments and annual redeterminations of clinical eligibility for the waiver. The Level of Care entity will verify MassHealth eligibility for participants. The Registered Nurses who are responsible for performing level of care re-evaluations will be staff of the Level of Care entity as previously described.

The Medicaid agency contracts with an Administrative Service Organization (ASO). The ASO solicits direct service providers, assists these providers in executing MassHealth provider agreements, verifies vendor qualifications and conducts vendor and quality monitoring activities. The ASO assumes or subcontracts billing agent responsibilities, and conducts customer service activities for both direct service providers and waiver participants.

The ASO engages in multiple third party administrator activities including the following:

- Recruiting and facilitating enrollment of waiver service providers in MassHealth so that waiver services and service locations are available and accessible to waiver participants.
- Establishing and using OOM-approved enrollment criteria for ensuring that waiver service providers are qualified to provide the appropriate waiver services.
- Assisting waiver service providers, as needed, with various aspects of waiver service claims processing and

other related transactions.

- Identifying quality issues and concerns for OOM and DDS.
- Undertaking training activities as appropriate for providers and their staff.

The Medicaid agency contracts with Fiscal Management Service (FMS) entities that will be responsible for supporting the participant as the employer of self-directed services as outlined in Appendix E. The State will manage the performance of the FMS via contract, including review of performance metrics and required monthly reports.

- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

MRC, with the collaboration of DDS will oversee and assess the performance of the administrative services organization that will monitor the performance of waiver service providers. DDS will report to OOM on at least a semi-annual basis regarding these activities and any issues or concerns regarding same.

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Massachusetts Rehabilitation Commission (MRC), with the collaboration of the Department of Developmental Services (DDS) will conduct an on-site audit of the Level of Care entity annually. The audit includes review of all waiver functions this entity performs on behalf of the Medicaid agency. As part of the audit process a random sample of waiver participants is selected. Both paper and electronic records are reviewed, as feasible, for this sample for compliance with identified compliance measures and quality indicators. Key informant interviews may be conducted to learn about agency practices and procedures.

The MRC, with the collaboration of DDS, will audit the Administrative Services Organization (ASO) annually. The audit includes review of all waiver functions this entity performs on behalf of the Medicaid agency. Review of the ASO will include examination of the functions outlined in A-3, including recordkeeping, efficiencies and general performance.

In addition, the ASO and the Level of Care entity will submit reports of identified performance and management indicators to DDS/ OOM on at least a semi-annual basis. MRC, with the collaboration of DDS, will be responsible for the annual submission of specific indicators and summary findings for waiver service and administrative oversight to the OOM.

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. Methods for Discovery: Administrative Authority**

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Participants are supported by competent and qualified case managers. (Number of Case Managers with a rating of “meets expectations” or “exceeds expectations” on their performance evaluations/ Number of Case Managers due for performance evaluation)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Performance Evaluations

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

The ASO reviews waiver service providers in accordance with the requirements and schedule outlined in the contract with the Medicaid Agency. (Number of service provider reviews conducted by ASO/Number of service providers due for review)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%; height: 20px;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Service Organization	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

OOM, MRC, DDS and the Fiscal Management Service agencies (FMS) work collaboratively to ensure systematic and continuous data collection and analysis of the FMS entity functions and systems, as evidenced by the timely and appropriate submission of required data reports. (The number of FMS reports submitted on time and in the correct format/Number of FMS reports due)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: Fiscal Management Service agencies	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: [Dropdown]
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: [Dropdown]
	<input type="checkbox"/> Other Specify: [Dropdown]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: [Dropdown]	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: [Dropdown]

Performance Measure:

% of annual redeterminations with a completed Waiver LOC determination instrument before the end of 365 days. (Number of annual redeterminations with a completed Waiver LOC determination instrument before the end of 365 days/ Total number of individuals needing annual redeterminations)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Entity reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Level of Care Entity	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The State Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Level of Care entity and the Administrative Service Organization. As problems are discovered with the management of the waiver program, the Department of Developmental Services (DDS) and the Office of Medicaid are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, DDS is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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 one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					

Target Group	Included	Target SubGroup	Minimum Age				Maximum Age	
							Maximum Age Limit	No Maximum Age Limit
	<input checked="" type="checkbox"/>	Aged	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"/>	Intellectual Disability						<input type="checkbox"/>
<input checked="" type="checkbox"/> Mental Illness								
	<input checked="" type="checkbox"/>	Mental Illness	18			64		
	<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) 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);
2. Meet the level of care criteria as specified in Appendix B.6.d.;
3. Be able to be safely served in the community within the terms of the MFP-RS Waiver;
4. In transitioning to the community setting from a facility, move to a qualified residence (i.e. a setting that meets the applicable requirements of the Community Rule (42 CFR 441.301(c)(4)).

The following individuals may request a transfer to the MFP-RS waiver: MFP-CL, ABI-RH, and ABI-N Waiver Participants; 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 item 1 above.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- Not applicable. There is no maximum age limit
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Not Applicable. There is no maximum age limit.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (*select one*):

- The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

- Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	<input type="text" value="65"/>
Year 2	<input type="text" value="120"/>
Year 3	<input type="text" value="181"/>

Waiver Year	Unduplicated Number of Participants
Year 4	249
Year 5	304

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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)*:

- Not applicable. The state does not reserve capacity.**
- The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Waiver Transfer	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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 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 item #1. 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:

The reserved capacity is an estimate of anticipated need for waiver transfers and will be adjusted if necessary based on actual experience.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	3
Year 2	3
Year 3	3
Year 4	3
Year 5	3

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- The waiver is not subject to a phase-in or a phase-out schedule.**
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- Waiver capacity is allocated/managed on a statewide basis.**
- Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

1. Applicants for the MFP-RS waiver shall meet all requirements for eligibility in Massachusetts' Medicaid program, including, without limitation, all regulations establishing medical assistance eligibility requirements related to the filing of applications for assistance, verifications, re-determinations, existence of a disabling condition, citizenship status, residency, institutional status, assistance unit composition and income and asset limits.

2. There is a limit on the number of participants in the waiver. Waiver entrance is managed against the approved limit. Applicants will be assessed on a first come first served basis based on the date of their application for the waiver. Entrance to the waiver is offered to individuals based on the date of their eligibility determination, with the ability to accommodate applicants meeting the criteria for the reserved capacity category.

3. Any applicants who are denied entry to the waiver will be offered the opportunity to request a fair hearing as noted in Appendix F.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- §1634 State
 SSI Criteria State
 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No
 Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- Low income families with children as provided in §1931 of the Act
 SSI recipients
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
 Optional State supplement recipients
 Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
 % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
 Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
 Medically needy in 209(b) States (42 CFR §435.330)
 Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
 Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**
- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- A special income level equal to:**

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- A dollar amount which is lower than 300%.**

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- Aged and disabled individuals who have income at:**

Select one:

- 100% of FPL**
- % of FPL, which is lower than 100%.**

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.**

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (select one):

- Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

- b. Regular Post-Eligibility Treatment of Income: SSI State.**

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

- i. Allowance for the needs of the waiver participant (select one):**

- The following standard included under the State plan**

Select one:

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of the FBR, which is less than 300%**

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:**

Specify:

- Other**

Specify:

ii. Allowance for the spouse only (select one):

- Not Applicable (see instructions)**
- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)**
- AFDC need standard**
- Medically needy income standard**

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- The following standard included under the State plan**

Select one:

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons**

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of the FBR, which is less than 300%

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

- The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

ii. Allowance for the spouse only (select one):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional State supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**
- A percentage of the Federal poverty level**

Specify percentage:

- The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- The following formula is used to determine the needs allowance:**

Specify formula:

- Other**

Specify:

300% of the SSI Federal Benefit Rate (FBR)

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- Allowance is the same**
 Allowance is different.

Explanation of difference:

- iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
 b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
 The State does not establish reasonable limits.
 The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires

regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The State requires (select one):

- The provision of waiver services at least monthly**
 Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Waiver services must be scheduled on at least a monthly basis. The participant's case manager will be responsible for monitoring on at least a monthly basis when the individual doesn't receive scheduled services for longer than one month (for example when absent from the home due to hospitalization). Monitoring may include face-to-face or telephone contact with the participant and may also include collateral contact with formal or informal supports. These contacts will be documented in the participant's case record.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (select one):

- Directly by the Medicaid agency**
 By the operating agency specified in Appendix A
 By an entity under contract with the Medicaid agency.

Specify the entity:

Registered nurses from the level of care entity are responsible for making initial level of care decisions and performing level of care reevaluations.

- Other**
Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The registered nurse performing waiver evaluations must:

Possess a valid license issued by the Massachusetts Board of Registration of Nursing and be in good standing;

Have knowledge and applicable experience working with frail elders, individuals with disabilities and their families;

Have knowledge of Medicaid, state agencies and the provider service system and community based resources available to serve persons with disabilities or elders; and

Have a minimum of two years of experience with home care, discharge planning, service planning and performing clinical eligibility determinations.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

A person will be considered to meet a nursing facility level of care if the individual meets the criteria as defined in 130 CMR 456.409 (MassHealth Nursing Facility Regulation that describe the requirements for medical eligibility for

nursing facility services). The MassHealth nursing facility provider regulations define in 130 CMR 456.409 the nursing facility level of care criteria. To be considered medically eligible for nursing facility services, you must require one skilled service daily or require a combination of at least three services that support activities of daily living and nursing services, one such service of which must be a nursing service.

Alternatively, a person will be considered to meet a chronic/rehabilitation hospital or a psychiatric hospital (only for those 18 -21 or 65 years of age or older) level of care if the individual has a medical, cognitive, or psychiatric condition that results in cognitive, behavioral and/or functional deficits that require assistance or support, for at least three needs, from within the categories described below, at least one of which must be from category II (Behavior Intervention) or category III (Cognitive Abilities). Regardless of whether an individual exhibits one or more impairments in category IV (Functional and Independent Living Skill Development) this category may count as a maximum of one deficit for purposes of determining eligibility.

I. Assistance with Activities of Daily Living (ADL) and Nursing Needs

A. ADL assistance includes continual supervision required throughout the task or activity, or daily limited, extensive, maximal physical assistance, or total dependence per MDS-HC, for needs with the following activities

1. Bathing - complete body bath via tub, shower or bathing system
2. Dressing - dressed in street clothes including underwear
3. Toileting - assistance to & from toilet, includes catheter, urostomy or colostomy care
4. Transfers - assistance to & from bed, chair or wheelchair
5. Locomotion Inside and Outside Home - movement inside and outside the home, excluding stairs. Note if the participant uses a wheelchair, self-sufficiency once in wheelchair
6. Eating - does not include meal or tray preparation
7. Bed Mobility-requires physical assistance of at least one person to change positions while in bed.

B. Nursing Services. Nursing services, including any of the following procedures performed at least three times a week, may be counted in the determination of eligibility:

1. Any physician-ordered skilled service specified in 130 CMR 456.409(A) (MassHealth Nursing Facility Regulation that describes the skilled service requirement for nursing facility eligibility);
2. Positioning while in bed or a chair as part of the written care plan;
3. Administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions;
4. Physician-ordered occupational, physical, speech/language therapy or some combination of the three;
5. Physician-ordered licensed registered nursing observation and/or vital-signs monitoring, specifically related to the need for medical or nursing intervention; and
6. 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.

II. Behavior Intervention - Staff intervention required for selected types of behaviors that are generally considered to present excessive risk of harm to self or others, or 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. Risk indicators and behaviors include:

1. Wandering or getting lost
2. Verbally abusive
3. Physically abusive (physically assaultive/exhibition of violence toward others)
4. Socially inappropriate/disruptive behavior that requires ongoing and consistent staff intervention, including problematic sexual behaviors (impulsivity, public masturbation, inappropriate sexual advances)
5. Inability to avoid simple dangers, to react appropriately to unsafe situations (ability to exit building in response to fire/natural disaster) and/or to curtail activities that create dangers to self or others such as fire safety issues, including unsafe smoking practices, unsafe cooking, fire setting behaviors
6. Substance abuse
7. History of non-adherence to treatment and/or medication regimens
8. Suicidal ideation or attempts

III. Cognitive Abilities:

1. Communication which includes Receptive language (comprehension) in the individual's native language - Ability to understand through any means such as verbal, written, sign language, Braille, computer technology or communication board;
2. Expressive language in the individual's native language - Ability to express needs through any means such as verbal, written, sign language, Braille, computer technology or communication board;
3. Memory and Learning - Ability to learn, understand, retain or retrieve information for purposes of habilitating day to day and generally managing within one's environment;
4. Orientation - Requiring ongoing and consistent staff intervention for reality orientation related to a specific diagnosis as diagnosed by a licensed clinician.

IV. Functional and Independent Living Skill Development

1. Meal preparation,
 2. Ordinary Housework (includes laundry)
 3. Budgeting and Personal Finances
 4. Managing Medications
 5. Outdoor Mobility
 6. Transportation
 7. Grocery Shopping
 8. Personal Hygiene
- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
 - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The MDS-HC, plus several additional assessment questions, are used for re-evaluation of level of care for the waiver. The additional questions are used to document the skilled nursing needs and their frequency, staff monitoring, oversight or intervention required for behavior intervention and staff intervention needed for memory and learning and reality orientation.

The MDS-HC is the same tool used by nursing facilities to evaluate level of care. Chronic and rehabilitation hospitals assess for level of care utilizing the Medicare Adult Appropriateness Evaluation Protocol (AEP) utilized by the Peer Review Organization. Psychiatric hospitals assessment of level of care is documented by the attending physician utilizing an admission certification form and the continued need for psychiatric hospital level of care is documented by the attending physician and the social worker in progress notes.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Evaluation- A Registered Nurse from the Level of Care entity will be responsible for reviewing the most recent assessment performed in the medical facility. The nurse will use this information to screen each waiver applicant to determine whether they meet the criteria outlined in Appendix B-1-a and B-1-b. For participants transferring from another 1915(c) waiver the Registered Nurse may either review the most recent level of care assessment performed for that waiver, or conduct an updated assessment to confirm that the participant meets a nursing facility or hospital level of care.

Re-evaluation- A registered nurse from the contracted Level of Care entity makes an evaluation of each waiver participant. Information gathered for the re-evaluation of level of care is derived from face to face interviews and includes a thorough evaluation of the client's individual circumstances and medical records.

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):
- Every three months**

- Every six months
 Every twelve months
 Other schedule
 Specify the other schedule:

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
 The qualifications are different.
 Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

The Level of Care entity will maintain a database of waiver participants, the dates of level of care evaluations and dates for re-evaluation. They will be responsible for ensuring that the re-evaluation is triggered 60 days prior to the date it is due. Through the use of management reports registered nurses are provided with the data needed to ensure timely completion of reevaluation. The nurse documents the results of the re-evaluation using the MDS-HC, additional assessment questions and case notes. Level of Care entity reports to DDS include the date each Level of Care (LOC) re-evaluation is completed and the results of the level of care determination. State monitoring is conducted on a sample of records to ensure that re-evaluations have been conducted in accordance with all requirements. In addition, MRC, in collaboration with DDS, will conduct periodic site visits and annual assessments of the Level of Care entity.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Determinations of level of care are maintained in electronic and paper records at the Level of Care entity offices. Paper records are maintained for each waiver participant in accordance with 808 CMR 1.00. (The State's Division of Purchased Services regulations that describe the contract compliance, financial reporting and auditing requirements applicable to state procurements of human and social services).

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

- i. Sub-Assurances:**

- a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

% of applicants who received an initial clinical eligibility assessment within 90 days of waiver application. (Number of individuals who received an initial clinical eligibility assessment within 90 days of waiver application/ Number of individuals who received an initial clinical eligibility assessment)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Entity reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Level of Care Entity	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. **Sub-assurance:** *The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
No longer needed given new QM system.

Data Source (Select one):

Other

If 'Other' is selected, specify:

No longer needed

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: No longer needed	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: No longer needed
	<input checked="" type="checkbox"/> Other Specify: No longer needed	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: No longer needed	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: No longer needed

c. **Sub-assurance:** *The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

% of applicants whose clinical eligibility assessment is documented in accordance with waiver requirements. (Number of applicants whose clinical eligibility

assessment was documented in accordance with waiver requirements/ Number of applicants whose clinical eligibility assessment was documented)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Entity reports

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Level of Care Entity	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
% of clinical determinations of "denial" that have been reviewed for appropriateness of denial. (Number of denials reviewed/ Number of denials)

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Entity reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Level of Care entity	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The State Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Level of Care entity and the Administrative Service Organization. As problems are discovered with the management of the waiver program, the Department of Developmental Services (DDS) and the Office of Medicaid are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, DDS is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

- ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Once initial waiver eligibility has been determined, the Case Manager delivers a Recipient Choice Form to the participant (or legal representative) either in person or by mail. This form includes written notification that the participant has been determined eligible for the waiver and offers the applicant the opportunity to choose between community-based or facility-based services. The participant indicates his/her preference on the Recipient Choice Form. The signed and dated form is maintained by the case manager in the client record. If the participant chooses to receive community-based services, the Case Manager informs the participant of the services available under the waiver as part of the person-centered service plan development process.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Recipient Choice Form is maintained in the client record at DDS' offices.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Office of Medicaid has made MassHealth eligibility notices and information regarding appeal rights, available in English and Spanish. In addition, these notices include a card instructing individuals in multiple languages that the information affects their health benefit, and to contact MassHealth Customer Service for assistance with translation.

DDS has developed multiple approaches to promote and help ensure access to the waiver for Limited English Proficient persons. One of the central methods is a contractual relationship established between DDS and the Multicultural Services

Translation Center in order to provide written information to families and individuals with Limited English Proficiency in their primary language. This includes information such as applications, brochures, forms that need to be signed by individuals and family members/guardians, service plans, etc. General Waiver and service information needed by families is typically translated into six languages, other than English, which are most commonly spoken by residents in Massachusetts. This includes Spanish, Portuguese, Chinese, Russian, Vietnamese, and Khmer. The Translation Center has a roster of translators and interpreters for other languages as well so that DDS can respond to the need of families who speak languages beyond those listed previously, such as Haitian Creole or French. In addition to providing translated information, interpreters are made available when needed to enable individuals and family members to fully participate in planning meetings. These interpreters can be made available through the Multicultural Services Translation Center or through other local providers under state contract.

Another important method DDS utilizes to promote access to Waiver services is by working to build capacity among service providers to become more culturally responsive in their delivery of services. One central effort involves building in contractual requirements stipulating that providers must be responsive to the specific ethnic, cultural, and linguistic needs of families in the geographic area they serve. It is expected that this is addressed in multiple ways including outreach efforts, hiring of bi-lingual and bicultural staff, providing information in the primary languages of the individuals and families receiving services, and developing working relationships with other multi-cultural community organizations in their communities. Another approach involves working collaboratively with minority community organizations that provide an array of social services to help in outreach to identify individuals and families who may be eligible for services from DDS and through the Waiver, as well as to build their capacity to provide waiver services. This is especially relevant in certain communities in which the presence of a “trusted member” from that particular ethnic and linguistic community is critical for individuals and families to be open to accepting disability related support services, such as in the Vietnamese, Cambodian, and Haitian communities.

DDS is committed to continue to develop and enhance efforts to provide meaningful access to services by individuals with Limited English Proficiency.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** *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:*

Service Type	Service		
Statutory Service	Prevocational Services		
Statutory Service	Residential Habilitation		
Statutory Service	Supported Employment		
Other Service	Addiction Services		
Other Service	Assisted Living Services		
Other Service	Community Crisis Stabilization		
Other Service	Community Psychiatric Support and Treatment		
Other Service	Day Services		
Other Service	Home Accessibility Adaptations		
Other Service	Individual Support and Community Habilitation		
Other Service	Medication Administration		
Other Service	Occupational Therapy		
Other Service	Orientation and Mobility Services		
Other Service	Peer Support		
Other Service	Physical Therapy		
Other Service	Residential Family Training		
Other Service	Shared Living - 24 Hour Supports		
Other Service	Skilled Nursing		
Other Service	Specialized Medical Equipment		
Other Service	Speech Therapy		

Service Type	Service		
Other Service	Transitional Assistance Services		
Other Service	Transportation		

Appendix C: Participant Services

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 Type:

Statutory Service 

Service:

Prevocational Services 

Alternate Service Title (if any):

 

HCBS Taxonomy:

Category 1:

 

Sub-Category 1:

Category 2:

 

Sub-Category 2:

Category 3:

 

Sub-Category 3:

Category 4:

 

Sub-Category 4:

Service Definition (Scope):

Prevocational Services comprises a range of learning and experiential type activities that prepare a participant for paid or unpaid employment in an integrated, community setting. Services are not job-task oriented but instead, aimed at a generalized result (e.g. attention span, motor skills). The service may include teaching such concepts as attendance, task completion, problem solving and safety as well as social skills training, improving attention span, and developing or improving motor skills. Basic skill-building activities are expected to specifically involve strategies to enhance a participant's employability in integrated, community settings.

The amount, duration and scope of Prevocational Services provided to a participant is based on an assessment of the participant's pre-employment needs that arise as a result of his or her functional limitations and/or conditions, including services that enable the participant to acquire, improve, retain/maintain, and prevent deterioration of functioning consistent with the participant's interests, strengths, priorities, abilities and capabilities.

Services are reflected in the participant's individualized service plan and are directed to address habilitative or rehabilitative rather than explicit employment objectives. Prevocational services may be provided one-to-one or in a group format. This service may be provided as a site-based service, in community settings or in a combination of these settings and must include integrated community activities that support the development of

vocational skills. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Service Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Prevocational Service Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:

- Education, Training, Supervision: Providers are responsible for ensuring staff are trained on:
- Applicable regulations and policies governing waiver service delivery and the principles of participant-centered, community-based care.
- Potential cognitive and/or mental health issues as well as physical needs of participants with disabilities
- All aspects of their job duties, including handling a range of potential emergency situations. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists.
- Adherence to Continuous QI Practices: Providers must have established strategies to prevent,

detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.

- Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate.

- Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies.

- Policies/Procedures: Providers must have policies and procedures that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

- Agencies must ensure that staff who provide Prevocational services: have been Criminal Offender Record Information (CORI) checked, have a College degree plus experience in providing community-based services to individuals with disabilities, or at least two years comparable community-based, life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information.

Physical Plant:

- Understanding and compliance with all required policies, procedures, and physical plant standards relevant to the community setting as established by MRC.

- Demonstrated compliance with health and safety, accessibility standards and the ADA, as applicable.

Providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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 Type:

Statutory Service ▼

Service:

Residential Habilitation ▼

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

Category 2:**Sub-Category 2:**

Category 3:**Sub-Category 3:**

Category 4:**Sub-Category 4:**

Service Definition (Scope):

Residential Habilitation consists of ongoing services and supports, by paid staff in a provider-operated residential setting, that are designed to assist individuals to acquire, maintain or improve the skills necessary to live in a non-institutional setting. Residential habilitation provides individuals with daily staff intervention for care, supervision and skills training in activities of daily living, home management and community integration in a qualified provider-operated residence, with no more than 4 non-related residents, and with 24 hour staffing. Residential Habilitation includes individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports (such as safety sign recognition and money management), and social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision. This service may include the provision of medical and health care services that are integral to meeting the daily needs of participants.

Provider owned or leased facilities where residential habilitation services are furnished must be compliant with the American with Disabilities Act. Residential habilitation will be provided in settings with at least two and no more than four individuals residing in the setting and receiving the service.

Residential Habilitation is not available to individuals who live with their immediate family unless the immediate family member (grandparent, parent, sibling or spouse) is also eligible for residential habilitation supports and had received prior authorization, as applicable, for residential habilitation. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5. Payment is not made, directly or indirectly, to members of the individual's family, except as provided in Appendix C-2.

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Habilitation Service Agencies

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency ▼

Provider Type:

Residential Habilitation Service Agencies

Provider Qualifications**License (specify):**

115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations) or 104 CMR Chapter 28 (Department of Mental Health regulations governing Licensing and Operational Standards for Community Programs).

Certificate (specify):

Residential Habilitation Provider employees must have a High School diploma, GED or relevant equivalencies or competencies.

Other Standard (specify):

Residential Habilitation Provider employees must possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Developmental Services (DDS) Office of Quality Enhancement, Survey and Certification staff.

Frequency of Verification:

every two years

Appendix C: Participant Services**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 Type:

Statutory Service ▼

Service:

Supported Employment ▼

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

Sub-Category 1:**Category 2:**

Sub-Category 2:**Category 3:**

Sub-Category 3:**Category 4:**

Sub-Category 4:**Service Definition (Scope):**

Supported employment services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an individual's supported employment program.

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

This service is not for use to provide continuous long-term 1:1 on the job support to enable an individual to complete work activities.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Employment Services Agencies

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Supported Employment****Provider Category:**Agency **Provider Type:**

Community-Based Employment Services Agencies

Provider Qualifications**License (specify):**


Certificate (specify):


Other Standard (specify):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has demonstrated the experience and ability to successfully provide four components of supported employment programs, including Assessment, Placement, Initial Employment Supports and Extended Employment Supports, as specified by the MassHealth agency and to meet, at a minimum, the following requirements:

Program:

- Experience providing supported employment services
- Demonstrated experience and/or willingness to work effectively with the MassHealth agency or its designee, with the Case Managers responsible for oversight and monitoring of the participants receiving these services, with the participants and their family/significant others;
- Adequate organizational structure to support the delivery and supervision of supported employment services, including:
 - Ability to appropriately assess participants' needs; obtain evaluative consultations; provide job development, matching and placement services; ensure necessary supports for employment (coaching/counseling/ training, transportation, accommodations, assistive technology); provide initial and extended supports to maintain job stability and retention, as appropriate; and respond to crisis situations;
 - Demonstrated ability to produce timely, complete and quality documentation including but not limited to assessments, incident reports, progress reports and program-specific service plans
 - Demonstrated compliance with health and safety standards, as applicable.
 - Demonstrated ability to work with and have established linkages with community employers; proven participant marketing/employer outreach strategies; developed employer education materials; plan for regular and on-going employer communication
 - Demonstrated compliance with health and safety, and Department of Labor standards, as applicable.

Staff and Training:

- Experience recruiting and maintaining qualified staff; assurance that all staff will be CORI checked; policies/practices which ensure that:

- There is a team approach to service delivery
- Program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principals of participant choice, as it relates to those with disabilities.

Quality:

- Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Every two years

Appendix C: Participant Services

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 Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Addiction Services

HCBS Taxonomy:

Category 1:



Sub-Category 1:

Category 2:



Sub-Category 2:

Category 3:



Sub-Category 3:

Category 4:



Sub-Category 4:

Service Definition (Scope):

Addiction services include an array of person-centered outpatient and intensive outpatient addiction treatment interventions consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors. These services are not otherwise covered in the Medicaid State Plan. Addiction treatment interventions are designed to help individuals achieve changes in their substance abuse behaviors. Addiction interventions include:

- Ambulatory detoxification to stabilize the individual's medical condition under circumstances where neither

life nor significant bodily functions are threatened.

- Clinically intensive, structured day and/or evening substance use disorder therapeutic interventions. These interventions can be utilized to transition an individual in the continuum of care for an individual being discharged from acute substance abuse treatment, or can be utilized by individuals, who need outpatient services, but who also need more structured treatment for a substance use disorder.

Addiction services are provided in Massachusetts Department of Public Health licensed mental health or substance abuse clinic settings.

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

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Addiction Service Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Addiction Services

Provider Category:

Agency

Provider Type:

Addiction Service Providers

Provider Qualifications

License (*specify*):

Services are provided in Massachusetts Department of Public Health-licensed freestanding facilities skilled in addiction recovery treatment in accordance with 105 CMR 164.000 (Department of Public Health regulations regarding the standards for the licensure and operation of all substance abuse treatment programs in Massachusetts); or in Massachusetts Department of Public Health-licensed outpatient departments in acute care hospitals in accordance with 105 CMR 130.000 (Department of Public Health Hospital Licensure Regulations that describe the standards for the maintenance and operations of hospitals in Massachusetts.); or in Massachusetts Department of Public Health-licensed clinics in accordance with 105 CMR 140.00 (Department of Public Health regulations regarding the standards for the licensure of clinics in Massachusetts).

Certificate (*specify*):

Other Standard (*specify*):

Detoxification interventions must be provided in an outpatient clinical setting, under the direction of a physician, and designed to stabilize the medical condition of an individual experiencing a serious episode of excessive substance use or withdrawal complications.

In accordance with MassHealth's behavioral health contract requirements, agencies providing clinically intensive, structured day and/or evening substance use disorder therapeutic interventions must employ a multidisciplinary staff that includes a minimum of one fulltime master's level clinician responsible for the clinical/educational operation of the program and supervision of the staff. The multidisciplinary staff must be trained in the integrated treatment of addictions, co-occurring disorders, biomedical, and related emotional/behavioral problems. All other staff must be bachelors or master's level trained. A program director must be available to respond to urgent or emergency situations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and/or MassHealth or its designee.

Frequency of Verification:

Every two years

Appendix C: Participant Services

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 Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assisted Living Services

HCBS Taxonomy:

Category 1:



Sub-Category 1:

Category 2:



Sub-Category 2:

Category 3:



Sub-Category 3:

Category 4:



Sub-Category 4:

Service Definition (Scope):

These services consist of personal care and supportive services (homemaker, chore, personal care services, meal preparation) that are furnished to waiver participants who reside in an MFP qualified assisted living residence (ALR) that includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also may include social and recreational programming, and medication assistance (consistent with ALR Certification and to the extent permitted under State law).

Nursing and skilled therapy services are incidental rather than integral to the provision of Assisted Living

Services. Intermittent skilled nursing services and therapy services may be provided to the extent allowed by applicable regulations.

Assisted Living Services do not include, and payment will not be made for, 24-hour skilled care. The following waiver services are not available to participants receiving Assisted Living Services: chore, homemaker, personal care, home health aide, and supportive home care aide. Duplicative waiver and state plan services are not available to participants receiving Assisted Living Services.

Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

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

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living Service Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Assisted Living Services

Provider Category:

Agency

Provider Type:

Assisted Living Service Agencies

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certified by the Executive Office of Elder Affairs in accordance with 651 CMR 12.00 (Department of Elder Affairs regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts).

Other Standard (*specify*):

Must meet the requirements of Money Follows the Person qualified residences.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

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 Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Crisis Stabilization

HCBS Taxonomy:

Category 1:

▼

Sub-Category 1:

Category 2:

▼

Sub-Category 2:

Category 3:

▼

Sub-Category 3:

Category 4:

▼

Sub-Category 4:

Service Definition (Scope):

Community Crisis Stabilization (CCS) service is provided as an alternative to hospitalization, including short-term psychiatric treatment in a structured, community-based therapeutic environment. CCS provides continuous 24-hour observation and supervision for individuals who do not require inpatient services.

CCS provides care where the primary objectives of the active multi-disciplinary treatment include restoration of functioning; strengthening the resources and capacities of the individual, family, and other natural supports; timely return to a natural setting and/or least restrictive setting in the community; development/strengthening of an individualized risk management/safety plan; and linkage to ongoing, medically necessary treatment and support services. CCS staff provide continuous observation of, and support to, individuals with mental health or co-occurring mental health/substance use conditions who might otherwise require treatment in an inpatient psychiatric setting and would benefit from short-term and structured crisis stabilization services. Components of this service include crisis stabilization; initial and continuing bio-psychosocial assessment; psychiatric evaluation and support with managing medication; peer-to-peer support; and mobilization of natural supports and community resources.

Federal financial participation is not claimed for the cost of room and board. Community crisis stabilization shall not be provided simultaneously with other waiver services.

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Crisis Stabilization Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Crisis Stabilization

Provider Category:

Agency ▼

Provider Type:

Community Crisis Stabilization Provider

Provider Qualifications

License (specify):

Services are provided in Massachusetts Department of Public-licensed clinic in accordance with 105 CMR 140.00 (Department of Public Health regulations regarding the standards for the licensure of clinics in Massachusetts).

Certificate (specify):

Other Standard (specify):

In accordance with MassHealth's behavioral health contract requirements providers must employ a multidisciplinary staff with established experience, skills, and training in the acute treatment of mental health and co-occurring mental health and substance use conditions. Providers must maintain appropriate staffing patterns to safely care for all persons 24/7. There must be a psychiatric clinician available for a psychiatric phone consultation within 15 minutes of request and for a face-to-face evaluation within 60 minutes of request, when clinically indicated.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and/or MassHealth or its designee.

Frequency of Verification:

Every two years.

Appendix C: Participant Services

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 Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Psychiatric Support and Treatment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Community Psychiatric Support and Treatment (CPST) includes an array of psychosocial rehabilitation strategies that are part of a comprehensive specialized psychiatric program for adults with significant functional impairments resulting from an identified mental health or substance abuse disorder diagnosis. CPST is not otherwise covered in the Medicaid State Plan. These strategies provide essential therapy to individuals with a long standing history of a psychiatric or substance use disorder and to their families, or to those individuals who are at varying degrees of increased medical risk, or who have behavioral health issues challenging their optimal level of functioning in the community setting. Home and community-based programs utilizing evidence-based strategies under this service must comply with state regulations and policies for the individual strategies. Community programs provided in facilities must comply with any state regulations and policies for the staffing and facility licensure type. These strategies may include:

- Assisting the individual and family members, or other formal or informal supports, to identify strategies or treatment options associated with the individual's mental illness, with the goal of minimizing the negative effects of mental illness symptoms, emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships and community integration.
- Individual supportive counseling, solution-focused interventions, emotional and behavioral management and problem behavior analysis with the individual, with the goal of assisting the individual in developing and implementing social, interpersonal, self care, daily living and independent living skills to restore stability, functional gains and to adapt to community living.
- Participation in and utilization of strengths-based planning and treatments which include assisting the individual and family members, or other formal or informal supports, with identifying strengths, needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources and natural supports to address functional deficits associated with their mental illness. These planning and treatment activities are specific to meeting the goals of the service as included in the individual's plan of care, and are not duplicative of the person-centered planning process as described in Appendix D.
- Assisting the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members, or other formal or informal supports, with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or, as appropriate, seeking other supports to restore stability and functioning.

- Restoration, rehabilitation and support to develop skills to locate, rent and keep a home, handle landlord/tenant negotiations, select a roommate and understand renter's rights and responsibilities.
- Assisting the individual through clinical interventions to develop daily living skills specific to managing their own home, including managing their money, medications and using community resources and other self-care requirements.

The strategies may include approaches such as:

- Treatment in nonresidential treatment settings that provides clinical, diagnostic, and treatment services on a level of intensity equal to an inpatient program, but on less than a 24-hour basis as a time-limited response to stabilize acute symptoms.
- Structured outpatient treatments which combine strategies from behavioral, cognitive, and supportive psychotherapies.
- Therapeutic services provided to an individual on a one-to-one basis, to maintain the individual's safety.
- Consultation conducted by outpatient providers in order to facilitate transition to less restrictive home or community-based settings.
- Multi-disciplinary team approaches to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. Approaches include assistance to individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and integration into the community.
- Clinically intensive approaches designed to improve functional status, provide stabilization in the community, divert an admission to an inpatient service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. Such approaches are time-limited, comprehensive, and coordinated multidisciplinary treatment.

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

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Psychiatric Support and Treatment Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Psychiatric Support and Treatment

Provider Category:

Agency ▼

Provider Type:

Community Psychiatric Support and Treatment Providers

Provider Qualifications**License** (*specify*):

Services are provided by acute care hospital outpatient departments licensed by the Massachusetts Department of Public Health in accordance with 105 CMR 130.000 (Department of Public Health Hospital Licensure Regulations that describe the standards for the maintenance and operations of hospitals in Massachusetts); or by clinics licensed by Massachusetts Department of Public Health in accordance with 105 CMR 140.00 (Department of Public Health regulations regarding the standards for the licensure of clinics in Massachusetts).

Certificate (*specify*):
Other Standard (*specify*):

In accordance with MassHealth's behavioral health contract requirements, any program utilizing Dialectical Behavior Therapy (DBT) approaches must have a minimum of two DBT-credentialed therapists who oversee the provision of all DBT services. Any program utilizing Program of Assertive Community Treatment approaches must have a one to ten staff client ratio; a full-time team leader with at least a master's degree in nursing, social work, psychiatric rehabilitation, or psychology; and a psychiatrist on a full-time or part-time basis for a minimum of 20 hours per week for 60 individuals.

Community programs provided in facilities must comply with any state regulations and policies for the staffing and facility licensure type. For example, any program licensed as a partial hospitalization program must have a staff-to-patient ratio sufficient to ensure necessary therapeutic services, professional monitoring, control, and protection. A psychiatrist must provide daily psychiatric management and active treatment comparable to that provided by an inpatient setting.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health and/or MassHealth or its designee.

Frequency of Verification:

Every two years.

Appendix C: Participant Services**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 Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Day Services

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

Category 2:**Sub-Category 2:**

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Day services/supports provide for structured day activity typically for individuals with pervasive and extensive support needs who are not ready to join the general workforce. Day Services are individually designed around consumer choice and preferences with a focus on improvement or maintenance of the person’s skills and their ability to live as independently as possible in the community. Day Services often include assistance to learn activities of daily living and functional skills; language and communication training; compensatory, cognitive and other strategies; interpersonal skills; recreational/socialization skills and other skills training to prepare the individual to undertake various community inclusion activities. This service may reinforce some aspects of other waiver and state plan services by allowing individuals to continue to strengthen skills, which are necessary for greater independence, productivity and community inclusion. Day Services are provided in a provider operated setting in the community and not in a participant's residence, and do not duplicate any services under the state plan.

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Rehabilitation Facilities
Agency	Human Service Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Day Services

Provider Category:

Provider Type:

Rehabilitation Facilities

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Any not-for-profit or proprietary organization that responds satisfactorily to the waiver provider enrollment process, which includes meeting requirements for staffing qualifications and training, and all prescribed operational policies and procedures, including, but not limited to:

Program and Physical Plant:

- Understanding of and compliance with all required policies, procedures, and physical plant standards
- Experience providing functional, community-based services and living skills training and understanding of the philosophy of maximizing independence, participant participation, community integration and a comprehensive blend of services;
- Demonstrated experience and/or willingness to work effectively with the MassHealth agency or its designee and with the Case Managers responsible for oversight and monitoring of the participants receiving these services;
- Adequate organizational structure to support the delivery and supervision of day services, including:
 - Ability to plan and deliver services in the prescribed settings
 - Demonstrated ability to produce timely, complete and quality documentation including but not limited to assessments, incident reports, progress reports and program-specific service plans
 - Demonstrated compliance with health and safety, accessibility standards and the ADA, as applicable.

Staff and Training:

- Demonstrates a team approach to service delivery including the ability to define, track and monitor service interventions that meet participant goals and objectives
- Ability to access relevant clinical support as needed
- Experience recruiting and maintaining qualified staff; assurance that all staff will be CORI checked; policies/practices which ensure that:
 - Program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principles of participant choice

Quality:

- Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.

Compliance with the licensure and/or certification standards of another Executive Office of Health and Human Services agency (for example Department of Developmental Services requirements at 115 CMR 7.00 & 8.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) or Department of Mental Health requirements at 104 CMR Subpart B (Department of Mental Health regulations for licensing and operational standards for mental health related community programs and which address protection from mistreatment and physical restraints) may be substituted for the above qualifications.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Day Services

Provider Category:

Agency

Provider Type:

Human Service Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Any not-for-profit or proprietary organization that responds satisfactorily to the waiver provider enrollment process, which includes meeting requirements for staffing qualifications and training, and all prescribed operational policies and procedures, including, but not limited to:

Program and Physical Plant:

- Understanding of and compliance with all required policies, procedures, and physical plant standards
- Experience providing functional, community-based services and living skills training and understanding of the philosophy of maximizing independence, participant participation, community integration and a comprehensive blend of services;
- Demonstrated experience and/or willingness to work effectively with the MassHealth agency or its designee and with the Case Managers responsible for oversight and monitoring of the participants receiving these services;
- Adequate organizational structure to support the delivery and supervision of day services, including:-
 - Ability to plan and deliver services in the prescribed settings
 - Demonstrated ability to produce timely, complete and quality documentation including but not limited to assessments, incident reports, progress reports and program-specific service plans
 - Demonstrated compliance with health and safety, accessibility standards and the ADA, as applicable.

Staff and Training:

- Demonstrates a team approach to service delivery including the ability to define, track and monitor service interventions that meet participant goals and objectives
- Ability to access relevant clinical support as needed
- Experience recruiting and maintaining qualified staff; assurance that all staff will be CORI checked; policies/practices which ensure that:
 - Program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principles of participant choice

Quality:

- Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.

Compliance with the licensure and/or certification standards of another Executive Office of Health and Human Services agency (for example Department of Developmental Services requirements at 115 CMR 7.00 & 8.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to

regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) or Department of Mental Health requirements at 104 CMR Subpart B (Department of Mental Health regulations for licensing and operational standards for mental health related community programs and which address protection from mistreatment and physical restraints) may be substituted for the above qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

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 Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Accessibility Adaptations

HCBS Taxonomy:

Category 1:



Sub-Category 1:

Category 2:



Sub-Category 2:

Category 3:



Sub-Category 3:

Category 4:



Sub-Category 4:

Service Definition (Scope):

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's Plan of Care (POC), that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

This service may also include architectural services to develop drawings and narrative specifications for architectural adaptations, adaptive equipment installation, and related construction as well as subsequent site inspections to oversee the completion of adaptations and conformance to local and state building codes,

acceptable building trade standards and bid specifications.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Also excluded are those modifications which would normally be considered the responsibility of the landlord. Home accessibility modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

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

Lifetime limit of \$50,000 per participant. Requests for exceptions to this limit must demonstrate that the exception is essential to the health and safety of the participant and must be approved by DDS, MRC and MassHealth.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Accessibility Adaptation Agencies
Individual	Architect/Designer
Individual	Home Accessibility Adaptation : Self-Employed
Agency	Architect/Design Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Accessibility Adaptations

Provider Category:

Agency ▼

Provider Type:

Home Accessibility Adaptation Agencies

Provider Qualifications

License (*specify*):

If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc.)

Certificate (*specify*):

Other Standard (*specify*):

Any not-for-profit or proprietary organization that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following:

Providers shall ensure that individual workers employed by the agency have been CORI checked,

and are able to perform assigned duties and responsibilities. If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any appropriate licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc.)

Verification of Provider Qualifications

Entity Responsible for Verification:

Massachusetts Rehabilitation Commission

Frequency of Verification:

Annually, or prior to utilization of service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Accessibility Adaptations

Provider Category:

Individual 

Provider Type:

Architect/Designer

Provider Qualifications

License (specify):



Certificate (specify):



Other Standard (specify):

Any self-employed provider that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following:

Staff responsible for architectural drawings must be: Licensed architects, certified designers or draftsmen.

Providers shall submit to a CORI check, and must be able to perform assigned duties and responsibilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Massachusetts Rehabilitation Commission

Frequency of Verification:

Annually, or prior to utilization of service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Accessibility Adaptations

Provider Category:

Individual 

Provider Type:

Home Accessibility Adaptation : Self-Employed

Provider Qualifications

License (specify):

If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any appropriate licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc.)

Certificate (*specify*):

Other Standard (*specify*):

Any self-employed provider that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following:

Providers shall submit to a CORI check, and must be able to perform assigned duties and responsibilities.

If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any appropriate licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc.)

Verification of Provider Qualifications

Entity Responsible for Verification:

Massachusetts Rehabilitation Commission

Frequency of Verification:

Annually, or prior to utilization of service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Architect/Design Agencies

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Any not-for-profit or proprietary organization that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following:

Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities.

Staff responsible for architectural drawings must be: Licensed architects, certified designers or draftsmen.

Verification of Provider Qualifications

Entity Responsible for Verification:

Massachusetts Rehabilitation Commission

Frequency of Verification:

Annually, or prior to utilization of service

Appendix C: Participant Services

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 Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual Support and Community Habilitation

HCBS Taxonomy:

Category 1:



Sub-Category 1:

Category 2:



Sub-Category 2:

Category 3:



Sub-Category 3:

Category 4:



Sub-Category 4:

Service Definition (Scope):

Services and supports in a variety of activities that may be provided regularly or intermittently, but not on a 24-hour basis, and are determined necessary to prevent institutionalization. These services may include locating appropriate housing, the acquisition, retention or improvement of skills related to personal finance, health, shopping, use of community resources, community safety, and other social and adaptive skills to live in the community. Individual support and community habilitation provide supports necessary for the individual to establish, live in and maintain a household of their choosing in the community. It may include training and education in self-determination and self-advocacy to enable the individual to acquire skills to exercise control and responsibility over the services and supports they receive, and to become more independent, integrated, and productive in their communities. These services must be provided in-person.

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



Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Human Service Agencies
Individual	Support Worker
Agency	Health Care Agencies

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Individual Support and Community Habilitation****Provider Category:**

Agency ▾

Provider Type:

Human Service Agencies

Provider Qualifications**License** (*specify*):
Certificate (*specify*):
Other Standard (*specify*):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:

- Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists.
- Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.
- Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate.
- Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies.
- Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Individual Support and Community Habilitation agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder

Abuse Reporting and Protective Services Program regulations).

- Individuals who provide Individual Support and Community Habilitation services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have a College degree plus experience in providing community-based services to individuals with disabilities, or at least two years comparable community-based, life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Individual Support and Community Habilitation

Provider Category:

Individual ▾

Provider Type:

Support Worker

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individuals who provide Individual Support and Community Habilitation services must have responded satisfactorily to the Waiver provider enrollment process, and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have a College degree plus experience in providing community-based services to individuals with disabilities, or at least two years comparable community-based, life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; certification in CPR is required.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Individual Support and Community Habilitation

Provider Category:

Agency **Provider Type:**

Health Care Agencies

Provider Qualifications**License (specify):**


Certificate (specify):


Other Standard (specify):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:

- Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists.
- Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.
- Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate.
- Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies.
- Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Individual Support and Community Habilitation agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).
- Individuals who provide Individual Support and Community Habilitation services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have a College degree plus experience in providing community-based services to individuals with disabilities, or at least two years comparable community-based, life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

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 Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Medication Administration

HCBS Taxonomy:

Category 1:



Sub-Category 1:

Category 2:



Sub-Category 2:

Category 3:



Sub-Category 3:

Category 4:



Sub-Category 4:

Service Definition (Scope):

Medication administration is the injection of intramuscular psychotherapeutic medication by qualified personnel and provided in an ambulatory care setting. These services are not otherwise covered in the Medicaid State Plan.

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

 

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
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Provider Category	Provider Type Title
Agency	Medication Administration Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Administration

Provider Category:

Agency ▼

Provider Type:

Medication Administration Providers

Provider Qualifications

License (*specify*):

This service can be provided in Massachusetts Department of Public Health licensed outpatient departments in acute care hospitals in accordance with 105 CMR 130.000 (Department of Public Health Hospital Licensure Regulations that describe the standards for the maintenance and operations of hospitals in Massachusetts); or in a Massachusetts Department of Public Health licensed clinic in accordance with 105 CMR 140.00 (Department of Public Health regulations regarding the standards for the licensure of clinics in Massachusetts).

Qualified personnel include nurses licensed in accordance with 244 CMR (Board of Registration in Nursing regulations governs the education and practice requirements applicable to nurses practicing in the expanded role), physician assistants license in accordance with 263 CMR (Board of Registration of Physician Assistants regulations describe the settings in which a physician assistant may properly work, the types of clinical activities in which a physician assistant may engage, the level of skill expected of the physician assistant, the nature and extent of the supervision required of the supervising licensed physician, and the allocation of liability for the acts or omissions of a physician assistant)and physicians licensed in accordance with 243 CMR (Board of Registration in Medicine regulations provide directions concerning licensing and the practice of medicine).

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health.

Frequency of Verification:

Every two years.

Appendix C: Participant Services

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 Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Occupational Therapy services, including the performance of a maintenance program beyond the scope of coverage in the State plan, provided by a licensed occupational therapist. Occupational therapy programs are designed to improve the quality of life by recovering competence, preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living. Services must be considered by the therapist to be necessary for the participant either to improve, develop, correct, rehabilitate, or prevent the worsening of physical, cognitive or sensory functions that have been lost, impaired or reduced as a result of acute or chronic medical conditions, congenital anomalies or injuries; or required to maintain or prevent the worsening of function. Services may also include the training and oversight necessary for the participant, family member or other person, to carry out the maintenance program. The provider qualifications specified in the State plan apply.

Occupational Therapy services must be authorized by the Case Manager in the service plan. This service is not subject to the Medical Referral Requirements found at 130 CMR 432.415 (MassHealth Therapist Regulations that describe the medical referral requirements necessary as a prerequisite to MassHealth payment) or the requirements for Prior Authorization found in the following regulations: 130 CMR 432.417 (MassHealth Therapist Regulations that describe the prior authorization process for therapy services) or 130 CMR 410.408 (MassHealth Chronic Disease and Rehabilitation Outpatient Hospital Regulations that describe the prior authorization process for therapy services) or 130 CMR 403.413 (MassHealth Home Health Agency Regulations that describe the prior authorization process for therapy services) or 130 CMR 430.601 (MassHealth Rehabilitation Center Regulations that describe the prior authorization process for therapy services). This service can not be provided in Adult Day Health or when the participant is receiving other services that include occupational therapy as part of the program.

MassHealth All Provider regulations at 130 CMR 450.140 through 149 detail the ESPDT requirements for MassHealth providers and the MassHealth provider manuals for therapists services lists ESPDT screening schedules at Appendix W.

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

These services are subject to the Service Limitations included in 130 CMR 432.414 (A) and (B) (MassHealth Therapist Regulations that describe the service limitations for therapy treatment per day). No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of service as a comprehensive evaluation.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist
Agency	Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital
Agency	Health Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
 Service Name: Occupational Therapy

Provider Category:

Individual ▾

Provider Type:

Occupational Therapist

Provider Qualifications

License (specify):

Occupational Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules)

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
 Service Name: Occupational Therapy

Provider Category:

Agency ▾

Provider Type:

Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital

Provider Qualifications

License (specify):

The hospital must be licensed as a Chronic Disease and Rehabilitation Inpatient Hospital in accordance with 130 CMR 435.000 (MassHealth Chronic Disease and Rehabilitation Inpatient Regulations that describe the provider eligibility requirements) or as a Chronic Disease and Rehabilitation Outpatient Hospital in accordance with 130 CMR 410.000 (MassHealth Chronic Disease and Rehabilitation Outpatient Regulations that describe the provider eligibility requirements)

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Health Care Agencies

Provider Qualifications

License (*specify*):

The agency must be licensed as a Group Practice in accordance with 130 CMR 432.404 (MassHealth Therapist Regulations that describe the provider eligibility requirements for in-State therapy providers) or as a Rehabilitation Center in accordance with 130 CMR 430.600 (MassHealth Rehabilitation Center Regulations that define provider eligibility requirements and program rules) or as a Home Health Agency in accordance with 130 CMR 403.000 (MassHealth Home Health Agency regulations that define provider eligibility requirements and program rules). Services must be performed by an Occupational Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules)

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

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 Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Orientation and Mobility Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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 (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Individual	Certified Orientation and Mobility Specialists (COMS)
Agency	Human Service Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Orientation and Mobility Services

Provider Category:

Individual ▾

Provider Type:

Certified Orientation and Mobility Specialists (COMS)

Provider Qualifications

License (specify):

Certificate (specify):

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.

Other Standard (specify):

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Orientation and Mobility Services

Provider Category:

Agency ▾

Provider Type:

Human Service Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Individuals providers and individuals employed by the agency providing 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-certified university program.

Other Standard (*specify*):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:

- Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities.

Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies.

Staff providing services must have:

- 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

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

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 Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Peer Support

HCBS Taxonomy:

Category 1:



Sub-Category 1:

Category 2:



Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:**Sub-Category 4:**

Service Definition (Scope):

Peer Support is designed to provide training, instruction and mentoring to individuals about self-advocacy, participant direction, civic participation, leadership, benefits, and participation in the community. Peer support may be provided in small groups or peer support may involve one peer providing support to another peer, the waiver participant, to promote and support the waiver participant's ability to participate in self-advocacy. The one to one peer support is instructional; it is not counseling. The service enhances the skills of the individual to function in the community and/or family home. Documentation in the individual's record demonstrates the benefit to the individual. This service may be self-directed.

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

Not to exceed 16 hours per week.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Peer Support Agencies
Individual	Individual Peer Support Specialist

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Peer Support

Provider Category:

Agency

Provider Type:

Peer Support Agencies

Provider Qualifications**License (specify):**

Agency needs to employ individuals who meet all relevant state and federal licensure or certification requirements in their discipline.

Certificate (specify):

If the agency is providing activities where certification is necessary, the applicant will have the necessary certifications.

Other Standard (specify):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following

- Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery

and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists.

- Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.
- Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate.
- Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies.
- Policies/Procedures: Providers must have policies and procedures that include: Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Peer Support Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).
- Individuals who provide Peer Support Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; can handle emergency situations; can set limits, and communicate effectively with participants, other providers and agencies; have ability to meet legal requirements in protecting confidential information.

The agency must employ individuals who are self-advocates and supporters and who are able to effectively communicate in the language and communication style of the individual for whom they are providing the training. Staff members providing Peer Support must have experience in providing peer support, self-advocacy, and skills training and independence.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Peer Support

Provider Category:

Individual ▾

Provider Type:

Individual Peer Support Specialist

Provider Qualifications

License (specify):

Certificate (specify):

Relevant competencies and experiences in Peer Support

Other Standard (*specify*):

Applicants must possess appropriate qualifications to serve as staff as evidenced by interview(s), two personal and or professional references and a Criminal Offense Records Inquiry (CORI). The applicant must have the ability to communicate effectively in the language and communication style of the participant to whom they are providing training; Must have experience in providing peer support, self-advocacy, and skills training and independence; Minimum of 18 years of age; Be knowledgeable about what to do in an emergency; Be knowledgeable about how to report abuse and neglect; Must maintain confidentiality and privacy of consumer information; Must be respectful and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed by an individual provider to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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 Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (*Scope*):

Physical Therapy services, including the performance of a maintenance program beyond the scope of coverage in the State plan, provided by a licensed physical therapist. Services must be considered by the therapist to be necessary for the participant either to improve, develop, correct, rehabilitate, or prevent the worsening of the

physical functions that have been lost, impaired or reduced as a result of acute or chronic medical conditions, congenital anomalies or injuries; or required to maintain or prevent the worsening of function. Services may also include the training and oversight necessary for the participant, family member or other person, to carry out the maintenance program. The provider qualifications specified in the State plan apply.

Physical Therapy services must be authorized by the Case Manager in the service plan. This service is not subject to the Medical Referral Requirements found at 130 CMR 432.415 (MassHealth Therapist Regulations that describe the medical referral requirements necessary as a prerequisite to MassHealth payment) or the requirements for Prior Authorization found in the following regulations: 130 CMR 432.417 (MassHealth Therapist Regulations that describe the prior authorization process for therapy services)) or 130 CMR 410.408 (MassHealth Chronic Disease and Rehabilitation Outpatient Hospital Regulations that describe the prior authorization process for therapy services) or 130 CMR 403.413 (MassHealth Home Health Agency Regulations that describe the prior authorization process for therapy services) or 130 CMR 430.601 (MassHealth Rehabilitation Center Regulations that describe the prior authorization process for therapy services). This service can not be provided in Adult Day Health or when the participant is receiving other services that include physical therapy as part of the program.

MassHealth All Provider regulations at 130 CMR 450.140 through 149 detail the ESPDT requirements for MassHealth providers and the MassHealth provider manuals for therapists services lists EPSDT screening schedules at Appendix W.

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

These services are subject to the Service Limitations included in 130 CMR 432.414 (A) and (B) (MassHealth Therapist Regulations that describe the service limitations for therapy treatment per day). No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of service as a comprehensive evaluation.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital
Individual	Physical Therapist
Agency	Health Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Physical Therapy

Provider Category:

Agency ▼

Provider Type:

Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital

Provider Qualifications

License (specify):

The hospital must be licensed as a Chronic Disease and Rehabilitation Inpatient Hospital in accordance with 130 CMR 435.000 (MassHealth Chronic Disease and Rehabilitation Inpatient

Regulations that describe the provider eligibility requirements) or as a Chronic Disease and Rehabilitation Outpatient Hospital in accordance with 130 CMR 410.000 (MassHealth Chronic Disease and Rehabilitation Outpatient Regulations that describe the provider eligibility requirements)

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License (*specify*):

Physical Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules).

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Health Care Agencies

Provider Qualifications

License (specify):

The agency must be licensed as a Group Practice in accordance with 130 CMR 432.404 (MassHealth Therapist Regulations that describe the provider eligibility requirements for in-State therapy providers) or as a Rehabilitation Center in accordance with 130 CMR 430.600 (MassHealth Rehabilitation Center Regulations that define provider eligibility requirements and program rules)) or as a Home Health Agency in accordance with 130 CMR 403.000 (MassHealth Home Health Agency regulations that define provider eligibility requirements and program rules). Services must be performed by a Physical Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules).

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

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 Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Residential Family Training

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Residential Family Training is designed to provide training and instruction about the treatment regimes, behavior plans, and the use of specialized equipment that supports the waiver participant to participate in the community. Residential Family Training may also include training in family leadership, support of self-advocacy, and independence for their family member. The service enhances the skill of the family to assist the waiver participant to function in the community and at home when the waiver participant visits his or her family. Documentation in the participant's record demonstrates the benefit to the participant. For the purposes of this service "family" is defined as the persons who provide care to a waiver participant and may include a parent or other relative. Family does not include individuals who are employed to care for the participant. Residential Family Training may be provided in a small group format or the Family Trainer may provide individual instruction to a specific family based on the needs of the family to understand the specialized needs of the waiver participant. The one to one family training is instructional; it is not counseling. Residential Family Training is not available in provider operated residential habilitation or assisted living sites or in shared living settings unless the waiver participant regularly leaves the site to visit his or her family.

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Family Training Agencies
Individual	Individual Family Training Provider

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Residential Family Training****Provider Category:**Agency **Provider Type:**

Family Training Agencies

Provider Qualifications**License (specify):**

If the agency is providing activities where licensure or certification is necessary, the applicant will have the necessary licensure/certifications. For mental health professionals such as Family Therapists, Rehabilitation Counselors, Social Workers, necessary licensure or certification requirements for those disciplines must be met.

Certificate (specify):

Other Standard (specify):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following

- Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists.

- Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.

- Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate.

- Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies.

- Policies/Procedures: Providers must have policies and procedures that comply with the applicable standards under 105 CMR 155.000 for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Family Training Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq.

- Individuals who provide Family Training Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information.

The agency must employ individuals who are able to effectively communicate in the language and communication style of the individual or family for whom they are providing the training. Staff members providing Family Training must have experience in promoting independence and in family leadership.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually or prior to utilization of service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Residential Family Training

Provider Category:

Individual ▾

Provider Type:

Individual Family Training Provider

Provider Qualifications

License (specify):

Individuals who meet all relevant state and federal licensure or certification requirements for their discipline.

Certificate (specify):

Relevant competencies and experiences in Family Training.

Other Standard (specify):

Applicants must possess appropriate qualifications to serve as staff as evidenced by interview(s), two personal or professional references, and a Criminal Offense Record Inquiry (CORI). The applicant must have the ability to communicate effectively in the language and communication style of the family to whom they are providing training. The applicant must have experience in providing family leadership, self-advocacy, and skills training in independence.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Administrative Service Organization

Frequency of Verification:

Annually or prior to utilization of service

Appendix C: Participant Services

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 Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Shared Living - 24 Hour Supports

HCBS Taxonomy:**Category 1:**



Sub-Category 1:**Category 2:**



Sub-Category 2:**Category 3:**



Sub-Category 3:**Category 4:**



Sub-Category 4:**Service Definition (Scope):**

Shared Living - 24 Hour Supports is a residential option that matches a participant with a Shared Living caregiver. This arrangement is overseen by a Residential Support Agency. The match between participant and caregiver is the keystone to the success of this model. Shared Living is an individually tailored 24 hour/7 day per week, supportive service.

Shared Living is available to participants who need daily structure and supervision. Shared Living includes supportive services that assist with the acquisition, retention, or improvement of skills related to living in the community. This includes such supports as: adaptive skill development, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), adult educational supports, social and leisure skill

development, protective oversight and supervision.

Shared Living integrates the participant into the usual activities of the caregiver's family life. In addition, there will be opportunities for learning, developing and maintaining skills including in such areas as ADL's, IADL's, social and recreational activities, and personal enrichment. The Residential Support Agency provides regular and ongoing oversight and supervision of the caregiver.

The caregiver lives with the participant at the residence of the caregiver or the participant. Shared Living agencies recruit caregivers, assess their abilities, coordinate placement of participant or caregiver, train and provide guidance, supervision and oversight for caregivers and provide oversight of participants' living situations. The caregiver may not be a legally responsible family member.

Duplicative waiver and state plan services are not available to participants receiving Shared Living services.

Shared Living services are not available to individuals who live with their immediate family unless the family member is not legally responsible for the individual and is employed as the caregiver, or the immediate family member (grandparent, parent, sibling or spouse) is also eligible for shared living and had received prior authorization, as applicable. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment is specified in Appendix I-5.

Shared Living may be provided to no more than two participants in a home.

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

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Support Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Shared Living - 24 Hour Supports

Provider Category:

Agency

Provider Type:

Residential Support Agencies

Provider Qualifications

License (*specify*):

115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR

8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations) or 104 CMR Chapter 28 (Department of Mental Health regulations governing Licensing and Operational Standards for Community Programs).

Certificate (*specify*):

Residential Support Agency Provider employees must have a High School diploma, GED or relevant equivalencies or competencies.

Other Standard (*specify*):

Residential Support Agency Provider employees must possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Developmental Services (DDS) Office of Quality Enhancement, Survey and Certification staff.

Frequency of Verification:

every two years

Appendix C: Participant Services

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 Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Skilled Nursing

HCBS Taxonomy:**Category 1:**



Sub-Category 1:**Category 2:**



Sub-Category 2:**Category 3:**



Sub-Category 3:**Category 4:**



Sub-Category 4:**Service Definition** (*Scope*):

Services listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license. Skilled nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training

and qualifications) from skilled nursing services in the State plan. The differences from the State plan are as follows:

1) Agencies that provide Skilled Nursing services under the waiver do not need to meet the requirements for participation in Medicare, as provided in 42 CFR §489.28.

MassHealth All Provider regulations at 130 CMR 450.140 through 149 detail the ESPDT requirements for MassHealth providers and the MassHealth provider manual for nursing services lists EPSDT screening schedules at Appendix W.

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

This service is limited to one Skilled Nursing visit per week. The State may grant exceptions to the limit on a temporary basis to facilitate transitions to a community setting, to ensure that an individual at risk for medical facility admission is able to remain in the community, or to otherwise stabilize a participant's medical condition

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homemaker/Personal Care Agencies
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency ▼

Provider Type:

Homemaker/Personal Care Agencies

Provider Qualifications

License (*specify*):

Skilled Nursing services must be performed by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license.

Certificate (*specify*):

Other Standard (*specify*):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:

- Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists.
- Adherence to Continuous QI Practices: Providers must have established strategies to prevent,

detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.

- Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate.

- Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies.

- Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Home Health Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

- Individuals who provide Skilled Nursing Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Skilled Nursing

Provider Category:

Agency 

Provider Type:

Home Health Agencies

Provider Qualifications

License (specify):

Skilled Nursing services must be performed by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license.

Certificate (specify):

Other Standard (specify):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:

- Education, Training, Supervision: Providers must ensure effective training of staff members in all

aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists.

- Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.
- Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate.
- Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies.
- Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Home Health Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq. (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).
- Individuals who provide Skilled Nursing Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

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 Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Specialized Medical Equipment includes: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan.

In addition to the acquisition of the Specialized Medical Equipment itself this service may include:

- Evaluations necessary for the selection, design, fitting or customizing of the equipment needs of a participant
- Customization, adaptations, fitting, set-up, maintenance or repairs to the equipment or devices
- Temporary replacement of equipment
- Training or technical assistance for the participant, or, where appropriate, the family members, guardians, or other caregivers of the participant on the use and maintenance of the equipment or devices.

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. This service does not include vehicle modifications or home accessibility adaptations.

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Assistive Technology Provider
Agency	Assistive Technology Agencies
Agency	Medical Equipment Suppliers

Provider Category	Provider Type Title
Agency	Pharmacies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment

Provider Category:

Individual ▾

Provider Type:

Individual Assistive Technology Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individuals who provide Assistive Technology services must have responded satisfactorily to the Waiver provider enrollment process and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information.

Individuals providing services must have:

- Bachelor's degree in a related technological field and at least one year of demonstrated experience providing adaptive technological assessment or training; or
- A Bachelor's degree in a related health or human service field with at least two years of demonstrated experience providing adaptive technological assessment or training; or
- Three years of demonstrated experience providing adaptive technological assessment or training.

Individuals providing services must also have:

- Knowledge and experience in the evaluation of the needs of an individual with a disability, including functional evaluation of the individual in the individual's customary environment.
- Knowledge and experience in the purchasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities.
- Knowledge and/or experience in selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.
- Knowledge and/or experience in coordinating and using other therapies, interventions, or services with assistive technology devices.
- Knowledge and/or experience in training or providing technical assistance for an individual with disabilities, or, when appropriate, the family of an individual with disabilities or others providing support to the individual.
- Knowledge and/or experience in training and/or providing technical assistance for professionals or other individuals whom provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Assistive Technology Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:

- Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities.
- Providers of specialized medical equipment and supplies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.

Staff providing services must have:

- Bachelor's degree in a related technological field and at least one year of demonstrated experience providing adaptive technological assessment or training; or
- A bachelor's degree in a related health or human service field with at least two years of demonstrated experience providing adaptive technological assessment or training; or
- Three years of demonstrated experience providing adaptive technological assessment or training.

Individuals providing services must also have:

- Knowledge and experience in the evaluation of the needs of an individual with a disability, including functional evaluation of the individual in the individual's customary environment.
- Knowledge and experience in the purchasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities.
- Knowledge and/or experience in selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.
- Knowledge and/or experience in coordinating and using other therapies, interventions, or services with assistive technology devices.
- Knowledge and/or experience in training or providing technical assistance for an individual with disabilities, or, when appropriate, the family of an individual with disabilities or others providing support to the individual.
- Knowledge and/or experience in training and/or providing technical assistance for professionals or other individuals whom provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Medical Equipment Suppliers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:

- Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities.

- Providers of specialized medical equipment and supplies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Pharmacies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:

- Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities.

- Providers of specialized medical equipment and supplies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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 Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Speech Therapy

HCBS Taxonomy:

Category 1:



Sub-Category 1:

Category 2:



Sub-Category 2:

Category 3:



Sub-Category 3:

Category 4:



Sub-Category 4:

Service Definition (Scope):

Speech Therapy services, including the performance of a maintenance program beyond the scope of coverage in the State plan, provided by a licensed speech therapist. Services must be considered by the therapist to be necessary for the participant either to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired or reduced as a result of acute or chronic medical conditions, congenital anomalies or injuries; or required to maintain or prevent the worsening of function. Services may also include the training and oversight necessary for the participant, family member or other person, to carry out the maintenance program. The provider qualifications specified in the State plan apply.

Speech Therapy services must be authorized by the Case Manager in the service plan. This service is not subject to the Medical Referral Requirements found at 130 CMR 413.419 (MassHealth Speech and Hearing Center Regulations that describe the medical referral requirements necessary as a prerequisite for MassHealth payment)

or the requirements for Prior Authorization found in the following regulations: 130 CMR 413.408 (MassHealth Speech and Hearing Center Regulations that describes the prior authorization process for therapy services) or 130 CMR 432.417 (MassHealth Therapist Regulations that describe the prior authorization process for therapy services) or 130 CMR 410.408 (MassHealth Chronic Disease and Rehabilitation Outpatient Hospital Regulations that describe the prior authorization process for therapy services) or 130 CMR 403.413 (MassHealth Home Health Agency Regulations that describe the prior authorization process for therapy services) or 130 CMR 430.601 (MassHealth Rehabilitation Center Regulations that describe the prior authorization process for therapy services). This service can not be provided in Adult Day Health or when the participant is receiving other services that include speech therapy as part of the program.

MassHealth All Provider regulations at 130 CMR 450.140 through 149 detail the ESPDT requirements for MassHealth providers and the MassHealth provider manuals for therapists services lists EPSDT screening schedules at Appendix W.

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

These services are subject to the Service Limitations included in 130 CMR 413.418 (A) and (B) (MassHealth Speech and Hearing Center Regulations that describe the prior authorization process for therapy services). No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of service as a comprehensive evaluation.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital
Individual	Speech/Language Therapist (Speech/Language Pathologist)
Agency	Health Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech Therapy

Provider Category:

Agency ▼

Provider Type:

Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital

Provider Qualifications

License (*specify*):

The hospital must be licensed as a Chronic Disease and Rehabilitation Inpatient Hospital in accordance with 130 CMR 435.000 (MassHealth Chronic Disease and Rehabilitation Inpatient Regulations that describe the provider eligibility requirements) or as a Chronic Disease and Rehabilitation Outpatient Hospital in accordance with 130 CMR 410.000 (MassHealth Chronic Disease and Rehabilitation Outpatient Regulations that describe the provider eligibility requirements)

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Speech Therapy

Provider Category:

Individual

Provider Type:

Speech/Language Therapist (Speech/Language Pathologist)

Provider Qualifications

License (*specify*):

Speech/Language Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules)

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Speech Therapy

Provider Category:

Agency

Provider Type:

Health Care Agencies

Provider Qualifications

License (*specify*):

The agency must be licensed as a Group Practice in accordance with 130 CMR 432.404 (MassHealth Therapist Regulations that describe the provider eligibility requirements for therapy providers) or as a Speech and Hearing Center in accordance with 130 CMR 413.404 (MassHealth Speech and Hearing Center Regulations that describe the provider eligibility requirements) or as a

Rehabilitation Center in accordance with 130 CMR 430.600 (MassHealth Rehabilitation Center Regulations that define provider eligibility requirements and program rules) or as a Home Health Agency in accordance with 130 CMR 403.000 (MassHealth Home Health Agency regulations that define provider eligibility requirements and program rules). Services must be performed by a Speech/Language Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules).

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

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 Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional Assistance Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (*Scope*):

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 (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Business

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Transitional Assistance Services

Provider Category:

Agency ▼

Provider Type:

Certified Business

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Certified Business

Other Standard (*specify*):

Will meet applicable State regulations and industry standards for type of goods/services provided.

Verification of Provider Qualifications

Entity Responsible for Verification:
Massachusetts Rehabilitation Commission

Frequency of Verification:
Annually or prior to utilization of service

Appendix C: Participant Services

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 Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:

▼

Sub-Category 1:

Category 2:

▼

Sub-Category 2:

Category 3:

▼

Sub-Category 3:

Category 4:

▼

Sub-Category 4:

Service Definition (Scope):

Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

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

▼

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transportation Provider Agencies

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency 

Provider Type:

Transportation Provider Agencies

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:

- Driver and Vehicle Requirements: Verification of valid driver's license, liability insurance, written certification of vehicle maintenance, age of vehicles; passenger capacity of vehicles; RMV inspection; seat belts; list of safety equipment; air conditioning and heating; first aid kits; snow tires in winter; and two-way communication.
- Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Established procedures for appraising staff performance and for effectively modifying poor performance where it exists.
- Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.
- Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate.
- Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies.
- Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a transportation

agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

Providers must ensure that staff who transport must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; and communicate effectively with participants, families, other providers and agencies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Administrative Service Organization

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).

Complete item C-1-c.

As an administrative activity. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

State agency staff from Department of Developmental Services (DDS)

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

In accordance with M.G.L. chapter 6, section 172C, the Commonwealth of Massachusetts requires entities to obtain Criminal Offender Record Information (CORI) checks on individuals before they can volunteer, be

employed or be referred for employment in an entity providing services to elderly or disabled persons in their homes or in a community setting. CORI checks are statewide in scope. Compliance is verified as part of the credentialing and/or licensure process. DDS, MRC, the FMS and the ASO will be responsible for reviewing compliance as part of the Waiver service provider enrollment process and ongoing provider review processes.

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) establishes a registry to be maintained by the Massachusetts Department of Public Health which contains: 1) the names of individuals who are certified as nurse aides, and (2) sanctions, findings and adjudicated findings of abuse, neglect, and mistreatment of patients or residents and misappropriation of patient or resident property imposed upon or made against nurse aides, home health aides and homemakers for the abuse, neglect, mistreatment of patients or residents or misappropriation of patient or resident property. Each employer is responsible for screening potential employees against the abuse registry. Screening must be conducted for any position requiring homemaker, personal care, home health aide or nurse aide training. Provider agency compliance with 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) is verified as part of the credentialing process.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

- c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

- i. Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Group Residences	
Assisted Living Residences	

- ii. Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Assisted living services are provided to participants who live in assisted living residences. The underlying philosophy of assisted living is based on providing needed services to residents in a way that enhances autonomy, privacy and individuality. Residents have the right to make choices in all aspects of their lives. Only Assisted Living Residences that meet the requirements for MFP qualified residences will be enrolled as MFP waiver service providers. This will include confirmation that units in the

Assisted Living Residence are apartments with living, sleeping, cooking and bathing areas, that units have lockable access and egress, and that the lease does not include any prohibited terms (such as requiring notification of absences from the residence or allowing the right to change apartment assignments). The ASO will verify that the Assisted Living Residence meets these criteria during the provider enrollment process, and before the delivery of any waiver services. The state does not specify a maximum number of individuals who may be served in an Assisted Living Residence. Rather the maximum occupancy is specified in the individual certification for the residence. All Assisted Living Residences must be certified by the Executive Office of Elder Affairs in accordance with 651 CMR 12.00.

Residential Habilitation group homes are limited to no more than 4 residents, and as such meet the requirements for MFP qualified residences. Each waiver participant will have a private bedroom. All Residential Habilitation residences are subject to the same requirements concerning maintaining a homelike environment. These residences are located in neighborhoods in cities and towns throughout Massachusetts. These residences and the services within them reflect the normal household with a kitchen, living room and bedroom. Participants are assisted in making choices and decisions regarding their lives and in planning their futures to the best of their abilities with staff support. The staff is expected to explore the individual participant's interests and abilities to participate in meaningful day activities, and to assist them to challenge themselves to live a full and satisfying life. The existence of a homelike environment and opportunities to access the community are a major review component of the provider enrollment and monitoring process.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Residences

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Peer Support	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Orientation and Mobility Services	<input type="checkbox"/>
Medication Administration	<input type="checkbox"/>
Individual Support and Community Habilitation	<input type="checkbox"/>
Transitional Assistance Services	<input type="checkbox"/>
Community Crisis Stabilization	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Community Psychiatric Support and Treatment	<input type="checkbox"/>
Specialized Medical Equipment	<input type="checkbox"/>
Day Services	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Residential Family Training	<input type="checkbox"/>

Waiver Service	Provided in Facility
Supported Employment	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Assisted Living Services	<input type="checkbox"/>
Shared Living - 24 Hour Supports	<input type="checkbox"/>
Addiction Services	<input type="checkbox"/>

Facility Capacity Limit:

4 Persons

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living Residences

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Peer Support	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>

Waiver Service	Provided in Facility
Residential Habilitation	<input type="checkbox"/>
Orientation and Mobility Services	<input type="checkbox"/>
Medication Administration	<input type="checkbox"/>
Individual Support and Community Habilitation	<input type="checkbox"/>
Transitional Assistance Services	<input type="checkbox"/>
Community Crisis Stabilization	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Community Psychiatric Support and Treatment	<input type="checkbox"/>
Specialized Medical Equipment	<input type="checkbox"/>
Day Services	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Residential Family Training	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Assisted Living Services	<input checked="" type="checkbox"/>
Shared Living - 24 Hour Supports	<input type="checkbox"/>
Addiction Services	<input type="checkbox"/>

Facility Capacity Limit:

As Certified

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	

Standard	Topic Addressed
	✓

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Relatives, but not legal guardians, are permitted to provide waiver services. A relative may not be a family member (defined as a spouse or any legally responsible relative), and must meet all provider qualifications for the service being provided. Under these circumstances, relatives may provide any of the services included in this waiver without limit. Provider agencies are responsible for ensuring that every employee meets service-specific qualifications and must demonstrate compliance with this during on-site audits. All other requirements under this waiver apply, e.g., services must be provided in accordance with an approved plan of care.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

With the exception of the Behavioral Health Diversionary Services (Addiction Services, Community Crisis Stabilization, Community Psychiatric Support and Treatment and Medication Administration) provided by the Managed Behavioral Health Plan, any willing and qualified provider has the opportunity to enroll as a provider of waiver services. Providers of waiver services available under this waiver will meet qualifications as specified in C-1. All waiver service providers, with the exception of Residential Habilitation, Shared Living - 24 Hour Supports and Home Accessibility Adaptations will enroll as MassHealth providers and the Administrative Service Organization will ensure they meet the applicable qualifications. Providers of Residential Habilitation and Shared Living - 24 Hour Supports will be qualified and licensed/certified by DDS. Providers of Home Accessibility Adaptations will be qualified by MRC.

Providers can access information through the MassHealth provider enrollment and credentialing website, which provides ready access to information regarding requirements and procedures to qualify as a waiver provider. Service providers can apply to enroll at any time.

MRC has issued open procurements to solicit all willing and qualified providers of Home Accessibility Adaptations. DDS will contract with all willing and qualified providers of Residential Habilitation and Shared Living-24 Hour Supports. These procurements are posted on the Commonwealth's online procurement access and solicitation system.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

% of new agency providers, licensed by DDS, that received an initial license to provide supports. (Number of new agency providers that received a license to operate within 6 months of initial review/ Number of new agency providers that were selected to provide support)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
 % of licensed or certified providers credentialed by the Provider Network Administration/Massachusetts Rehabilitation Commission that initially meet applicable licensure or certification requirements. (Number of licensed or certified providers with appropriate credentials/ Number of licensed or certified providers)

Data Source (Select one):
Provider performance monitoring
 If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Service Organization	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

% of providers licensed by DDS that continue to meet applicable licensure or certification standards. (Number of providers that continue to meet applicable licensure or certification standards/ Number of providers subject to licensure/certification)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

% of licensed/certified providers credentialed by the Provider Network Administration/Massachusetts Rehabilitation Commission who continue to meet applicable licensure/certification requirements. (Number of licensed/certified providers who continue to meet applicable licensure requirements/Number of licensed/certified providers who are required to have applicable state licensure or certification)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: Administrative Service Organization	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

% of agency providers licensed by DDS that have corrected identified deficiencies. (Number of providers that have corrected deficiencies/ Number of providers with identified deficiencies)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

% of licensed or certified providers credentialed by the Provider Network Administration/Massachusetts Rehabilitation Commission that have corrected identified findings. (Number of licensed or certified providers that have corrected identified findings/ Total number of licensed or certified providers that have findings)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Service Organization	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
 % of providers not subject to licensure or certification who are offering services who initially meet requirements to provide supports. (Number of providers not subject to licensure or certification who initially meet the qualification requirements to provide services/ Number of providers)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: Administrative Service Organization	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other	

	Specify:	
	<input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>

Performance Measure:

% of providers who are not subject to licensure or certification who continue to meet qualifications to provide services. (Number of providers who continue to meet requirements/ Total number of providers not subject to licensure or certification)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>
<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

Administrative Service Organization		<input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

% of providers who are not subject to licensure or certification who have corrected identified findings. (Number of providers who are not subject to licensure or certification that have corrected all identified findings/ Total number of providers who are not subject to licensure or certification that have findings)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Service Organization	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

% of DDS licensed/certified providers that have staff trained and current in required trainings including medication administration, CPR, first aid, restraint utilization and abuse/neglect reporting. (Number of DDS licensed/certified providers that have staff trained/ Number of DDS licensed/certified providers reviewed through survey and certification)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
 % of providers that are not subject to DDS licensure and/or certification that have been trained and are current in all required trainings. (Number of providers not subject to DDS licensure and/or certification) that have been trained/ Number of providers reviewed)

Data Source (Select one):
Provider performance monitoring
 If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Administrative Service Organization	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The State Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Level of Care entity and the Administrative Service Organization. As problems are discovered with the management of the waiver program, the Department of Developmental Services (DDS) and the Office of Medicaid are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, DDS is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable -** The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.
- Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

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.

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 residential and non-residential settings to determine if those settings met standards consistent with the federal HCB settings requirements.

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 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 activities, and resubmit the STP for CMS approval.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Care (POC)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**
 Licensed practical or vocational nurse, acting within the scope of practice under State law
 Licensed physician (M.D. or D.O)
 Case Manager (qualifications specified in Appendix C-1/C-3)
 Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Case Managers must have a Bachelor's degree in social work, human services, nursing, psychology, sociology or a related field. Candidates with a Bachelor's degree in another discipline must demonstrate experience or strong interest in the field of human services via previous employment, internships, volunteer activities and/or additional studies. Three years of experience working with elders and/or individuals with disabilities in community settings providing direct case management including performing assessments may be substituted for the degree requirement.

- Social Worker**

Specify qualifications:

- Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

- b. Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
 Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The service plan development process is driven by the individual and facilitated by Case Managers utilizing a person-centered planning approach and assessment tool designed to promote enabling the individual to live as independently and self-sufficiently as possible and as desired. Case Managers must be aware of and know how to access a wide variety of community-based services, as well as work collaboratively with Transition Entities, as appropriate, in order to explain to participants the full array of waiver, Title XIX State Plan, and other services, such

as MFP demonstration services, available to meet the participant's needs. Case Managers will work with the participant to identify who the participant wishes to include in the service planning process and the development of the Plan of Care (POC).

The Case Manager supports a participant through the entire service planning process. The Service Planning Process described in Appendix D produces the Waiver Plan of Care (POC) document.

The Case Manager has a discussion with the participant or guardian prior to the service plan meeting. At the participant's discretion, other team members such as family and staff also participate in this discussion. The discussion includes:

- An explanation of the service planning process to the participant/guardian and designated representative such as a family member.
- Identification of the person's goals, strengths, and preferences regarding services and Care Plan Team members.
- A review of all assessment materials, medical and service records and/or the past year's progress and the participant's ongoing needs.
- A review of waiver services, state plan and other services available to the participant and how they relate to and will support his or her needs and goals.
- Identification of additional assessments, if any, needed to inform the service planning process.

Other preparation includes at the direction of the participant, talking to people who know the participant well such as staff, friends, advocates, and involved family members. In selecting people to talk to, the Case Manager respects the participant's wishes about who is part of the service planning process. When participants cannot communicate their preferences, Case Managers collect information through observation, inference from behavior, and discussions with people who know the participant well. All conversations are respectful of the participant and focus on the person's strengths and preferences. The Case Manager also looks for creative ways to focus the team on the unique characteristics of the person and his (or her) situation. The Case Manager does this by helping team members think creatively about how they can better support the person within the context of the participant's strengths, abilities and preferences.

During the service planning consultation, the participant identifies who will be invited to the meeting. These individuals constitute the team members. In situations where personal and sensitive issues are discussed, certain team members may be invited to only part of the meeting, as the participant prefers. Any issue about attendance at the service planning meeting is addressed by the Case Manager based upon the preferences of the participant and or guardian.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Case Managers will follow standard procedures and time frames in performing the intake, assessment, case conferencing, service planning and review process that ensure participants' strengths, needs, risk factors, personal goals and preferences are identified and appropriately addressed.

Participant needs are identified beginning at referral and continuing through the person-centered service needs assessment and the POC development processes. Through the person-centered planning process and using a state-approved tool, the assessment gathers information on a participant's goals, capabilities, medical/skilled nursing needs, support/service needs and need for skill development and/or other training to enhance community integration

and increase independence, including the opportunity to seek employment, engage in community life and control of personal resources. The service needs assessment will reflect the residential setting that has been chosen by the waiver participant. The process also identifies informal supports available to the participant and all other resources that may be available to assist the participant in remaining in the community, achieving positive outcomes and avoiding unnecessary utilization of waiver services.

The initial service needs assessment is conducted by a Case Manager, and then based on this assessment the participant, if they agree, may be referred to other professionals, such as a registered nurse, psychiatrist, therapist or neuropsychologist for further assessment and identification of needs.

Those participants who have identified behavioral issues will undergo an initial behavioral assessment and, as indicated, periodic reviews. Should a behavior support plan be indicated it will be developed only by a licensed clinician and implemented under the clinician's guidance, with the informed consent of the participant or, when applicable, his or her guardian.

Behavior support plans should also include target behaviors that may also be addressed through prescribed psychotropic medications. Behavior support plans must always be cognitively accessible, and must be reviewed with and signed by the participant and, when applicable, his/her legal guardian.

If the assessment process identifies the need for any modifications of the requirements for provider-owned or controlled residential settings the service plan development process shall: document the specific and individualized assessed need for the modifications; document other interventions and supports used prior to any modifications; include a timeline and process for the collection and review of data measuring the effectiveness of the modifications; and include an assurance that the interventions and supports will cause no harm to the participant. Any modifications must be reviewed with and signed by the participant and, when applicable, his/her legal guardian.

Linked to the participant's vision, goals and needs, the Case Manager facilitates development of the service plan with the participant. Participant's guardians and other formal and informal supports identified by the participant are part of the service planning process. This may include providers with knowledge and history of serving the participant. The Case Manager is responsible for providing information about non-waiver services and supports to address identified needs and to prevent the provision of unnecessary or inappropriate waiver services, coordinating and communicating service plans and/or changes to appropriate community agencies and ensuring that waiver participants have access, as appropriate, to waiver and Medicaid State plan services. The Case Manager also identifies other public benefits to ensure that waiver participant needs are met.

The Case Manager's responsibilities include: facilitating the service planning process and development of the POC with the participant and his/her guardian, ensuring the final plan is signed by the participant and addresses his or her expressed and assessed needs, monitoring the participant's satisfaction with the plan and assisting to ensure that participant receives the services in the plan, notification to participants/guardians, facilitating subsequent monitoring meetings, meeting routinely with the participant to assess the participant's progress towards identified goals and making POC changes with the participant as necessary or as requested by the participant.

The Case Manager ensures that the participant receives a copy of the plan of care. The Case Manager also ensures that a 24-hour back up plan is created, and that the participant understands and is able to implement the 24-hour back up plan when necessary.

During the service planning process and development of the POC, the Case Manager identifies specialized assessments or evaluations that should be completed, and assists the participant to identify their preferred Care Plan Team members. The Case Manager explains programs and services to the participant/guardian, including explaining the opportunity to self-direct certain waiver services, and assists him or her in selecting waiver services and Medicaid state plan services which address the participant's needs and expressed goals.

The participant/guardian may choose to identify other people, for example a representative such as a family member or friend, to be present for the assessment visit and subsequent service planning meetings. The waiver participant/guardian may also choose to exclude individuals from the service plan development process. If the primary language of the program participant, or his/her legal guardian, is not English, the information in service plans must be translated into his/her primary language and/or explained with the assistance of an interpreter, including ASL. If the program participant is unable to read or exhibits other cognitive deficits (e.g. memory

disorder) which may compromise his/her response to the service plan, and he or she does not have a guardian, alternative methods (e.g. audio-taping) shall be utilized in order to ensure that the information is cognitively accessible.

A Plan of Care that has been signed by the participant/guardian is required in order for the Case Manager to initiate authorization of waiver service. The Plan of Care is reviewed periodically with the participant and his/her Care Plan Team and is modified as needed or as requested by the participant.

The participant will receive a quarterly visit by the Case Manager. The Case Manager may determine that more frequent visits would be beneficial and visit the participant more frequently if he/she agrees. In addition, if the Case Manager becomes aware of changes in the participant's health condition or living circumstances, s/he may suggest that it would be beneficial for other clinical professionals to visit the participant. The Case Manager will maintain regular contact through a variety of means with the participant between these visits. The POC may be revised at any point by the Case Manager with the participant/guardian, based on changes in the participant's needs or circumstances.

The Case Manager will document reassessments of the waiver participant in the participant's file. All contact with the participant/guardian, family, vendors and any other persons involved with the participant is also documented in the file.

The Case Manager is responsible for any reasonable accommodations needed for the participant's and family's involvement in the service planning meetings. Accommodations may include personal care assistants, interpreters, peers, translators, physical accessibility, assistive devices, and transportation. These needs may be coordinated and accessed through a waiver service provider involved with the participant.

A very small subset of MFP waiver participants may meet the State's criteria for Targeted Case Management for the mentally ill. For such individuals, the Targeted Case Manager (TCM) would support the individual and coordinate services the person receives through the Department of Mental Health, including such elements as coordinating access to services that DMH provides or contracts for the provision of (which are not duplicative of waiver services), providing supportive counseling, or serving as the person's advocate/supporting the person to advocate for him or herself. The TCM will not play a central role in the planning, authorization or monitoring of waiver services for a participant. The administrative case manager will coordinate closely with the TCM in development of the service plan and in other relevant areas in order to ensure both seamless integration and coordination of waiver services with state agency-provided or -contracted services and, importantly, that neither planned/authorized services, nor case management functions are duplicative.

Administratively claimed case management functions will be limited to the establishment and coordination of Medicaid waiver and state plan services focused on the provision of long term services and supports in the community and are not provided through the Massachusetts Department of Mental Health. Administrative case management that will be claimed is an administrative activity necessary for the proper and efficient administration of the State Medicaid plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk assessment and mitigation are a core part of the service planning process. Through multiple assessments, specific to the participant, reviewed during the service planning process, potential risks to the participant's health and safety and the participant's ability to remain in the community are identified by the participant with the case manager's assistance. With the participant, the case manager facilitates with the rest of the Care Plan Team the development of a set of prevention strategies and responses that will mitigate these risks. Having the participant at the center of this process ensures that the responses are sensitive to his/her needs and preferences.

Residential Habilitation, Shared Living - 24 Hour Supports and Assisted Living Services providers are required to

have policies and procedures in place to address their:

- Risk Assessment Processes
- Emergency Response and Management Protocols
- Emergency Evacuation Safety Plans
- Participants Elopement from the Program

The participant's case record will specifically include the participant's 24 hour back-up plan. Residential Supports providers will have primary responsibility for participant's 24-hour back-up plan. Potential risk areas identified through the assessment process and the POC identifies services or interventions to mitigate those risks, as necessary and agreed to by the participant. The Case Managers works with the participant's service providers to ensure that the identified risks are appropriately managed. The participant's case record will make note of participants, agencies, and informal supports that provide back-up. The Case Manager communicates the back-up plan to the participant, and his/her guardian/informal supports as appropriate, work with the participant to ensure they know the steps to take to activate the back-up plan.

Participants who are self-directing their services will develop with the Case Manager, a back up plan to address issues related to their self-direction and to ensure their ability to obtain back-up services as needed. This plan addresses the potential pitfalls and contingencies that must be identified and agreed to with the participant, and is required to be included in both the participant's case record and the participant's Agreement for Self Directed Supports. Broader risk issues related to the participant and their circumstances will be addressed as necessary and appropriate within the participant's case record.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

As part of the plan of care development process, case management staff review with participants/guardians the range of waiver and non-waiver services available to address the individual's identified needs. The Case Manager works with the participant to identify any specific preferences or requirements, such as a worker who speaks a particular language. The Case Manager makes inquiries regarding the availability of workers, discusses options with the participant (including schedules), and works with the participant to identify the providers best able to meet the requirements and preferences of the waiver participant. The participant ultimately chooses which providers will deliver his/her services. The participant will be advised regarding how to raise concerns about providers and the Case Manager will provide information to the participant regarding how to complain, how to seek assistance from the Case Manager, and how to raise issues with their Program Development and Services Oversight Coordinator if he/she has a complaint about the Case Manager.

At each visit, Case Managers inquire as to the participant's satisfaction with both the services included in the POC and the service providers. The participant may, at any time, request a change of service providers or Case Manager.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DDS will maintain electronic POCs. Additional information may be maintained in a paper record at the Department of Developmental Services Regional Office. Service Plans are reviewed for content, quality, and required components. The sample size is intended to meet requirements of a 95% confidence interval and a +/-5% confidence level. The sample will be randomly generated by a computerized formula which will generate the sample on a quarterly basis throughout the year and it will assure that each Program Development and Services Oversight Coordinator reviews the Service Plans completed by Case Managers from the regions assigned to them.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Hard copies of the person centered planning documents, Plans of Care and 24 hour backup plans are maintained in the participant's paper record in the respective DDS regional office. Electronic service plan records are recorded by case management staff and maintained in DDS's Meditech System. All records are maintained for seven years after the date the case is closed.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Case Manager has overall responsibility for monitoring the implementation of the service plan to ensure that the participant is satisfied with waiver services, that they are furnished in accordance with the POC, meet the participant's needs and achieve their intended outcomes. This is done through periodic progress and update meetings and ongoing contact with the participant, his/her Care Plan Team, and other service providers as appropriate.

The participant will receive a quarterly in-person visit by the case manager. The case manager may determine that more frequent visits would be beneficial and visit the participant in-person more frequently if the participant agrees. If the case manager becomes aware of changes in the participant's health condition or living circumstances, they may suggest that it would be beneficial for other clinical professionals to visit the participant. In addition, the case manager will maintain regular contact with the participant through a variety of means between the in-person visits. The POC may be revised at any point by the case manager with the participant, based on changes in the participant's needs or circumstances.

The case manager will review with the participant the range of waiver and non-waiver services available to address the participant's identified needs and ensure access to services. At each in-person visit and telephone contact, the case manager will inquire as to the participant's satisfaction with both the services included in their POC and the service providers. The participant has free choice of service providers and may, at any time, request a change of service providers.

The case manager will ensure that a 24-hour back up plan is created, and that the participant, and his/her guardian/informal supports as appropriate, understands and is able to implement the 24-hour back up plan when

necessary. Case managers will work with the participant's service providers to ensure that the identified risks are appropriately managed.

In addition there are several other quality management processes, conducted by other departmental staff as well as providers to assure that individual participants are getting the services they need and that their health and welfare is protected. These processes are described more fully in other appendices, and include but are not limited to:

- a) incident reporting and management (described in Appendix G)
- b) medication occurrence reporting (described in Appendix G)
- c) investigations process (described in Appendix G)
- d) "trigger" reports (described in Appendix G)
- e) bi-monthly site visits
- f) risk assessment and management system
- g) human rights and peer review processes
- h) licensure and certification system
- i) annual standard contract review process
- j) periodic progress and update meetings
- k) on-going contact with the participant and service providers.

Through the web based incident reporting and management system, Case Managers are notified of incidents and medication occurrences that occur for individuals on their caseload. The system, known as the Home and Community Services Information System (HCSIS) alerts Case Managers in a timely manner, to any reportable event. Case Managers are required to review and approve action steps taken by the reporting provider. Incidents may not be "closed" until such time as action steps have been approved. In addition, Case Managers receive monthly "trigger" reports, which identify individuals who have reached a certain threshold of incidents. Case Managers are required to review all "trigger" reports to assure that appropriate action has been taken to protect the health and welfare of participants.

The Department also has an extensive risk management system. Risk management teams identify, assess and develop risk management plans for individuals identified who require specific supports in order to mitigate risk to health and safety. Plans are reviewed on a regular basis by the Risk teams to assure their continued efficacy.

Frequency of direct in-person contact with the waiver participant is based on individual needs. Each waiver participant has direct in-person contact at least quarterly. The amount of direct contact is related to a number of variables including whether the participant has a risk plan in place, the number of potential providers who have daily contact with the participant, the frequency of program monitoring activities within the provider site, the frequency and type of family citizen monitoring etc. In response to incidents reported through HCSIS the system produces "trigger reports" which provide additional information to the Case Manager about the need to potentially increase direct in-person contact. Individuals with changing needs are seen more frequently based on their individual needs. Case Managers review progress notes from providers and maintain regular contact with providers of waiver services which also serves to inform the frequency of direct in-person contact. Individuals who have not received at least one waiver service monthly, receive direct in-person contact in the following month.

DDS uses the Supervisory Tool to monitor the access to all needed services on a quarterly basis. Program Development and Services Oversight Coordinators routinely review Case Manager notes to monitor participant access to non-waiver services in the service plan including health services.

Case Managers also conduct bi-monthly site visits of 24 hour residential supports. Case Managers utilize a standardized site visit form that reviews such issues as the condition of the homes, interactions and knowledge of staff of the individual and his/her needs, and whether the individual's health and clinical needs are being addressed. Issues are identified and follow up is conducted by either the Case Manager, program development and service oversight coordinator or other identified regional office staff.

DDS also requires all residential providers to maintain active human rights committees as well as site based human rights officers. Human rights committees review all behavioral interventions to assure that participants' rights have been reviewed and safeguarded. The Human Rights Committee function to insure that the behavioral interventions described and the data collected present a coherent plan and that the treatment is effective. DDS as part of its Survey and Certification process reviews whether all behavioral interventions have all required components and have undergone all required reviews. This includes 1) the composition of the Human Rights Committee. 2) obtaining informed consent from the individual and/or guardians, 3) assuring that all behavior plans are in written format, 4) whether all behavior plans have all the required components, 5) reviewed all of the required reviews which include the POC team, the Human Rights Committee, individual and/or guardian, Peer Review and a Physician Review, 6)

that the data is maintained and used to determine the efficacy of the intervention and that 7) restrictions for one individual do not impinge on the rights of other individuals.

Case Managers conduct quarterly reviews of the service plan and its continued efficacy in assisting individuals to reach their goals and objectives. Providers submit progress reviews and modifications may be made if deemed necessary.

b. Monitoring Safeguards. *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

**% of service plans that reflect needs identified through the assessment process.
(Number of service plans that address needs identified during the assessment process/ Number of service plans reviewed)**

Data Source (Select one):

Other

If 'Other' is selected, specify:

SC Supervisor Tool

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

% of service plans that reflect personal goals identified through the assessment process. (Number of service plans that address personal goals identified during the assessment process/ Number of service plans reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

SC Supervisor Tool

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
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Performance Measure:

% of service plans that have been developed in accordance with waiver requirements as indicated by the inclusion of all required components, including all required assessments, support strategies, choice forms, LOC & POC. (Number of service plans developed in accordance with waiver requirements as indicated by the inclusion of all required components/ Number of service plans reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

SC Supervisor Tool

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
 % of service plans in which communication and contact has been maintained as required to assure that services are being provided and meet the person’s needs. (Number of service plans in which communication and contact has been maintained as required to assure that services are being provided and meet the person’s needs / Number of service plans reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

SC Supervisor Tool

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input type="text"/>
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
No longer needed in new QM system

Data Source (Select one):
Record reviews, on-site
 If 'Other' is selected, specify:
No longer needed

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	

		<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: No longer needed	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: No longer needed
	<input checked="" type="checkbox"/> Other Specify: No longer needed	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: No longer needed	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: No longer needed

c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s needs.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

% of service plans that are completed and/or updated annually. (Number of service plans completed and/or updated annually/ Number of service plans reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

SC Supervisor Tool

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: <input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
% of service plans updated when warranted by changes in participants' needs.
(Number of service plans updated when needs change/ Number of participants reviewed with changing needs)

Data Source (Select one):

Other

If 'Other' is selected, specify:

SC Supervisor Tool

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

% of individuals who are receiving services according to the type, amount, frequency and duration identified in their plan of care. (Number of individuals who are receiving services according to the type, amount, frequency and duration in their plan of care/ Number of individual plans of care reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

SC Supervisor Tool

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	

		<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

e. *Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

% of service plans that contain documentation indicating that participant was informed of his/her choice between service providers and method of service delivery. (Number of service plans that contain documentation indicating that participant was informed of his/her choice between service providers and method of service delivery/ Number of service plans reviewed)

Data Source (Select one):

Other

If 'Other' is selected, specify:

SC Supervisor Tool

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Program Development and Services Oversight Coordinators will review a sample of service plans of each of the service coordinators they supervise utilizing the SC Supervisor Tool. The tool has two components. The first is a checklist that is completed with every service plan submitted for review and approval. The second is a qualitative review which includes discussion with the service coordinator as well as review of supplementary material. This will be done on a quarterly basis. Included will be a review of documentation (including service coordinator notes, site visit forms, and the service plan) and discussion with the service coordinator to verify that service planning and implementation requirements have been met. Each indicator on the tool will be rated according to whether it met the applicable standard.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The State Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Level of Care entity and the Administrative Service Organization. As problems are discovered with the management of the waiver program, the Department of Developmental Services (DDS)and the Office of Medicaid are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, DDS is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

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

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

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*):

Yes. The State requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- 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 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.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual's family has domain and control.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.**
- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Self direction opportunities will be available to all participants enrolled in the waiver.

Participants must express their desire to self-direct services and may be assessed for their need for a surrogate to help them self-direct. The need for surrogacy will be assessed during the service planning process by the care planning team and reviewed annually. If it is determined the participant needs a surrogate, the participant will seek a voluntary surrogate from family, friends, or other sources. If there is absolutely no resource who can serve as a voluntary surrogate, the Case Manager will work with the participant to determine if Individual Support and Community Habilitation services can provide surrogacy support to the participant.

The Case Manager will provide or arrange for skills training to the participant or participant's unpaid surrogate and assist the participant/surrogate in on-going management of the self-directed supports. Should evidence arise that a participant who is self-directing his/her services is no longer able to do so, s/he will be offered the option to have a surrogate, as described above, to assist with their self-direction decisions. If a participant who has been assessed to require surrogacy does not wish to use or continue to use a surrogate he/she will not be able to self-direct and will transition to receiving supports through a traditional provider. Appeal rights will be granted.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant

direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

As part of the intake and waiver eligibility process, information about the waiver and opportunities for self-direction will be provided to each individual. The range of options will be discussed as part of the person-centered planning process and throughout the implementation of the POC by the Case Manager. The case manager will provide written materials to the participant describing both the benefits and potential liabilities of self direction, and the role of the Fiscal Management Service in managing these services. When a participant elects to self direct some of their services, additional information and a handbook about the Fiscal Management Service (FMS) and the requirements for self directing will be provided. The FMS has the responsibility for providing fiscal services relate to income tax and social security tax withholding, and state worker compensation taxes.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The state's practice is to allow Waiver Participants the opportunity to self-direct their waiver services independently if they are able to do so, or with assistance if needed from a non-legal representative chosen by the Waiver Participant.

The Case Manager will provide support as needed to the Waiver Participant to ensure that proper safeguards are in place to ensure effective oversight and implementation of the POC.

The Waiver Participant and the Participant's non-legal representative delineate agreed upon responsibilities of the representative in the Agreement for Self Direction.

The Case Manager will address any concerns they have about self-directed services through regular meetings with the Waiver Participant and their representative. In addition, meetings can occur anytime an issue or concern arises.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Peer Support	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Individual Support and Community Habilitation	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- Governmental entities**
 Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.**
Do not complete Item E-1-i.

Appendix E: Participant Direction of Services**E-1: Overview (8 of 13)**

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

- FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Service (FMS) will be provided through a financial management service entity. These services will be procured in accordance with state procurement laws.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS will be furnished as an administrative activity. The administrative fee is set by MassHealth through the FMS contract and is paid on a per person per day basis. The fee paid is currently \$1.80 per person per day for those participants who choose to self-direct. The FMS contract requires that MassHealth conduct an annual reconciliation of the fee to determine whether or not it is sufficient. Each human and social service organization that delivers services to the Commonwealth's consumers via contracts with state departments is required to complete and submit annual Uniform Financial Statements and Independent Auditor's Report (UFR). MassHealth uses each FMS's annual UFR to compare the FMS's reasonable expenditures for administrative tasks identified in the UFR and paid claims to determine if the FMS expenditures fall within 90% - 110% of the total MassHealth reimbursement. If the FMS reasonable expenditures exceed the reimbursement by more than 10% of what MassHealth has paid, then MassHealth will pay the FMS the amount exceeded, and the rate would most likely be increased. If the reconciliation process shows that FMS expenditures fall below 90% of what they were paid, then the FMS would owe MassHealth, and the rate would be decreased. If the expenditures fall within the 90% - 110% range then no action is needed and no money is either returned or paid out.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

- Assist participant in verifying support worker citizenship status**

- Collect and process timesheets of support workers**
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- Other**

Specify:

The FMS conducts the CORI and List of Excluded Individuals and Entities (LEIE) checks.

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget**
- Track and report participant funds, disbursements and the balance of participant funds**
- Process and pay invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

Specify:

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

Specify:

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 the 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 also provides periodic reports to the participant and case manager regarding utilization of participant-directed services.

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The State will manage the performance of the FMS via contract. The State will establish performance metrics as part of the FMS contract and will require that its FMS meet them and have an established process of remediation if they do not achieve them. Monthly FMS reports will reconcile expenditures for a participant with that participant's approved plan of care. The FMS will also be required to maintain a log of complaints.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify

the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Each participant who desires to self-direct their services will be assessed to determine their capacity to do so and the types of supports that will be required to assist them. Each Participant will have a Case Manager to provide information and assistance to support self-direction. The Case Manager will monitor the implementation of the support plan and provide coordination and oversight of supports. The role of the Case Manager in individual planning is to support the person and other team members to develop and implement a plan that addresses the participant's needs and preferences. Case Managers support participants to be actively involved in the planning process, share information about choice of qualified providers and self-directed options, and assist with arranging supports and services as described in the plan. They also assist the participant to monitor services and make changes as needed. The Case Manager may also assist participants to hire, train and manage their employees, develop emergency back up plans, and provide support and training to access and develop self-advocacy skills.

Case Managers are responsible for ensuring that participants understand their responsibilities under self direction and that the participant has signed the Agreement for Self Directed Supports.

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Peer Support	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>
Residential Habilitation	<input type="checkbox"/>
Orientation and Mobility Services	<input type="checkbox"/>
Medication Administration	<input type="checkbox"/>
Individual Support and Community Habilitation	<input type="checkbox"/>
Transitional Assistance Services	<input type="checkbox"/>
Community Crisis Stabilization	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Community Psychiatric Support and Treatment	<input type="checkbox"/>
Specialized Medical Equipment	<input type="checkbox"/>
Day Services	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Transportation	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Residential Family Training	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Assisted Living Services	<input type="checkbox"/>

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Shared Living - 24 Hour Supports	<input type="checkbox"/>
Addiction Services	<input type="checkbox"/>

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Each participant who desires to self-direct their services will be assessed to determine their capacity to do so and the types of supports that will be required to assist them. Each Participant will have a Case Manager to provide information and assistance to support self-direction.

The Case Manager assists the participant or their legal representative in arranging for, directing, and managing waiver services. Assistance is provided in identifying immediate and long-term needs, developing options to meet those needs and accessing identified waiver supports and waiver services. Participants or their legal representatives may also receive information on recruiting and hiring direct service workers, managing workers and providing information on effective problem solving and communication. The Case Manager function includes providing information to ensure that the participant or legal representative understand the responsibilities of directing their own services; the extent of assistance furnished to the participant is discussed by the team and specified in the service plan. The Case Manager will assist in developing the self-direction specifics of the Plan of Care (POC) to ensure that the needs and preferences are clearly understood and reflected in the plan. In addition the Case Manager will ensure the participant receives skills training to enable him/her to arrange for, direct and manage waiver services. The Case Manager will focus on the following sets of activities in support of participant-directed services:

- Assist the individual to recruit, train and hire staff
- Facilitate community access and inclusion opportunities
- Monitor and assist the individual participant when revisions to the POC are needed
- Assist the participant in working with the Fiscal Management Service to recruit, screen, hire, train, schedule, monitor and pay support workers

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Repeated efforts will be made by the Case Manager to sustain the participant in his/her self-direction of services. If after multiple efforts, the waiver participant voluntarily chooses to terminate this method of receiving services, it is the Case Manager’s responsibility to arrange for and ensure continuity of services/supports through traditional providers to meet the individual’s health and welfare needs outlined in their participant-centered plan of care. When appropriate, the Case Manager will work with the participant to adjust the POC to ensure that it meets the needs and desires of the participant and to ensure health and safety during the transition from participant-directed services to more traditional provider based services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

In the case of an involuntary termination of participant direction, the individual and the support team meet to develop a transition plan and modify the Waiver Plan of Care. The Case Manager ensures that the participant’s health and safety needs are met during the transition, coordinates the transition of services and assists the individual to choose a qualified provider to replace the directly hired staff.

Although the State will work to prevent situations of involuntary termination of self-direction, they may be necessary. Reasons for involuntary termination of self direction will include (but not be limited to) such things as refusal on the part of the participant to be involved in the development and implementation of the Individual Service Planning Process, the participant authorizing payment for services or supports that are not in accordance with the plan of care, the participant’s commission of fraudulent or criminal activity associated with self-direction, demonstration that the participant requires a surrogate to ensure adequate management of workers, but declines such surrogate when informed one is necessary in order to self direct, on-going inability to locate, supervise, and retain employees, and/or to submit time-sheets in a timely manner, and other individual circumstances that may preclude continued self direction.

Each participant who self-directs will have an Agreement for Self Directed Supports describing the expectations of participation. As part of this agreement, the individual acknowledges that the authorization and payment for services that are not rendered could subject him/her to Medicaid fraud charges under state and federal law. Breach of any of the requirements with or without intent may disqualify the individual from self-directing-services. Termination of the participant’s self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement for Self Directed Supports.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority	
Waiver Year	Number of Participants	Number of Participants	
Year 1	6		
Year 2	12		
Year 3	18		
Year 4	23		

	Employer Authority Only		Budget Authority Only or Budget Authority in Combination with Employer Authority		
Waiver Year	Number of Participants		Number of Participants		
Year 5		29			

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. **Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**
 Refer staff to agency for hiring (co-employer)
 Select staff from worker registry
 Hire staff common law employer
 Verify staff qualifications
 Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
 Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
 Determine staff wages and benefits subject to State limits
 Schedule staff
 Orient and instruct staff in duties
 Supervise staff
 Evaluate staff performance
 Verify time worked by staff and approve time sheets

- Discharge staff (common law employer)**
 Discharge staff from providing services (co-employer)
 Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

- b. Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget**
 Determine the amount paid for services within the State's established limits
 Substitute service providers
 Schedule the provision of services
 Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
 Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
 Identify service providers and refer for provider enrollment
 Authorize payment for waiver goods and services
 Review and approve provider invoices for services rendered
 Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

- b. Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the

request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Waiver applicants and participants are afforded the opportunity to request a fair hearing disputing actions under the MFP-RS Waiver in all instances when: (1) they are not provided the choice of home and community-based services as an alternative to institutional care; (2) they are denied participation in the MFP-RS Waiver; (3) there is a denial, suspension, reduction or termination of services, including a substantial failure to implement the services contained in their Individual Service Plan, within the terms and conditions of the MFP-RS Waiver as approved by CMS.

Individuals are informed in writing of the procedures for requesting a Fair Hearing as part of the waiver entrance process. If entrance to the waiver is denied, the person is given formal written notice of the denial and information about how to request a Fair Hearing to appeal the denial of entrance to the waiver. In order to ensure that individuals are fully informed of their right to Fair Hearing, the written information will be supplemented with a verbal explanation of the Right to Fair Hearing when necessary. Appellants are notified that they can seek judicial review of the final decision of the hearing officer in accordance with M.G.L. c. 30A (the Massachusetts Administrative Procedures Act). It is up to the individual to decide whether to request a Fair Hearing.

Whenever an action is taken that adversely affects a waiver participant post-enrollment (e.g., services are denied, reduced or terminated), the participant is notified in writing by letter of the action on a timely basis in advance of the effective date of the action. The notice includes information about how the participant may appeal the action by requesting a Fair Hearing and provides, as appropriate, for the continuation of services while the participant's appeal is under consideration. Copies of notices are maintained in the person's record. It is up to the participant to decide whether to request a Fair Hearing.

The notices regarding the right to appeal in each instance provides a brief description of the appeals process and instructions regarding how to appeal. In addition, it includes contact information for a Case Management staff person who is available to answer questions or to assist the individual in filing an appeal. Regulations of the Executive Office of Administration and Finance at 801 CMR 1.02 et seq (Executive Office for Administration and Finance regulations establishing standard adjudicatory rules of practice and procedure), shall govern MFP-RS Waiver appeal proceedings.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
 Yes. The State operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)
- No. This Appendix does not apply** (*do not complete Items b through e*)
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDS and MRC utilize a web based incident reporting system, based upon the Pennsylvania Home and Community Services Information System (HCSIS) system. The incident reporting system provides invaluable information regarding individual incidents, immediate and long range actions taken as well as aggregate information that informs analyses of patterns and trends. Providers are required to report incidents when they occur and DDS case managers are required to report incidents when they learn about them if they have not already been reported. Incidents are classified as requiring either a minor or major level of review. Deaths, physical and sexual assaults, suicide attempts, unplanned hospitalizations, missing person, injuries, are examples of incidents requiring a major level of review. Suspected verbal or emotional abuse, theft, property damage, and behavioral incidents in the community are examples of incidents requiring a minor level of review. The HCSIS system is an integrated system and as such medication occurrences, and any unauthorized use of restraints or restrictive interventions are also reported. These processes are more fully described in this appendix. Incidents classified as requiring a minor level of review must be reported within 3 business days. Minor incidents may be elevated to major, if determined necessary. Incidents requiring a major level of review must be reported within 1 business day, and the provider has the responsibility to immediately report major incidents by phone or e-mail to the case manager. Immediate and longer term actions steps are delineated and must be reviewed and approved by the case manager for minor incidents and by Regional supervisory staff for

major incidents. An incident cannot be considered closed until all appropriate parties agree on the action steps to be taken. Standard management reports for Regional and Central office staff for purposes of follow up on provider and systemic levels are provided on a monthly basis. Each quarter aggregate data regarding specific incident types are reported. The reports detail both the number of incidents as well as the rate of incidents so that comparisons can be made between Areas, Regions and Statewide.

In addition to the incident reporting system, all alleged instances of abuse or neglect must be reported to the Disabled Persons Protection Commission (DPPC) for all individuals between the ages of 18 and 59 and to both the DPPC and the Executive Office of Elder Affairs for individuals over the age of 59. DPPC is the independent State agency responsible for screening and investigating or referring for investigation all allegations of abuse or neglect for individuals with disabilities between the ages of 18 and 59. DPPC will also screen allegations for individuals over the age of 59 when the abuse is alleged to have occurred in a state funded or operated residential setting. Mandated reporters as well as individuals and families report suspected cases of abuse or neglect directly to the DPPC. DPPC reviews all reports, then determines and assigns investigation responsibility.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

As part of their responsibility, providers are required to inform all participants and families of their right to be free from abuse and neglect and the appropriate agency to whom they should report allegations of abuse, neglect or exploitation. Individuals and their families are given the information both in written and verbal formats. As part of their role, case managers also inform individuals about how to report alleged cases of abuse or neglect. Quality Enhancement surveyors conducting licensure and certification reviews check to assure that individuals and guardians have received information regarding how to report suspected instances of abuse or neglect. They also check to assure that the information is imparted in the format most appropriate to the individual's or family's learning style.

As part of its ongoing commitment to providing participants with information to prevent and report abuse or neglect, DDS has partnered with self-advocacy groups such as Massachusetts Advocates Standing Strong to support awareness and action training program taught by and for self-advocates regarding how to prevent and report abuse. In addition, DDS is a partner with a private provider as part of a Robert Wood Johnson grant to train self-advocates in self defense and to support providers to create a culture of zero tolerance for abuse/neglect.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

As mentioned in G-1-b, there are two distinct processes for reporting incidents one for incidents (classified as requiring a minor or major level of review) and one for reporting of suspected instances of abuse or neglect. A reported incident may also be the subject of an investigation, but the processes are different and carried out by different entities. The processes are described below.

Minor and major incidents must be reported by the staff person observing or discovering the incident. An incident requiring a major level of review must be immediately reported verbally to the case manager. The incident must also be entered into the electronic web based system (HCSIS). A major incident must be reported through HCSIS within 1 business day; a minor incident within 3 business days. The initial report is reviewed by the case manager to assure that immediate actions have been taken to protect the individual. The provider must also submit a final report which includes the action steps that will be taken beyond those already identified. Both minor and major incident reports are reviewed by the case manager. Major incidents are escalated to the regional level for review. The final report, which includes action steps, must be agreed upon by both the provider and DDS. If DDS does not concur with the action steps, the report is sent back to the provider for additional action. Incident reports are considered closed only after there is consensus among the parties as to the action steps taken. A similar process is in place for response to medication occurrences. In the event of a medication occurrence, the review is completed by the regional Medication Administration Program (MAP) coordinator, who is required to be an RN.

Incidents that rise to the level of a reportable event, i.e. allegation of abuse or neglect, potentially subject to

investigation, are reported to the Disabled Persons Protection Commission (DPPC). DPPC receives and reviews all reports and makes the determination as to whether a reported event meets the criteria to require an investigation. It then refers the case to the appropriate agency for investigation. DPPC can decide to conduct the investigation itself, refer the case to the DDS Investigations Unit for investigation, or refer the case to law enforcement entities as the circumstances require. If a report filed suggests that a crime may have been committed, the report is sent to the office of the District Attorney with jurisdiction by the DPPC as a referral. Should the DA decide to pursue the matter criminally, the civil investigation is put on hold, protective services are provided as deemed necessary and law enforcement is assigned to investigate. All reports of abuse or neglect are processed by trained, experienced staff. When deemed necessary, immediate protective services are put into place to ensure that the individual is safe while the investigation is completed. Once referred for investigation, investigators have 30 days to complete their investigation and issue findings. Upon request, the alleged victim, the alleged abuser, and the Reporter can receive a copy of the report. Completed investigations are referred to complaint resolution teams (CRT) comprised of DDS staff and citizen volunteers. It is the CRT's responsibility to develop an action plan and assure that the recommended actions are completed.

In addition, the Human Rights Committee (HRC) for the Residential Habilitation and Shared Living 24 Hour Supports provider agency responsible at the time of the incident is a party to all complaints regarding that agency. In addition to ensuring the alleged victim has access to support for filing complaints of abuse or mistreatment, the HRC is responsible for applying their knowledge of the persons and programs involved and ensuring that any investigation has considered all aspects of the incident. They have the power to appeal the disposition of the complaint, the decisions of the investigation, or the action plan submitted to resolve the investigation. If any major or minor incident appears to involve or impinge on the human rights of an individual, the HRC must be informed of the incident and outcomes.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The responsibility for overseeing the reporting of and response to critical incidents rests with DDS as the operating agency for the waiver. Oversight of the incident management system occurs on three levels- the individual, the provider and the system. As previously mentioned, the incident reporting and management system is a web based system. As such incidents are reported by providers according to clearly defined timelines. The system generates a variety of standard management reports that allow for tracking of timelines for action and follow up as well as for tracking of patterns and trends by individual, location, provider, area, region and state. On an individual level, case managers are responsible for assuring that appropriate actions have been taken and followed up on. On a provider level, Program Development and Service Oversight Coordinators track patterns and trends by location and provider. On a systems level, regional directors and central office senior managers track patterns and trends in order to make service improvements. Licensure and certification staff review incidents and provider actions when they conduct their surveys of residential habilitation and shared living-24 hour supports providers. DDS will forward data on incidents related to specific providers to the Administrative Services Organization (ASO) so that it can incorporate this data into the re-credentialing process for the providers that it credentials.

A central office risk management committee reviews all incident data on a system-wide basis. The committee meets monthly and reviews and analyzes systemic reports generated on specific incident types. Quarterly reports are disseminated to each area and region detailing the numbers and rates of specific incident types. In addition, reports based upon 10 thresholds are disseminated to each case manager monthly. This serves as an additional safeguard to assure that responsible staff are aware of, have taken appropriate action when there are a series of incidents that reach the trigger threshold and to follow up on potential patterns and trends for the individuals they support.

In addition to the processes mentioned above, staff in the Office of Quality Management conduct a bi-weekly review of identified risk categories to assure that they received the appropriate reviews. A report is generated which goes to Regional Risk Managers. In addition, the bi-weekly report with a synopsis of key incidents is distributed to Senior DDS management staff, including the Commissioner.

Finally, on a quarterly basis, a random sample of reports are selected and reviewed by the Program Development and Services Oversight Coordinator. The sample gets reviewed to determine whether appropriate action was taken, whether the actions were consistent with the nature of the incident and whether additional actions are recommended.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The State does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

No use of restraints or seclusion are allowed in the MFP waivers, thus, all such use is unauthorized. While extremely rare, the unauthorized use of a restraint is reported must be reported by providers as an incident in the HCSIS incident reporting system. Providers must also report these incidents to DPPC which screens all allegations of abuse, neglect and mistreatment. Regulations requiring investigation of all reports of abuse and neglect and mistreatment, which would include the unauthorized use of restraints may be found at 118 CMR 5.00 (Regulations for the state's Disabled Persons Protection Commission [the Commission] that define the requirements for abuse investigations conducted by the Commission and the review and oversight standards to be used by the Commission).

In addition, surveyors review whether there are any unauthorized use of restraints or restrictive procedures during routine licensure and certification surveys. Finally, case managers review to assure that no unauthorized procedures are utilized during the course of their visits. Review of data reported on incidents provides case managers and Program Development and Services Oversight Coordinators with information that is used to detect any use of restraints or seclusion.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. Use of Restrictive Interventions.** *(Select one):*

The State does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

-
- **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

DDS has very stringent standards pertaining to the use of restrictive interventions. DDS has a stated policy that all interventions designed to modify behavior must be the least restrictive and least intrusive. Interventions are subject to stringent reviews and safeguards. Interventions that are intrusive or restrictive are used only as a last resort and are subject to the highest level of oversight and monitoring. All restrictive interventions must be discussed and approved by the participant or his/her guardian, as part of the person-centered planning process and documented in the Plan of Care. Case managers review the implementation of any restrictive procedures as part of their routine visits, and licensure and certification staff review the use of any interventions considered to be restrictive as part of their licensure surveys.

DDS is immersed in a major Departmental service improvement initiative to imbed the principles of Positive Behavioral Supports (PBS) into all aspects of its services and supports. This includes training, manuals and tools, and support to providers of service to implement the principles of PBS for all individuals the Department and its providers support.

As DDS moves forward with implementing PBS as the primary approach to supporting individuals, it plans to eliminate the current levels, as defined below, and replace them with the more holistic and clinically accepted approach which PBS represents. Full implementation of PBS into all aspects of services and supports will remain an ongoing focus for the foreseeable future.

Current important safeguards in the DDS policies pertaining to restrictive interventions continue to be in effect. All behavior plans regardless of the level must be in written form and part of the individual's service plan. The plan must include a clear description of the behaviors to treat, specification of how the behavior will be measured, a functional analysis of the antecedents and consequences, the duration and type of intervention, other less restrictive alternatives that have been tried, the name of the treating clinician and a procedure for monitoring, evaluating and documenting the use of the intervention. The levels of intervention currently utilized, include:

Level I- Positive reinforcement procedures and procedures which may also include aversive properties, neither of which pose any more than a minimal risk of physical or psychological harm and that do not involve significant physical exercise or physical enforcement to overcome the individual's active resistance. Examples include differential reinforcement, satiation, tokens, corrective feedback and social disapproval, relaxation, restitution, ignoring, extinction, and time out not exceeding 15 minutes. The use of the strategy of "extinction," is very similar to "ignoring". It refers to the utilization of strategies designed to ignore the targeted behavior so as not to re-enforce or positively reward it. The intent is to extinguish the use of the behavior and replace it with more positive behavior.

As examples, restrictive interventions may include locking refrigerator doors for an individual with Prader-Willi syndrome or placing an alarm on a door to alert staff to participants who are prone to elopement and where this would represent concerns for the participant's safety.

Level II- Any intervention otherwise classified as Level I where the procedure must be enforced over the person's active resistance, or a time out with the individual in the room alone with a closed (but not locked) door for no longer than 15 minutes. No plan may deny an individual adequate sleep, a nutritionally sound diet, adequate bedding, adequate access to bathroom facilities and adequate clothing. All Level II plans must be in written form and must be reviewed and approved prior to implementation by a qualified clinician. In addition, each plan must be reviewed by the provider's human rights committee, (whose composition is prescribed in DDS regulations) and any concerns addressed prior to

the implementation of the plan. Each plan is also reviewed by a physician to assure that the intervention is not medically contraindicated. Each plan is also reviewed by a peer review committee composed of three or more clinicians, at least one of whom must be a licensed psychologist. Behavior plans may not be implemented unless informed consent has been obtained from either the individual or his/her guardian. All plans are subject to the requirements of the service planning process and subject to periodic review and appeal procedures.

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Developmental Services has primary responsibility for the monitoring and oversight of restrictive interventions. In addition to the previously mentioned reviews by the care plan team, the human rights committee, and the peer review committee, the use of restrictive interventions is monitored in the following ways:

- 1) Case managers conduct bi-monthly site visits of homes providing 24 hour supports and quarterly visits of homes providing less than 24 hour supports. As part of the visit, case managers check to see whether behavior plans are being appropriately implemented if an individual has one.
- 2) Licensure and certification staff do an extensive review of interventions to assure that they have gone through all the necessary reviews, whether they are the least intrusive necessary to meet an individual's needs, whether they are being implemented according to requirements, whether staff has received appropriate training, whether documentation is maintained, and whether it has been reviewed periodically. Licensure staff will cite areas of concern in reports to providers if any of the above requirements have not been met. Follow up is conducted by licensure and certification staff when a pattern or trend is noted.
- 3) Any instance of serious physical injury or death of a person who is also the subject of a Level II intervention is reported in the HCSIS database and immediately reported to the Commissioner or designee for review and follow up.
- 4) Aggregate data regarding the review, approval and monitoring of interventions collected during the licensure and certification process is included in the Department's Quality Assurance Reports and subject to review by the statewide quality council for the identification of patterns and trends.
- 5) Any individual, family member, provider staff or DDS employee may seek the guidance of the DDS Human Rights Specialist if he/she has any concerns regarding the plan or its implementation.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

No use of restraints or seclusion are allowed in the MFP waivers, thus, all such use is unauthorized. While extremely rare, the unauthorized use of seclusion must be reported by providers as an incident in the HCSIS incident reporting system. Providers must also report these incidents to DPPC which screens all allegations of abuse, neglect and mistreatment. Regulations requiring investigation of all reports of abuse and neglect and mistreatment, which would include the unauthorized use of seclusion may be found at 118 CMR 5.00 (Regulations for the state's Disabled Persons Protection Commission [the Commission] that define the requirements for abuse investigations conducted by the Commission and the review and oversight standards to be used by the Commission). Case managers review to assure that no unauthorized procedures are utilized during the course of their visits. Review of data reported on incidents provides case managers and supervisors with information that is used to detect any use of restraints or seclusion.

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
- Yes. This Appendix applies** (complete the remaining items)

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

For waiver participants in Residential Habilitation settings the responsibility for monitoring medication regimens is a joint one between providers and DDS staff (specifically, case managers, area office nurses, and the care plan team). DDS has an electronic Health Care Record for all individuals that is maintained by providers and case managers and is updated for purposes of the annual service planning process and development of the POC. Included in the health care record is a list of all medications the individual is taking. This allows for review of medications by the care plan team, as well as facilitating thorough communication of relevant medication information to primary health care providers. Provider agency nurses monitor the use of medication and side effects on an on-going basis. DDS area office nurses are available for consultation and support to providers when individuals are taking multiple medications. Direct support professionals are educated about the side effects of the specific medications individuals they are supporting are taking, and report any issues to the appropriate supervisory personnel.

Medication management in Assisted Living Residences is overseen by the Executive Office of Elder Affairs in accordance with 651 CMR 12.00 (Department of Elder Affairs regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts).

DDS requires staff of Residential Habilitation providers to be trained in a medication administration curriculum (MAP), and to pass this training in order to administer medications. Provider management must demonstrate that medication administration staff have gone through the curriculum and maintain records of their competence with the material upon which they are trained.

As part of the licensing process, DDS will provide ongoing oversight and quality management for each residential habilitation, including the review of medication records and documentation of physician orders, the dispensing of medications and the assessments of the relative independence of each resident in self-administration. DDS oversight will include monitoring of the physical management of medications, including locking and storage of all medications. DDS will oversee and track the reporting of all medication

occurrences for each residential program, aggregate the data and identify trends by residential program as well as system-wide on a quarterly basis or more frequently if needed. If specific issues are identified, staff will intervene to clarify procedures, and require adjustments in operations. If necessary, DDS will develop and monitor adherence to corrective action plans on an individual provider and program basis. DDS has instituted a provider self-monitoring process and will ensure that providers conduct periodic audits utilizing professional/nursing staff from elsewhere within the provider organization, if available, to review their internal operations, methods, and systems of medication administration.

DDS requires Shared Living Placement Agencies to have a system in place for oversight of medication administration in each shared living home. The Placement agency must demonstrate that it has an effective mechanism to monitor and oversee medication administration for shared living provider homes. MAP training is strongly encouraged. Shared living providers must be able to demonstrate that they have a system in their home to assure that there are current health care provider orders, side effect information, labeled pharmacy containers, safe storage of medications, and a process to track and document administration of medications.

Shared Living Provider Agencies do monthly site visits of shared living homes to monitor compliance with regulatory requirements and review medication administration at this time. As a part of the licensure and certification surveys, DDS licensure and certification staff review both the system that the Shared Living Provider Agency has in place to monitor medication administration as well as reviewing individual shared living homes to assure that medication is being correctly administered.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Case managers maintain regular contact with individuals on their caseload and monitor the health status of individuals they are supporting. In addition, through its Health Promotion and Coordination Initiative, DDS has created several processes that facilitate the exchange of information regarding health status and medication regimens between the DDS provider and the health care provider. DDS licensure and certification staff conduct an extensive review of the health care systems that providers have in place to assure coordination, communication and follow up with health care providers on key issues. They also review the level of training and knowledge that direct support professionals have about the health status and medications that the individual is taking. Aggregate data about health and medication status is reported in DDS Quality Assurance Briefs and reviewed by the Statewide quality council.

The Executive Office of Elder Affairs provides oversight for Assisted Living Residence. Oversight in these settings is provided in accordance with 651 CMR 12.00 (Department of Elder Affairs regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts).

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws,

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

Medication administration is allowed in Residential Habilitation, site based respite services and site based day programs that are licensed or operated by DDS. The state medication administration program (MAP) is implemented by the Department of Developmental Services and overseen by the Department of Public Health. Pertinent regulations are 115 CMR 5.15 as well as an extensive policy manual. The MAP program provides for the registration of locations where medication is administered, the requirements about storage and security of medications, the specific training and certification requirements for non-licensed staff, and documentation and record keeping requirements.

Group residences, day programs and short-term site-based respite services are required to obtain a site registration for the purpose of permitting medication administration by MAP certified staff and the storage of medications on site.

Direct support professionals, including licensed nurses working in positions that do not require a nursing license, must be certified in MAP in order to administer medications. MAP certification is valid for two years. Staff must be re-certified every two years. In order to be certified, staff must take part in an approved training curriculum not less than 16 hours, including classroom instruction, testing and a practicum. Trainers must be a registered nurse, nurse practitioner, physician assistant, registered pharmacist or licensed physician who meets applicable requirements as a trainer. Individuals must pass a test consisting of three distinct components (written knowledge, transcription and medication administration) in order to be certified to administer medications. The initial certification is done by an independent contractor, currently D & S Diversified Technologies.

Re-certifications may be done by D & S or by an approved MAP trainer. MAP certified staff and providers must maintain proof of current certification. An individual's certification may be revoked for cause, after an informal hearing process. A record of revoked certifications is maintained by D & S.

Providers are required to adhere to a strict set of standards with respect to storage of medications, documentation of medication counts at the start and end of each shift, labeling of medications and documentation of medication administration for each individual.

Oversight of the medication administration program is conducted by nurses within provider programs as well as DDS MAP nurses and the Department of Public Health Clinical Review process.

Self-medication: An individual is determined to be self medicating when the medication is under the complete control of the individual with no more than minimal assistance from program staff. The ability to self-medicate is determined in conjunction with the individual's care plan team as a result of an assessment process. If the individual is determined to be capable of learning to self-medicate, a teaching plan is developed and documented as part of the service planning process. Once an individual is determined to be self-medicating, an oversight system is developed with built in review periods of at least every 3 months. An individual's ability to continue to self-medicate is reviewed in conjunction with the annual service planning process. Self-medication is applicable to individuals in both 24 hour residential settings as well as shared living settings.

Self-Administration Medication Management (SAMM) is allowed in an Assisted Living Residence if the participant's service plan so specifies. Staff of the Assisted Living who perform SAMM are required to complete Personal Care Service Training as set forth in 651 CMR 12.07(4) or (7)(Department of Elder Affairs regulations describing the certification procedures and standards for Assisted Living Residences); a practitioner, as defined in MGL c. 94C; or a nurse registered or licensed under the provisions of MGL c.112, s. 74 or 74A to the extent allowed by laws, regulations and standards governing nurse practice in Massachusetts MGL c. 94C (the Massachusetts Controlled Substances Act) and MGL c. 112 s. 74 and 74A (which address the regulation of certain professions).

Provider staff:

- remind the residence to take the medication
- check the package to ensure that the name on the package is that of the participant
- observe the participant take the medication

- document in writing the observation of the participant's actions regarding the medication
- if requested by the participant, the staff may open prepackaged medication or open containers, read the name of the medication and the directions on the label to the participant, and respond to any questions the participant may have regarding the directions
- staff may assist a participant with SAMM from a medication container that has been removed from its original pharmacy labeled packaging, if the Assisted Living and participant have a full written disclosure of the risks involved and consent by the participant.

iii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

- (a) Specify State agency (or agencies) to which errors are reported:

Residential Habilitation and site-based day programs that are licensed or operated by DDS. Providers are required to file medication occurrence reports (MOR) to the Department of Developmental Services through the HCSIS web-based event reporting system. MOR's that involve any intervention by a health care provider are also reported to the State Department of Public Health. Pharmacy errors get reported to the Board of Registration in Pharmacy.

Assisted Living service providers must report medication errors to the Executive Office of Elder Affairs.

- (b) Specify the types of medication errors that providers are required to *record*:

Residential Habilitation Providers and site-based day programs are required to record a MOR in all of the following circumstances: anytime a medication is given to the wrong person, anytime the wrong medication is given, anytime a medication is given at the wrong time, anytime a wrong dose is given, anytime a medication is administered through the wrong route, or when the medication is omitted.

- (c) Specify the types of medication errors that providers must *report* to the State:

Residential Habilitation Providers are required to report in all of the following circumstances: anytime a medication is given to the wrong person, anytime the wrong medication is given, anytime a medication is given at the wrong time, anytime a wrong dose is given, anytime a medication is administered through the wrong route, or when the medication is omitted.

Shared Living Placement Agencies monitor the medication administration procedures of their individual shared living homes, and take corrective action when necessary.

An Assisted Living Residence must report to the Certification Unit at Elder Affairs the occurrence of an incident or accident that has or may have a significant negative effect on a resident's health, safety or welfare. This includes medication errors with an adverse effect requiring medical attention.

These reports must be made by telephone and in writing within 24 hours after the occurrence of the incident or accident. Telephone reports are made to a dedicated voice mail line at Elder Affairs and written reports must be faxed to a designated Elder Affairs incident report email address. Reports must include: the nature of the incident or accident; any remedial action taken; the Resident's status at the time the report is made to Elder Affairs; a list of other parties or agencies contacted; and other information as specified in the Assisted Living Certification Standards.

Assisted Living staff must document all assistance with medication, including whether or not the participant took the medication and, when applicable, the reason why medication was not taken.

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department of Developmental Services has primary responsibility of oversight of the Medication Administration Program. The Department of Public Health (DPH) also participates in the oversight responsibility. Providers are required to report all medication occurrences within 24 hours through the HCSIS system. The HCSIS MOR report details the person involved, the type of error, the medications involved, the consultant contacted, any medical interventions that were involved, what followed from the intervention and supervisory follow up action taken. Any MOR that involves medical intervention is also reported to the DPH and is defined as a “hot-line” call. All MOR’s get reviewed by area MAP coordinators who are registered nurses. Follow-up occurs with providers on all MOR’s. This may be accomplished through a phone conversation or a direct site visit, utilizing a clinical review checklist.

On an individual level, MOR’s are reviewed by case managers and are part of an integrated review of all incidents that pertain to the individual. Program monitors and area directors review MOR information as part of the standard contract review process. Licensure and certification staff do a thorough review of both the medication storage and administration records as well as the certification of staff and their knowledge of the medications and their side effects.

Finally, on a systems level, all information regarding medication occurrences is aggregated and management reports are generated semi-annually. These reports detailing the number of medication occurrences including the type and follow up action go to the legislature, Department of Public Health and other stakeholders. In addition, the HCSIS medication occurrence data base includes detailed information as to the factors contributing to a medication occurrence. Review of the management reports enable senior staff and the Statewide Quality Council to identify areas and strategies that may lead to a reduction in the number of medication occurrences, a target for service improvement. Information is then shared through training, publication of newsletters and advisories aimed at steps providers can take to reduce the number of medication occurrences. Data is also aggregated on an annual basis and incorporated into the DDS Quality Assurance Briefs, which are reviewed by the statewide quality council for purposes of service improvement targets.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information

on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

No. and rate of substantiated investigations by type. (Number of substantiated investigations by type/ Number of total adults served and rate per 100 adults)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS Investigations database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
 % of intakes screened in for investigation of abuse where the need for protective services were reviewed as recommended. (Number of intakes screened in for investigation of abuse where the need for protective services were reviewed/ Total number of intakes where a review for protective services were recommended by the senior investigator)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS Investigations database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

	<input type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

% of participants receiving services subject to licensure and certification who know how to report abuse and/or neglect. (Number of participants receiving services subject to licensure and certification who know how to report abuse and neglect/ Number of individuals reviewed)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

% of medication occurrences. (Number of medication occurrences report/ Number of medication doses administered)

Data Source (Select one):

Medication administration data reports, logs

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Semi-Annually

Performance Measure:

% of deaths that are required to have a clinical review that received a clinical review. (Number of deaths that have a clinical review/ Total number of deaths required to have a clinical review)

Data Source (Select one):

Mortality reviews

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

% of providers, subject to DDS licensure and certification, that report abuse and neglect as mandated. (Number of provider agencies that report abuse and neglect as mandated/ Number of providers reviewed)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data		Sampling Approach (check each that applies):
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collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

% of providers who conduct CORI's of prospective employees and take appropriate action when necessary. (Number of providers that conduct CORI's of prospective employees and take required action/ Total number of providers reviewed)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. **Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

% of incident “trigger” reports that have had follow up action taken. (Number of incidents that reach the "trigger" threshold for which action has been taken/ Total number of incidents that reach the "trigger" threshold)

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
		<input type="checkbox"/> Other

	<input checked="" type="checkbox"/> Continuously and Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

% of action/safety plans implemented. (number of action/safety plans implemented for substantiated investigations/ Number of action/safety plans written)

Data Source (Select one):

Other

If 'Other' is selected, specify:

HCSIS Investigations database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

% of providers that are in compliance with requirements concerning restrictive interventions. (Number of providers that are in compliance with requirements concerning restrictive interventions/ Number of providers reviewed by survey and certification with restrictive interventions)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

% of providers that are in compliance with requirements concerning unauthorized use of restraints. (Number of providers that are in compliance with requirements concerning unauthorized use of restraints/ Number of providers reviewed by survey and certification)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. **Sub-assurance:** The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

% of individuals who have had an annual physician visit in the last 15 months.
(Number of individuals with a documented physician visit in the past 15 months/
Number of individuals reviewed)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample

		Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

% of individuals who have had an annual dental visit in the last 15 months.
 (Number of individuals with a documented dental visit in the past 15 months/
 Number of individuals reviewed)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> State Medicaid Agency		
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

% of physicians' orders and treatment protocols followed. (Number of individuals for whom a treatment protocol/physicians' orders are followed/ Number of individuals reviewed with treatment protocols/physicians' orders)

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The State Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Level of Care entity and the Administrative Service Organization. As problems are discovered with the management of the waiver program, the Department of Developmental Services (DDS) and the Office of Medicaid are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, DDS is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Medicaid Agency's quality management strategy is designed to assure that essential safeguards are met with respect to health, safety and quality of life for waiver participants. While there are multiple approaches in place that comprise a robust system, the overall quality management and improvement system continues to evolve and improve. The Office of Medicaid (OOM) has put in place an overarching approach and plan for quality management and improvement across Massachusetts' HCBS waivers. This plan will ensure that the state is able to stratify information to relate to each specific waiver program it operates. The strategy is based on the following key operational principles:

1. The system is designed to create a continuous loop of quality assessment and initiation of improvement including the identification of issues, notification to concerned parties, remediation, follow-up analysis of patterns and trends, and improvement activities.
2. Quality is measured based upon a set of outcome measures agreed upon by waiver stakeholders, which are based on the fundamental purposes of the waiver, CMS assurances, Massachusetts' regulations, and quality goals.
3. The system also assesses quality by measuring health and safety for participants and places a strong emphasis on other quality of life indicators including participant access, person-centered planning and service delivery, rights and responsibilities, participant satisfaction and participant involvement. In addition, MFP Quality of Life survey data will be examined for participants in order to obtain their reflection on quality of life given the long term services and supports available through this waiver.

Three Tiers of Quality Management

The Quality Management and Improvement System (QMIS) approaches quality from three perspectives: the individual, the provider and the system. On each tier, the focus is on the discovery of issues, remediation of identified issues, and system improvement. OOM in collaboration with the Department of Developmental Services (DDS) and the Massachusetts Rehabilitation Commission (MRC) have oversight responsibility for all aspects of the Waiver QMIS for this waiver and the Money Follows the Person – Community Living Waiver, Acquired Brain Injury Residential Habilitation Waiver and the Acquired Brain Injury Non-Residential Habilitation Waiver. Specific areas of oversight include: Level of Care Determination, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability to ensure that direct service providers, the contracted LOC entity, contracted ASO entity and Case Managers are in compliance with applicable standards, policies and procedures.

Systems level improvement efforts are organizationally structured to occur on multiple levels within DDS and MRC. The DDS Office of Quality Management maintains overall responsibility for designing and overseeing the waiver's QMIS and assuring that appropriate data are collected, disseminated, and reviewed, and that service improvement targets are established for participants in these Waivers. The DDS Assistant Commissioner for Quality Management reports in a direct line to the Commissioner, in order to maintain independence from the Operational Services Division.

DDS has an organizational structure of 23 Area Offices and 4 Regional Offices. Case Managers for this waiver are based in the Regional Offices and can draw from staffing and expertise available at both the Area and Regional level. Each Regional Office is overseen by a Regional Director under whose direct supervision the Area Directors function. It is ultimately the Regional Directors, who report directly to the Deputy Commissioner, who are accountable for assuring that identified service improvement efforts are implemented and reviewed.

DDS will work collaboratively with MRC to obtain and aggregate data from all sources including providers, the LOC entity and the ASO and make available system-wide data, analysis of such data, and reports to OOM in order to facilitate the discovery, remediation planning and overall system quality improvement strategies.

Processes for trending, prioritizing and implementing system improvements

Tier I: The Individual Level

DDS maintains a number of databases that enable it to collect information on important outcomes pertaining to individuals, providers and overall systems, to review patterns and trends and establish service improvement targets.

On an individual level, the Home and Community Services Information System (HCSIS) previously described in Appendix G, collects information regarding incidents, medication occurrences, and investigations. This is a web-based system that has been in use by DDS since 2006 and has been adapted to incorporate incident types specific to individuals in this Waiver. The HCSIS system includes a Service Coordinator Supervisor Tool which collects aggregate information regarding the development, implementation and oversight of the service planning process and development of the POC through the review of a sample of individuals and their plans.

In addition, DDS will utilize data and reports available through various sources, including the Meditech database and data from the LOC entity that provides both individual and aggregate information regarding eligibility determinations, level of care determinations and re-determinations.

Tier II-The Provider Level

The next level of the Medicaid Agency's quality management and information system relates to ensuring, on an ongoing basis, that providers are qualified and are performing effectively. For providers of 24-hour residential supports and shared living that entails utilization of the DDS licensure and certification process which has been in effect since 1994 and most recently revised in 2010. Providers of Home Accessibility Adaptations will be credentialed, recertified, and overseen by MRC. For all other waiver services described in Appendix C providers are credentialed and recertified by the ASO. Aggregate data from these processes are collected, reviewed, and analyzed to determine whether there are any patterns or trends that merit the establishment of service improvement initiatives.

Tier III- The System Level

With the current complement of HCBS waivers in Massachusetts, processes have been and continue to be established to support and enhance quality oversight. OOM and DDS are working to ensure that the quality management strategies and infrastructure implemented for the operation of this waiver are consistent with those related to the other HCBS waivers.

OOM, DDS and MRC will review and evaluate measures related to provider capacity and capability; provider qualifications, performance and compliance with applicable standards and requirements; safeguards/critical incident management; client satisfaction; and system performance and wherever appropriate align applicable performance measures with those in other waivers. Data gathered from all sources and processes noted are analyzed and reviewed by a variety of stakeholders and through a variety of committees. The goal of these processes is to assure that both internal and external stakeholders review essential aggregate data on an ongoing basis in order to improve services and supports for all Waiver participants.

As a starting point, DDS, MRC and OOM are committed to assuring the ongoing integrity of data obtained through various collection mechanisms. Two major standards groups exist to oversee the Meditech database and HCSIS. These groups function to continually review and agree upon the business processes as well as the definitions and interpretations that guide the system in order to ensure data integrity and consistency.

A Statewide Incident Review Committee (SIRC) composed of staff from DDS Operations, Investigations, human rights, survey and certification, risk management and health services meets regularly to review aggregate data generated from HCSIS. With research support of the University of Massachusetts Medical School/Center for Developmental Disabilities Evaluation and Research (CDDER), aggregate reports analyzing specific incident types are generated. The reports are based on queries that SIRC determines helpful in analyzing the data. The reports are reviewed by SIRC and form the basis for identifying patterns and trends that may lead to specific service improvement targets. Examples of service improvement targets directly related to analysis of HCSIS data include, but are not limited to, a major falls prevention initiative, and an initiative to reduce medication occurrences. The SIRC membership and purview will be expanded to include the review and analysis of data related to participants in this waiver.

In addition, since 2008, Area, Region and Provider specific aggregate data on incidents are disseminated quarterly (for frequently occurring incidents). These reports show data on incidents by both number and rate that enables comparison between Areas, Regions and the State. Case Managers and Areas also receive

monthly reports on individuals who have reached a threshold of specifically designated incidents that then trigger a review by the Case Manager. These reports enable Areas and Regions to identify patterns and trends with respect to particular individuals they support and to “connect the dots” between different incidents. Areas review the reports to assure that all necessary follow up steps have been taken. As part of the on-going quality assurance process, Regional Risk Managers do a quarterly review of a random sample of individuals who have reached the “trigger” threshold. The review looks into whether appropriate follow up actions were taken consistent with the issues identified. This process includes individuals in this waiver.

DDS also publishes an Annual Mortality Report which details the number of deaths, the age, gender, residential status and cause of death of individuals served by DDS. It is anticipated that a similar report will be published for individuals in this Waiver. The results of this report will enable DDS and OOM to determine whether there are any patterns and trends, particularly with respect to preventable deaths.

As an important component of its commitment to stakeholder and participant input, MRC established an ABI Waiver Stakeholder Advisory Committee to obtain valuable input from constituents. This committee includes ABI waiver participants, case managers, provider agencies, participant family members and individuals with brain injuries. MRC and DDS are using this Committee and have expanded both the focus and the membership of this Advisory Committee to include the MFP Waivers. The committee plays an advisory role and will assist in evaluating waiver program performance. Specifically, it will review data and reports generated from the previously mentioned data systems, e.g. HCSIS, Death Reporting, Licensure and Certification system to determine whether any service improvement projects should be initiated.

Finally, DDS has a variety of publications that are disseminated widely to DDS staff, provider staff, individuals and families that provide important information derived from all of the existing data systems. The information is presented in easy to read formats and in many cases provides “actionable” recommendations to improve health and safety and quality of life for Waiver participants. These publications include the “Quality is no Accident” Brief, the “Living Well Newsletter”, Quality Assurance Briefs on specific subject areas, and on-going advisories to the field. These publications will be expanded, as appropriate, to include data for providers, DDS staff and other stakeholders regarding both MFP and ABI Waiver participants.

We are consolidating the reporting for this waiver with ABI with Residential Habilitation (MA.40701) (see H.1.b.ii).

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Office of Medicaid, DDS and MRC have a strong commitment to a quality management system which continuously evaluates the processes in place to monitor waiver activities and participant outcomes. As this Waiver created a new mechanism to provide HCBS to a population that previously was largely not able to

access these services through publicly-funded programs, OOM and DDS have the opportunity to put in place best practices experienced in other HCBS waivers. The cornerstone of this quality management system is the collaboration between OOM, DDS, and MRC.

A goal of the waiver quality management system is to obtain concrete discovery data which, when aggregated and analyzed, allows for identification of any assurance areas which need immediate quality improvement strategies to remedy the findings. The DDS Office of Quality Management, has primary responsibility for monitoring the effectiveness of system design changes. Implementation of strategies to meet service improvement targets can occur on a variety of levels depending upon the nature of the target. Senior Staff from DDS will review and evaluate the effectiveness of service improvement targets and system design changes on an ongoing basis. In addition, previously mentioned groups, notably, the Statewide Incident Review Committee and the ABI/MFP/TBI Stakeholder Advisory Committee will review progress towards achieving targets and making mid-course corrections, if necessary.

Reviews of the effectiveness of service improvement targets are also conducted by CDDER. As an independent research and policy support to DDS, CDDER has conducted several formative and summative evaluations of specific initiatives. Methods have included focus groups, surveys and evaluation of specific indicators related to the service improvement target.

OOM, DDS and MRC are committed to working with stakeholders, including participants, to ensure an effective quality management strategy for the Waiver program which utilizes participant-focused quality indicators. The ABI/MFP/TBI Waiver Stakeholder Advisory Committee meets on no less than a quarterly basis and reviews performance, system design changes and assessments. This Committee will review quality management data as well as other aspects of the quality management strategy for the Waiver program to identify and support the ways OOM, DDS and MRC can assess and ensure for the highest quality services. Other meetings with stakeholders (i.e., providers, advocates and families) are conducted on an ad-hoc basis throughout the year. Stakeholder involvement and communication are welcomed and encouraged through the formal Committee as well as ad-hoc meetings.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

In collaboration with OOM, MRC and DDS are committed to evaluating the processes and systems in place which comprise our quality management strategy.

The Office of Quality Management within DDS, in close collaboration with MRC, has primary day to day responsibility for assuring that there is an effective and robust quality management system. DDS and MRC work closely with internal and external stakeholders and make recommendations regarding enhancements to the QMIS system on an ongoing basis.

DDS and MRC will continue to work with CDDER to evaluate the effectiveness of its QMIS system and to make recommendations for improvements.

As part of the evaluation of the Quality Improvement Strategy that OOM, DDS and MRC engaged in during this amendment process, we analyzed reporting across several waivers. As determined by that evaluation process and as noted above, we are consolidating the reporting for the ABI with Residential Habilitation (MA.40701) and MFP Residential Supports (MA.1028) Waivers. Our evaluation determined that because these waivers utilize the same quality management and improvement system, that is, they are monitored in the same way, and discovery, remediation and improvement activities are the same, these waivers meet the CMS conditions for a consolidated evidence report. Specifically, the following conditions are present:

1. The design of these waivers is very similar as determined by the similarity in participant services (very similar), participant safeguards (the same) and quality management (the same);
2. The quality management approach is the same across these two waivers including:
 - a. methodology for discovering information with the same HCSIS system and sample selection,
 - b. remediation methods,
 - c. pattern/trend analysis process, and
 - d. all of the same performance indicators;
3. The provider network is the same; and
4. Provider oversight is the same.

For performance measures based on sampling the sample size will be based on a simple random sample of the combined populations with a confidence level of .95.

As part of our intent to consolidate evidence reports, OOM and DDS will transition from the current approved performance measures to proposed amended performance measures during waiver year two. The consolidated evidence reports will contain one year of the originally approved measures; waiver year 2 will be a transition year and subsequent years will reflect the amended performance measures. This will enable us to assure alignment with the modified DDS quality management and data systems referenced in previous appendices.

In waiver year 2, certain performance measures and methodologies (management and data systems) will be in transition to the revised and amended measures and methodologies that are able to take full advantage of Department of Developmental Services management and data systems. A prime example is the Service Coordinator (SC) Supervisor Tool. In waiver year 2, the tool is used as a manual process, with the sample being randomly selected by the Office of Quality Management and supervisors conducting the reviews on paper. Starting in June 2015 (quarter 1 of consolidated waiver reporting), the SC Supervisor tool is online through HCSIS and is an electronic sampling and data collection process. For certain Qualified Provider measures, data will be collected from either the QE5 system, which went online in June 2014 (after the beginning of the waiver year), or the previous MRC site visit review methodology. For all measures, data will be collected and reported, with the transition limited to changes in the management and data systems. In Waiver Year 3 and going forward, all measures, methodologies and data systems will be fully aligned.

The ABI with Residential Habilitation (MA.40701) and MFP Residential Supports (MA.1028) Waivers operate on similar waiver cycles with only one month difference between the effective dates for these waivers. The combined evidence report will be based on the schedule for the MFP Residential Supports Waiver (MA.1028). Because the state is moving the reporting up by one month for MA.40701 (one month earlier), there will be no loss of data. The state will carefully review to ensure data integrity and avoid double counting data for the first waiver year of consolidated reporting. Data will be hand checked to ensure its accuracy for that month (May 2013 for MA.40701).

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) Office of Medicaid (OOM) will engage an Administrative Service Organization (ASO) to recruit qualified direct service providers who are in good financial standing however providers of Residential Habilitation and Shared Living – 24 Hour Supports will be qualified by DDS. Providers of Home Accessibility Adaptations will be qualified by MRC. All direct service providers will execute MassHealth Provider Agreements. The ASO will be required to have an annual independent audit.

(b) The integrity of provider billing data for Medicaid payment of waiver services is managed by the Massachusetts Medicaid Management Information System (MMIS). MassHealth confirms the delivery of services, the units of services and the cost of all services through contract and invoice management prior to submitting claims to Medicaid. MassHealth establishes rates for each waiver service. MMIS sets payment ceilings to ensure integrity of payment and also confirms each participant's Medicaid waiver eligibility as a condition of payment.

(c) The Executive Office of Health and Human Services is responsible for conducting the financial audit program. The Program Integrity Unit is responsible and required by federal regulation to perform post payment reviews of paid claims data to identify duplicate, inconsistent or excessive activity that may be considered fraudulent or abusive. This is accomplished by developing reports/algorithms and/or conducting audits to uncover aberrant billing patterns in which an improper payment may have been made.

KPMG is the contractor that performs the Single State Audit for the Commonwealth of Massachusetts.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.** (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Services are billed in accordance with the plan of care. % of claims submitted to and paid by MMIS will be monitored and reported by DDS using remittance advices. (Approved and paid MMIS claims/ Total service claims submitted)

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Services are billed in accordance with the plan of care. % of claims for services with the Fiscal Intermediary Service that are filed appropriately. (Approved claims filed with the Fiscal Intermediary Service/ Total number of claims filed with the Fiscal Intermediary Service)

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. Sub-assurance: *The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information

on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Services are coded and paid for in accordance with the reimbursement methodology. (number of services with rates derived from and consistent with rate regulations/ Number of services for which claims were submitted)

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Administrative Service Organization reviews all claims prior to submission. The ASO will submit quarterly reports to DDS. Data are aggregated and analyzed annually to ensure services are billed in accordance with established waiver service payment rates.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DDS will be responsible for ensuring that provider billing is in accordance with the services authorized in the service plan. The Administrative Service Organization (ASO) will ensure that services are billed in accordance with the established rate for the service provided. If any discrepancy is noted the ASO will report the error to DDS and/or service provider and the services will only be claimed upon reconciliation of the discrepancy. Claims that cannot be reconciled with payment vouchers or other service documentation will be reported to the Department of Developmental Services.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- 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/mashealth/.

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 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.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Administrative Service Organization reviews all claims prior to submission, comparing the services billed with the services authorized in the waiver Plan of Care (POC). If any discrepancy is noted the ASO will report the error to DDS and/or the service provider and the services will only be claimed upon reconciliation of the discrepancy. Claims that cannot be reconciled will be reported to DDS. Once reconciled the ASO will submit claims for all services (except Residential Habilitation, Shared Living - 24 Hour Supports and Home Accessibility Adaptation) to the MMIS which will process and pay claims as appropriate. Prior to payment, the MMIS system verifies each participant's MassHealth eligibility. Claims payments will be made directly to the waiver service providers.

Payment of provider claims for waiver services are made in accordance with Medicaid timeframes and promptness requirements.

Providers of Residential Habilitation and Shared Living - 24 Hour Supports are reimbursed by DDS on a monthly basis subsequent to the provision of services and upon receipt of an electronic invoice through the Electronic Invoice Management System (EIM). DDS reviews and approves invoices with information from case managers and the Electronic Invoice Management System (EIM) or the Massachusetts Management Accounting and Reporting System (MMARS).

Providers of Home Accessibility Adaptations are reimbursed by MRC on a monthly basis subsequent to the provision of services and upon receipt of an invoice. MRC reviews and approves invoices with information from case managers, via the Electronic Invoice Management System (EIM) or the Massachusetts Management Accounting and Reporting System (MMARS).

Residential Habilitation, Shared Living - 24 Hour Supports and Home Accessibility Adaptations expenditure reports are then generated and processed, and are submitted to MMIS to determine Federal Financial Participation (FFP) amounts. Claims for Residential Habilitation, Shared Living - 24 Hour Supports and Home Accessibility Adaptations services are adjudicated through the state's approved MMIS system. Once the claims have been adjudicated through the CMS approved MMIS system, which validates that the claims are eligible for FFP, the expenditures for waiver services are reported on the CMS 64 report. On a routine basis, at a minimum, quarterly, the claim data is electronically submitted to MMIS for claim editing and processing for eligible participants and expenditures.

When a participant chooses one of the Participant Directed Services listed in Appendix E-1, the Participant Directed Service will be included in the participant's POC. The POC will include the frequency and duration of the authorized Participant Directed Service. The participant will submit their timesheet weekly to the Financial Management Service (FMS) for each worker who provided Participant Directed Services. The FMS will then submit a claim to MMIS for the Participant Directed Service. MMIS will generate payment to the FMS. 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 the 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.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (*select one*):

No. State or local government agencies do not certify expenditures for waiver services.

- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

Expenditures for Residential Habilitation, Shared Living - 24 Hour Supports and Home Accessibility Adaptations services are funded from annual legislative appropriations to the Executive Office of Health and Human Services. Claims for these services are adjudicated through the state's approved MMIS system. Rates are based on the total costs for and utilization of waiver services. Once the claims have adjudicated through the CMS approved MMIS system, which validates that the claims are eligible for Federal Financial participation, the expenditures for waiver services are reported on the CMS 64 report.

MRC is the agency that certifies public expenditures for Home Accessibility Adaptations waiver service. DDS is the agency that certifies public expenditures for Residential Habilitation and Shared Living - 24 Hour Supports waiver services. Expenditures are certified annually utilizing cost report data. Staff from the Public Provider Reimbursement Unit at the University of Massachusetts Medical School (UMMS) Center for Health Care Financing review cost reports and identify allowable and disallowable costs (such as room and board). Payments are made to private providers contracted through MRC and DDS. These providers retain 100% of the payment.

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Massachusetts Medicaid Management Information System (MMIS) maintains date specific eligibility on Medicaid waiver participants. Only service claims for participants whose MassHealth waiver eligibility is verified are submitted for payment processing. MMIS also maintains eligibility data to ensure that a participant is enrolled in a Medicaid waiver program prior to payment of claims. The case manager will validate that the service was in fact provided and is included in the participant's approved service plan.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For Participant Directed Services, the participant will submit timesheets for workers to the FMS providing financial management services. The FMS reviews time sheets for participant-directed services, verifies that they are in accordance with the POC and submits claims to MMIS for payment. The FMS contract includes performance metrics and the submission of monthly reports reconciling expenditures for each participant with their approved service plan. The Medicaid agency conducts an annual monitoring visit to the FMS.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Payment for Diversionary Behavioral Health Services (Addiction Services, Community Crisis Stabilization, Community Psychiatric Support and Treatment and Medication Administration) are made by the managed care entity to the service provider. Payment for participant-directed services is made through a limited fiscal agent. Payment of all other waiver service providers is made directly by the Medicaid agency.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

- e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Providers of Behavioral Health Diversionary Services (Addiction Services, Community Crisis Stabilization, Community Psychiatric Support and Treatment and Medication Administration) are paid by a managed care entity that is paid a monthly capitated payment. Both the managed care entity for Behavioral Health Diversionary Services and all other waiver service providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appropriation of State Tax Revenues is made to the Executive Office of Health and Human Services, the single State Medicaid Agency. Expenditures for Residential Habilitation, Shared Living – 24 Hour Supports and Home Accessibility Adaptations waiver services are funded from annual legislative appropriations to the Executive Office of Health and Human Services. EOHHS then transfers to MRC 100% of the funds for the

Home Accessibility Adaptations waiver service and transfers to DDS 100% of the funds for the Residential Habilitation and Shared Living – 24 Hour Supports waiver services. Both MRC and DDS are organized under EOHHHS and subject to its oversight authority. As indicated in Appendix A-1, each is a separate agency established by and subject to its own enabling legislation. The transfer of funds and requirements for each party are specified in an Interagency Service Agreement (ISA) between EOHHHS and MRC and between EOHHHS and DDS, respectively. MRC and DDS use the funds to make payments for these services to private providers contracted through either MRC or DDS. These providers retain 100% of the payment.

DDS certifies public expenditures for Residential Habilitation and Shared Living – 24 Hour Supports services and MRC certifies public expenditures for Home Accessibility Adaptations services. Expenditures are certified annually utilizing cost report data. Staff from the Public Provider Reimbursement Unit at the University of Massachusetts Medical School (UMMS) Center for Health Care Financing review cost reports and identify allowable and disallowable costs (such as room and board). Claims for these services are adjudicated through the state's approved MMIS system. Rates are based on the total costs for and utilization of waiver services. Once the claims have adjudicated through the CMS approved MMIS system, which validates that the claims are eligible for Federal Financial participation, the expenditures for waiver services are reported on the CMS 64 report.

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

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v

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

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v

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

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v

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**
Check each that applies:
- Health care-related taxes or fees**
- Provider-related donations**
- Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The Executive Office of Health and Human Services (EOHHS) has developed rates that are used to pay for the service delivered in residential habilitation, assisted living and shared living-24 hour supports settings for participants in this waiver.

EOHHS developed the service rates by examining the Uniform Financial Reports (UFRs) of several current providers of the residential habilitation service. The UFRs detail costs incurred by the providers for particular activities, and clearly separate activity costs that are part of the residential habilitation service from activity costs that related to providing room and board to residents in these settings. Shared Living-24 Hour Supports services and Assisted Living Services rates were developed based on an amalgamation of existing rates for comparable service components and an analysis of provider cost data. All room and board costs are excluded from the rate computation.

For residential habilitation EOHHS developed a separate schedule of rates reflecting the cost of room and board for participants; the Commonwealth will make room and board payments separately from the service rate payments. The Commonwealth makes payments for room and board directly to the providers of residential habilitation service through the state accounting system MMARS. These payments are not submitted to the MMIS system. The Commonwealth's payments to providers for the cost of room and board will not be submitted for Medicaid claims.

Participants receiving Assisted Living Services and Shared Living-24 Hour Supports are responsible for payment of room and board charges directly to the landlord.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)****a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**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-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: 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 (Col 7 less Column4)
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		126511.61			136605.82	10094.21

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 (Col 7 less Column4)
		16289.63		130019.61	6586.21		
4	120539.47	17705.87	138245.34	141251.09	7155.15	148406.24	10160.90
5	127897.69	18843.06	146740.75	150244.87	7610.73	157855.60	11114.85

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- 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	249	101	148
Year 5	304	124	180

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay for each year of the waiver reflects enrollment ramp up for new participants each year; once a person is on the waiver, we expect the average length of stay will be 338 days, based on experience with populations in similar waivers. Therefore, in Year 1 the average length of stay is 169 days, which is half of the 338 days, an average of 5.5 months. This accounts for people entering the waiver year early in the waiver year and later in the waiver year. In subsequent years, waiver participants from the previous year are assumed to have an average length of stay of 338 days, and new participants are averaged at 169 days. Thus the average length of stay in Years 2, 3, 4 and 5 are 254, 282, 296 and 304 days respectively.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- 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 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, 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 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.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' estimates are based on a weighted average of the utilization of all other Medicaid services (D') by the Traumatic Brain Injury Waiver MA.0359 participants as reported on the 2007 CMS-372 and by the Frail Elder Waiver MA.0059 participants as reported on the 2008 CMS-372. The weighting is based on the expected proportion of waiver participants that will be at a Hospital Level of Care to those expected to be at a Nursing Facility Level of Care, over the 5 year waiver period. The respective average per capita D' costs are trended at the 3.5% CPI rate to Waiver Year 1 (SFY 2013) and forward. These average costs are further adjusted to reflect the estimated Behavioral Health PIHP PMPM cost for the set of services that would be delivered in an inpatient setting (54.3% of the total estimated PIHP PMPM), for the estimated 90% of the 1915(c) waiver population that will access managed behavioral health services via this concurrent 1915(b)/(c) waiver. This portion of the Behavioral Health PIHP PMPM 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 average per capita costs for State Plan behavioral health services are backed out of the D' base weighted average for the 90% of the waiver population that will access managed behavioral health services. The annualized value of Factor D' is adjusted by the average length of stay used for Factor D to make the period of comparison comparable.

Any pharmacy costs incurred as a result of Medicare Part D implementation has been identified and excluded from the trend.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is derived from a weighted average of SFY 2011 actual average cost per member per year for a comparable population in a continuous nursing facility or chronic rehabilitation hospital stay, based on the expected proportion of waiver participants at each level of care over the 5 year waiver period. As the expected waiver population is broader than existing home and community based waiver programs, we pulled recent data on long stay facility populations age 18+, rather than trend from existing CMS-372 reports, for comparable population expenditures. The weighted average is trended forward at the 3.5% CPI rate, annually. The annualized value of Factor G is adjusted by the average length of stay used for Factor D to make the period of comparison comparable.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is derived from a weighted average of SFY 2011 actual average cost per member per year for non-facility Medicaid State Plan costs for a comparable population in a continuous nursing facility or chronic rehabilitation hospital stay, as referenced above. The weighted average is trended forward at the 3.5% CPI rate, annually. Any pharmacy cost that will no longer be incurred as a result of Medicare Part D implementation has been identified and excluded from the trend. The annualized value of Factor G' is adjusted by the average length of stay used for Factor D to make the period of comparison comparable.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Prevocational Services	
Residential Habilitation	
Supported Employment	
Addiction Services	
Assisted Living Services	
Community Crisis Stabilization	
Community Psychiatric Support and Treatment	
Day Services	
Home Accessibility Adaptations	
Individual Support and Community Habilitation	
Medication Administration	
Occupational Therapy	
Orientation and Mobility Services	
Peer Support	
Physical Therapy	
Residential Family Training	
Shared Living - 24 Hour Supports	
Skilled Nursing	
Specialized Medical Equipment	

Waiver Services	
Speech Therapy	
Transitional Assistance Services	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. 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 1

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:							11282.16
Prevocational Services	<input type="checkbox"/>	Per Diem	1	48.00	102.90	4939.20	
15 min	<input type="checkbox"/>	15 Min	1	741.00	8.56	6342.96	
Residential Habilitation Total:							3486758.99
Residential Habilitation	<input type="checkbox"/>	Per Diem	59	169.00	349.69	3486758.99	
Supported Employment Total:							6608.32
Supported Employment	<input type="checkbox"/>	15 Min	2	386.00	8.56	6608.32	
Addiction Services Total:							3258.21
Addiction Services	<input checked="" type="checkbox"/>	15 Min	11	18.05	16.41	3258.21	
Assisted Living Services Total:							52996.71
Assisted Living Services	<input type="checkbox"/>	Per Diem	3	169.00	104.53	52996.71	
Community Crisis Stabilization Total:							3667.86
Community Crisis Stabilization	<input checked="" type="checkbox"/>	15 Min	21	4.92	35.50	3667.86	
Community Psychiatric Support and Treatment Total:							13051.67
GRAND TOTAL:							4044252.41
Total: Services included in capitation:							19990.37
Total: Services not included in capitation:							4024262.04
Total Estimated Unduplicated Participants:							65
Factor D (Divide total by number of participants):							62219.27
Services included in capitation:							307.54
Services not included in capitation:							61911.72
Average Length of Stay on the Waiver:							169

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Psychiatric Support and Treatment	<input checked="" type="checkbox"/>	15 Min	47	9.18	30.25	13051.66	
Day Services Total:							192628.80
Day Services - Per Diem	<input type="checkbox"/>	Per Diem	26	72.00	102.90	192628.80	
Day Services - 15 min	<input type="checkbox"/>	15 min.	0	0.00	0.01	0.00	
Home Accessibility Adaptations Total:							15000.00
Home Accessibility Adaptations	<input type="checkbox"/>	Item	1	1.00	15000.00	15000.00	
Individual Support and Community Habilitation Total:							5726.80
Individual Support and Community Habilitation	<input type="checkbox"/>	15 Min	1	556.00	10.30	5726.80	
Medication Administration Total:							12.64
Medication Administration	<input checked="" type="checkbox"/>	15 Min	6	0.65	3.24	12.64	
Occupational Therapy Total:							11961.60
Occupational Therapy	<input type="checkbox"/>	Visit	7	24.00	71.20	11961.60	
Orientation and Mobility Services Total:							0.00
Orientation and Mobility Services	<input type="checkbox"/>	15 min.	0	0.00	0.01	0.00	
Peer Support Total:							22551.36
Peer Support	<input type="checkbox"/>	15 Min	13	556.00	3.12	22551.36	
Physical Therapy Total:							26227.20
Physical Therapy	<input type="checkbox"/>	Visit	16	24.00	68.30	26227.20	
Residential Family Training Total:							340.08
Residential Family Training	<input type="checkbox"/>	15 Min	1	109.00	3.12	340.08	
Shared Living - 24 Hour Supports Total:							78585.00
Shared Living - 24 Hour Supports	<input type="checkbox"/>	Per Diem	3	169.00	155.00	78585.00	
Skilled Nursing Total:							5219.28
GRAND TOTAL:							4044252.41
Total: Services included in capitation:							19990.37
Total: Services not included in capitation:							4024262.04
Total Estimated Unduplicated Participants:							65
Factor D (Divide total by number of participants):							62219.27
Services included in capitation:							307.54
Services not included in capitation:							61911.72
Average Length of Stay on the Waiver:							169

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled Nursing	<input type="checkbox"/>	Visit	3	24.00	72.49	5219.28	
Specialized Medical Equipment Total:							36418.40
Specialized Medical Equipment	<input type="checkbox"/>	Item	16	1.00	2276.15	36418.40	
Speech Therapy Total:							12243.84
Speech Therapy	<input type="checkbox"/>	Visit	7	24.00	72.88	12243.84	
Transitional Assistance Services Total:							0.00
Transitional Assistance Services	<input type="checkbox"/>	Per Episode	0	0.00	0.01	0.00	
Transportation Total:							59713.50
Transportation	<input type="checkbox"/>	1 Way Trip	33	94.00	19.25	59713.50	
GRAND TOTAL:							4044252.41
Total: Services included in capitation:							19990.37
Total: Services not included in capitation:							4024262.04
Total Estimated Unduplicated Participants:							65
Factor D (Divide total by number of participants):							62219.27
Services included in capitation:							307.54
Services not included in capitation:							61911.72
Average Length of Stay on the Waiver:							169

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. **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 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:							35058.36
Prevocational Services	<input type="checkbox"/>	Per Diem	2	72.00	106.50	15336.00	
15 min	<input type="checkbox"/>	15 Min	2	1113.00	8.86	19722.36	
GRAND TOTAL:							11498325.98
Total: Services included in capitation:							51183.42
Total: Services not included in capitation:							11447142.56
Total Estimated Unduplicated Participants:							120
Factor D (Divide total by number of participants):							95819.38
Services included in capitation:							426.53
Services not included in capitation:							95392.85
Average Length of Stay on the Waiver:							254

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:							9928463.76
Residential Habilitation	<input type="checkbox"/>	Per Diem	108	254.00	361.93	9928463.76	
Supported Employment Total:							20555.20
Supported Employment	<input type="checkbox"/>	15 Min	4	580.00	8.86	20555.20	
Addiction Services Total:							8342.71
Addiction Services	<input checked="" type="checkbox"/>	15 Min	19	26.23	16.74	8342.71	
Assisted Living Services Total:							164881.56
Assisted Living Services	<input type="checkbox"/>	Per Diem	6	254.00	108.19	164881.56	
Community Crisis Stabilization Total:							9397.94
Community Crisis Stabilization	<input checked="" type="checkbox"/>	15 Min	38	6.83	36.21	9397.94	
Community Psychiatric Support and Treatment Total:							33413.36
Community Psychiatric Support and Treatment	<input checked="" type="checkbox"/>	15 Min	86	12.59	30.86	33413.36	
Day Services Total:							557208.00
Day Services - Per Diem	<input type="checkbox"/>	Per Diem	48	109.00	106.50	557208.00	
Day Services - 15 min	<input type="checkbox"/>	15 min.	0	0.00	0.01	0.00	
Home Accessibility Adaptations Total:							15525.00
Home Accessibility Adaptations	<input type="checkbox"/>	Item	1	1.00	15525.00	15525.00	
Individual Support and Community Habilitation Total:							17802.20
Individual Support and Community Habilitation	<input type="checkbox"/>	15 Min	2	835.00	10.66	17802.20	
Medication Administration Total:							29.40
Medication Administration	<input checked="" type="checkbox"/>	15 Min	11	0.81	3.30	29.40	
Occupational Therapy Total:							31834.08
Occupational Therapy	<input type="checkbox"/>	Visit	12	36.00	73.69	31834.08	
GRAND TOTAL:							11498325.98
Total: Services included in capitation:							51183.42
Total: Services not included in capitation:							11447142.56
Total Estimated Unduplicated Participants:							120
Factor D (Divide total by number of participants):							95819.38
Services included in capitation:							426.53
Services not included in capitation:							95392.85
Average Length of Stay on the Waiver:							254

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Orientation and Mobility Services Total:							0.00
Orientation and Mobility Services	<input type="checkbox"/>	15 min.	0	0.00	0.01	0.00	
Peer Support Total:							64729.20
Peer Support	<input type="checkbox"/>	15 Min	24	835.00	3.23	64729.20	
Physical Therapy Total:							76345.20
Physical Therapy	<input type="checkbox"/>	Visit	30	36.00	70.69	76345.20	
Residential Family Training Total:							1059.44
Residential Family Training	<input type="checkbox"/>	15 Min	2	164.00	3.23	1059.44	
Shared Living - 24 Hour Supports Total:							244495.32
Shared Living - 24 Hour Supports	<input type="checkbox"/>	Per Diem	6	254.00	160.43	244495.32	
Skilled Nursing Total:							16206.48
Skilled Nursing	<input type="checkbox"/>	Visit	6	36.00	75.03	16206.48	
Specialized Medical Equipment Total:							70674.60
Specialized Medical Equipment	<input type="checkbox"/>	Item	30	1.00	2355.82	70674.60	
Speech Therapy Total:							32585.76
Speech Therapy	<input type="checkbox"/>	Visit	12	36.00	75.43	32585.76	
Transitional Assistance Services Total:							0.00
Transitional Assistance Services	<input type="checkbox"/>	Per Episode	0	0.00	0.01	0.00	
Transportation Total:							169718.40
Transportation	<input type="checkbox"/>	1 Way Trip	60	142.00	19.92	169718.40	
GRAND TOTAL:							11498325.98
Total: Services included in capitation:							51183.42
Total: Services not included in capitation:							11447142.56
Total Estimated Unduplicated Participants:							120
Factor D (Divide total by number of participants):							95819.38
Services included in capitation:							426.53
Services not included in capitation:							95392.85
Average Length of Stay on the Waiver:							254

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. 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 3

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:							80610.08
Prevocational Services	<input type="checkbox"/>	Per Diem	4	80.00	110.23	35273.60	
15 min	<input type="checkbox"/>	15 Min	4	1236.00	9.17	45336.48	
Residential Habilitation Total:							17218863.60
Residential Habilitation	<input type="checkbox"/>	Per Diem	163	282.00	374.60	17218863.60	
Supported Employment Total:							29527.40
Supported Employment	<input type="checkbox"/>	15 Min	5	644.00	9.17	29527.40	
Addiction Services Total:							14920.20
Addiction Services	<input checked="" type="checkbox"/>	15 Min	29	30.14	17.07	14920.20	
Assisted Living Services Total:							284205.24
Assisted Living Services	<input type="checkbox"/>	Per Diem	9	282.00	111.98	284205.24	
Community Crisis Stabilization Total:							16819.03
Community Crisis Stabilization	<input checked="" type="checkbox"/>	15 Min	57	7.99	36.93	16819.03	
Community Psychiatric Support and Treatment Total:							59503.50
Community Psychiatric Support and Treatment	<input checked="" type="checkbox"/>	15 Min	130	14.54	31.48	59503.50	
Day Services Total:							960323.76
Day Services - Per Diem	<input type="checkbox"/>	Per Diem	72	121.00	110.23	960323.76	
Day Services - 15 min	<input type="checkbox"/>	15 min.	0	0.00	0.01	0.00	
Home Accessibility Adaptations Total:							32136.76
GRAND TOTAL:							19950179.10
Total: Services included in capitation:							91317.21
Total: Services not included in capitation:							19858861.89
Total Estimated Unduplicated Participants:							181
Factor D (Divide total by number of participants):							110221.98
Services included in capitation:							504.51
Services not included in capitation:							109717.47
Average Length of Stay on the Waiver:							282

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Accessibility Adaptations	<input type="checkbox"/>	Item	2	1.00	16068.38	32136.76	
Individual Support and Community Habilitation Total:							40899.24
Individual Support and Community Habilitation	<input type="checkbox"/>	15 Min	4	927.00	11.03	40899.24	
Medication Administration Total:							74.48
Medication Administration	<input checked="" type="checkbox"/>	15 Min	17	1.30	3.37	74.48	
Occupational Therapy Total:							54914.40
Occupational Therapy	<input type="checkbox"/>	Visit	18	40.00	76.27	54914.40	
Orientation and Mobility Services Total:							0.00
Orientation and Mobility Services	<input type="checkbox"/>	15 min.	0	0.00	0.01	0.00	
Peer Support Total:							111462.48
Peer Support	<input type="checkbox"/>	15 Min	36	927.00	3.34	111462.48	
Physical Therapy Total:							131688.00
Physical Therapy	<input type="checkbox"/>	Visit	45	40.00	73.16	131688.00	
Residential Family Training Total:							2431.52
Residential Family Training	<input type="checkbox"/>	15 Min	4	182.00	3.34	2431.52	
Shared Living - 24 Hour Supports Total:							421434.90
Shared Living - 24 Hour Supports	<input type="checkbox"/>	Per Diem	9	282.00	166.05	421434.90	
Skilled Nursing Total:							27957.60
Skilled Nursing	<input type="checkbox"/>	Visit	9	40.00	77.66	27957.60	
Specialized Medical Equipment Total:							109722.15
Specialized Medical Equipment	<input type="checkbox"/>	Item	45	1.00	2438.27	109722.15	
Speech Therapy Total:							56210.40
Speech Therapy	<input type="checkbox"/>					56210.40	
GRAND TOTAL:							19950179.10
Total: Services included in capitation:							91317.21
Total: Services not included in capitation:							19858861.89
Total Estimated Unduplicated Participants:							181
Factor D (Divide total by number of participants):							110221.98
Services included in capitation:							504.51
Services not included in capitation:							109717.47
Average Length of Stay on the Waiver:							282

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Visit	18	40.00	78.07		
Transitional Assistance Services Total:							0.00
Transitional Assistance Services	<input type="checkbox"/>	Per Episode	0	0.00	0.01	0.00	
Transportation Total:							296474.36
Transportation	<input type="checkbox"/>	1 Way Trip	91	158.00	20.62	296474.36	
GRAND TOTAL:							19950179.10
Total: Services included in capitation:							91317.21
Total: Services not included in capitation:							19858861.89
Total Estimated Unduplicated Participants:							181
Factor D (Divide total by number of participants):							110221.98
Services included in capitation:							504.51
Services not included in capitation:							109717.47
Average Length of Stay on the Waiver:							282

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. 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

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:							187420.80
Prevocational Services	<input type="checkbox"/>	Per Diem	5	84.00	114.09	47917.80	
15 min	<input type="checkbox"/>	15 Min	25	588.00	9.49	139503.00	
Residential Habilitation Total:							25706723.84
Residential Habilitation	<input type="checkbox"/>	Per Diem	224	296.00	387.71	25706723.84	
Supported Employment Total:							44906.68
	<input type="checkbox"/>					44906.68	
GRAND TOTAL:							30014328.99
Total: Services included in capitation:							146092.72
Total: Services not included in capitation:							29868236.27
Total Estimated Unduplicated Participants:							249
Factor D (Divide total by number of participants):							120539.47
Services included in capitation:							586.72
Services not included in capitation:							119952.76
Average Length of Stay on the Waiver:							296

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment		15 Min	7	676.00	9.49		
Addiction Services Total:							23719.38
Addiction Services	<input checked="" type="checkbox"/>	15 Min	40	34.06	17.41	23719.38	
Assisted Living Services Total:							411676.80
Assisted Living Services	<input type="checkbox"/>	Per Diem	12	296.00	115.90	411676.80	
Community Crisis Stabilization Total:							26738.17
Community Crisis Stabilization	<input checked="" type="checkbox"/>	15 Min	78	9.10	37.67	26738.17	
Community Psychiatric Support and Treatment Total:							95482.30
Community Psychiatric Support and Treatment	<input checked="" type="checkbox"/>	15 Min	180	16.52	32.11	95482.30	
Day Services Total:							1475296.77
Day Services - Per Diem	<input type="checkbox"/>	Per Diem	100	95.25	114.09	1086707.25	
Day Services - 15 min	<input type="checkbox"/>	15 min.	122	762.00	4.18	388589.52	
Home Accessibility Adaptations Total:							33261.54
Home Accessibility Adaptations	<input type="checkbox"/>	Item	2	1.00	16630.77	33261.54	
Individual Support and Community Habilitation Total:							55558.30
Individual Support and Community Habilitation	<input type="checkbox"/>	15 Min	5	973.00	11.42	55558.30	
Medication Administration Total:							152.87
Medication Administration	<input checked="" type="checkbox"/>	15 Min	22	2.02	3.44	152.87	
Occupational Therapy Total:							82887.00
Occupational Therapy	<input type="checkbox"/>	Visit	25	42.00	78.94	82887.00	
Orientation and Mobility Services Total:							496.32
Orientation and Mobility Services	<input type="checkbox"/>	15 min.	1	16.00	31.02	496.32	
GRAND TOTAL:							30014328.99
Total: Services included in capitation:							146092.72
Total: Services not included in capitation:							29868236.27
Total Estimated Unduplicated Participants:							249
Factor D (Divide total by number of participants):							120539.47
Services included in capitation:							586.72
Services not included in capitation:							119952.76
Average Length of Stay on the Waiver:							296

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Peer Support Total:							168329.00
Peer Support	<input type="checkbox"/>	15 Min	50	973.00	3.46	168329.00	
Physical Therapy Total:							197174.88
Physical Therapy	<input type="checkbox"/>	Visit	62	42.00	75.72	197174.88	
Residential Family Training Total:							3304.30
Residential Family Training	<input type="checkbox"/>	15 Min	5	191.00	3.46	3304.30	
Shared Living - 24 Hour Supports Total:							610446.72
Shared Living - 24 Hour Supports	<input type="checkbox"/>	Per Diem	12	296.00	171.86	610446.72	
Skilled Nursing Total:							40511.52
Skilled Nursing	<input type="checkbox"/>	Visit	12	42.00	80.38	40511.52	
Specialized Medical Equipment Total:							156463.82
Specialized Medical Equipment	<input type="checkbox"/>	Item	62	1.00	2523.61	156463.82	
Speech Therapy Total:							84840.00
Speech Therapy	<input type="checkbox"/>	Visit	25	42.00	80.80	84840.00	
Transitional Assistance Services Total:							168800.48
Transitional Assistance Services	<input type="checkbox"/>	Per Episode	34	2.00	2482.36	168800.48	
Transportation Total:							440137.50
Transportation	<input type="checkbox"/>	1 Way Trip	125	165.00	21.34	440137.50	
GRAND TOTAL:							30014328.99
Total: Services included in capitation:							146092.72
Total: Services not included in capitation:							29868236.27
Total Estimated Unduplicated Participants:							249
Factor D (Divide total by number of participants):							120539.47
Services included in capitation:							586.72
Services not included in capitation:							119952.76
Average Length of Stay on the Waiver:							296

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. **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

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:							173224.80
Prevocational Services	<input type="checkbox"/>	Per Diem	0	0.00	0.01	0.00	
15 min	<input type="checkbox"/>	15 Min	30	588.00	9.82	173224.80	
Residential Habilitation Total:							33425018.88
Residential Habilitation	<input type="checkbox"/>	Per Diem	274	304.00	401.28	33425018.88	
Supported Employment Total:							61335.72
Supported Employment	<input type="checkbox"/>	15 Min	9	694.00	9.82	61335.72	
Addiction Services Total:							30345.27
Addiction Services	<input checked="" type="checkbox"/>	15 Min	49	34.87	17.76	30345.27	
Assisted Living Services Total:							547017.60
Assisted Living Services	<input type="checkbox"/>	Per Diem	15	304.00	119.96	547017.60	
Community Crisis Stabilization Total:							34199.56
Community Crisis Stabilization	<input checked="" type="checkbox"/>	15 Min	95	9.37	38.42	34199.56	
Community Psychiatric Support and Treatment Total:							122071.70
Community Psychiatric Support and Treatment	<input checked="" type="checkbox"/>	15 Min	219	17.02	32.75	122071.70	
Day Services Total:							1898355.36
Day Services - Per Diem	<input type="checkbox"/>	Per Diem	0	0.00	0.01	0.00	
Day Services - 15 min	<input type="checkbox"/>	15 min.	149	3048.00	4.18	1898355.36	
Home Accessibility Adaptations Total:							51638.55
Home Accessibility Adaptations	<input type="checkbox"/>	Item	3	1.00	17212.85	51638.55	
							70920.00
GRAND TOTAL:							3888098.21
Total: Services included in capitation:							186782.37
Total: Services not included in capitation:							38694115.84
Total Estimated Unduplicated Participants:							304
Factor D (Divide total by number of participants):							127897.69
Services included in capitation:							614.42
Services not included in capitation:							127283.28
Average Length of Stay on the Waiver:							304

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Support and Community Habilitation Total:							
Individual Support and Community Habilitation	<input type="checkbox"/>	15 Min	6	1000.00	11.82	70920.00	
Medication Administration Total:							165.85
Medication Administration	<input checked="" type="checkbox"/>	15 Min	27	1.75	3.51	165.85	
Occupational Therapy Total:							105393.00
Occupational Therapy	<input type="checkbox"/>	Visit	30	43.00	81.70	105393.00	
Orientation and Mobility Services Total:							1488.96
Orientation and Mobility Services	<input type="checkbox"/>	15 min.	3	16.00	31.02	1488.96	
Peer Support Total:							218380.00
Peer Support	<input type="checkbox"/>	15 Min	61	1000.00	3.58	218380.00	
Physical Therapy Total:							256113.16
Physical Therapy	<input type="checkbox"/>	Visit	76	43.00	78.37	256113.16	
Residential Family Training Total:							4231.56
Residential Family Training	<input type="checkbox"/>	15 Min	6	197.00	3.58	4231.56	
Shared Living - 24 Hour Supports Total:							811132.80
Shared Living - 24 Hour Supports	<input type="checkbox"/>	Per Diem	15	304.00	177.88	811132.80	
Skilled Nursing Total:							53657.55
Skilled Nursing	<input type="checkbox"/>	Visit	15	43.00	83.19	53657.55	
Specialized Medical Equipment Total:							198507.44
Specialized Medical Equipment	<input type="checkbox"/>	Item	76	1.00	2611.94	198507.44	
Speech Therapy Total:							107882.70
Speech Therapy	<input type="checkbox"/>	Visit	30	43.00	83.63	107882.70	
							139012.16
GRAND TOTAL:							3888098.21
Total: Services included in capitation:							186782.37
Total: Services not included in capitation:							38694115.84
Total Estimated Unduplicated Participants:							304
Factor D (Divide total by number of participants):							127897.69
Services included in capitation:							614.42
Services not included in capitation:							127283.28
Average Length of Stay on the Waiver:							304

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transitional Assistance Services Total:							
Transitional Assistance Services	<input type="checkbox"/>	Per Episode	28	2.00	2482.36	139012.16	
Transportation Total:							570805.60
Transportation	<input type="checkbox"/>	1 Way Trip	152	170.00	22.09	570805.60	
GRAND TOTAL:							3888098.21
Total: Services included in capitation:							186782.37
Total: Services not included in capitation:							38694115.84
Total Estimated Unduplicated Participants:							304
Factor D (Divide total by number of participants):							127897.69
Services included in capitation:							614.42
Services not included in capitation:							127283.28
Average Length of Stay on the Waiver:							304