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

I. 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. Waiver Title (*optional*): Intensive Supports Waiver

C. CMS Waiver Number: MA.0827

D. Amendment Number (*Assigned by CMS***):**

E.1 Proposed Effective Date: 07/01/2015

E.2 Approved Effective Date *(CMS Use):*

II. Purpose(s) of Amendment

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

Revisions to the performance measures have been made to align with the new sub-assurances and reflect the continued evolution of our quality oversight of this waiver. Appendix H is updated to reflect that reporting for this waiver will be combined with reporting for the Community Living Waiver (MA.0826) and the Adult Supports Waiver (MA.0828).

III. Nature of the Amendment

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

	Component of the Approved Waiver	Subsection(s)
☑	Waiver Application	Public Input, Contacts, Attachment #2
☑	Appendix A – Waiver Administration and Operation	Quality Improvement
☑	Appendix B – Participant Access and Eligibility	B-5, Quality Improvement
☑	Appendix C – Participant Services	C-5, Quality Improvement
☑	Appendix D – Participant Centered Service Planning and Delivery	Quality Improvement
☐	Appendix E – Participant Direction of Services	
☐	Appendix F – Participant Rights	
☑	Appendix G – Participant Safeguards	G-2, Quality Improvement

	Component of the Approved Waiver	Subsection(s)
☑	Appendix I – Financial Accountability	Quality Improvement
☐	Appendix J – Cost-Neutrality Demonstration	

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):
	Revisions to the performance measures have been made to align with the new sub-assurances and reflect the continued evolution of our quality oversight of this waiver. Appendix H is updated to reflect that reporting for this waiver will be combined with reporting for the Community Living Waiver (MA.0826) and the Adult Supports Waiver (MA.0828). Appendix B-5 has been modified to ensure this waiver conforms to section 1924. Attachment #2 and Appendix C-5 reflect the waiver-specific transition plan for this waiver. Appendix G-2 has been updated to include information in the new subsection G-2-c on the prohibition on use of seclusion in this waiver.

IV. Contact Person(s)

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

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

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

First Name:	Janet
Last Name	George
Title:	Assistant Commissioner of Policy, Planning, and Children's Services
Agency:	Department of Developmental Services
Address 1:	500 Harrison Avenue
Address 2:	
City	Boston
State	Massachusetts
Zip Code	02128
Telephone:	(617) 624-7766
E-mail	Janet.George@state.ma.us
Fax Number	(617) 624-7578

V. Authorizing Signature

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

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Daniel
Last Name	Tsai
Title:	Assistant Secretary and Director of MassHealth
Agency:	Executive Office of Health and Human Services
Address 1:	One Ashburton Place
Address 2:	11th Floor
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Attachment 2: *(Instructions here indicate this section should describe the "status of a transition process at the point in time of submission." Instructions at Appendix C-5 indicate that the narrative in Attachment 2 is supposed to provide a description of settings that do not meet HCBS Rule requirements at the time of submission. When all waiver settings meet federal HCB settings requirements, we're supposed to enter "completed" in this field, and include in Appendix 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 Intensive Supports, Adult Supports, and the Community Living waivers, participated in the workgroup. All regulations, policies, standards, certifications and procedures have been reviewed against the Community Rule HCBS Regulations and necessary changes identified.

Participants in the Intensive Supports Waiver live in a variety of settings, including their family home or 24-hour residential settings, including settings that are private/provider owned or leased, state operated settings and placement services. Participants receiving Placement services may live either in their own homes or apartments, or in the home or apartment of the Placement Services caregiver. Homes or apartments owned or rented by waiver participants are considered to fully comply with the HCBS Regulations.

Additional details regarding the process used to review HCB Settings types and whether they comply with the HCBS Regulations may be found in the revised Statewide Transition Plan submitted informally to CMS on February 25, 2016. After CMS review, this revised Statewide Transition Plan will be put forth for public input and formally submitted to CMS.

As indicated in Appendix C-5, concurrent with the systemic review of regulations, policies and procedures and provider qualification processes related to residential settings, the state embarked on a review, in conjunction with its providers, to assess whether 24-hour residential settings are in compliance with the Community Rule. This review included development of a review tool that borrowed extensively from the CMS exploratory questions and review of settings by DDS Central Office, Regional and Area Office staff to categorize settings as meets, not yet (but could with minor changes), not yet (but could with substantive changes) and no (cannot meet).

Based upon the DDS review and assessment, all the 24-hour residential settings serving participants in the Intensive Supports waiver were determined to be either be in compliance with federal HCB settings requirements (1,012 placement services), not yet be in compliance with federal HCB settings requirements but could with minor changes (2,183 private or state operated settings - because of the requirement to have locks on all individual participant's bedroom doors, and legally enforceable leases), and not yet in compliance with federal HCB settings requirements because of the need for more substantial changes (14 private or state providers, representing 57 sites).

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

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Concurrent with the systemic review of regulations, policies and procedures and provider qualification processes, DDS developed a voluntary survey that was distributed to Community-Based Day Support (CBDS) providers. The tool was instrumental in evaluating the current state of CBDS settings statewide with respect to the Community Rule requirements by asking providers about their progress in Community Rule compliance. It provided valuable information to inform DDS's approach to enhancing CBDS services through capacity building, technical assistance, training and fiscal support.

Survey data indicates that a wide variety of activities are offered by most CBDS settings; that activities are offered both on-site and off-site; that many activities are most commonly offered in a group; and that offered activities are disability-specific as well as integrated into the community. Based upon the review and assessment, the non-residential settings mentioned above fall into the following designations:

- The non-residential setting complies: 300 (these represent group and individual employment settings)
- The non-residential setting, with minor or more substantive changes, will comply: 170 (these represent CBDS settings)
- The non-residential setting cannot meet the requirements: none

(Note: all sheltered workshops are scheduled to close no later than 6/30/16).

A DDS/provider workgroup has been formed and is meeting regularly to address systemic changes that are needed in order to bring all CBDS services into compliance with the Community Rule. Such changes, given the survey data, may include, without limitation, reforms in provider certification requirements and/or processes, enhanced training and staff development activities, standards for meaningful community integration in the context of CBDS programs, provider technical assistance to enhance program design and operation, and contract-based incentives related to outcome goals in the Community Rule. Findings will be validated through ongoing Licensure and Certification processes. All waiver providers will be subject to ongoing review on the schedule outlined in Appendix C of the waiver application.
The state anticipates development of clear guidelines and standards that define day services, including what constitutes meaningful day activities, and how services and supports can be integrated into the community more fully. Technical assistance, training and staff development will be provided to assist providers in complying with the HCBS Regulations.

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

For all settings in which changes will be required, DDS has instituted an on-going compliance review process to assure that the changes are monitored and occur timely and appropriately. This process will include consultation and support to providers to enable them to successfully transition, quarterly reporting by providers to update DDS on progress towards compliance, and reviews by designated Area, Regional and Central Office DDS staff to assure adherence to transition plans and processes. All settings in which waiver services are delivered will be fully compliant with the HCBS Regulations no later than March 16, 2019.

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Massachusetts outreached to the public to solicit input on this Intensive Supports Waiver amendment through multiple formats. The waiver was posted to MassHealth's website and newspaper public notices were issued in the Boston Globe **(DATE)**, Worcester Telegram and Gazette **(DATE)**, and the Springfield Republican **(DATE)**. In addition, emails were sent on **(DATE)** 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 DDS-IS amendment, the public comment period, and, for anyone wishing to send comments, both email and mailing addresses. The waiver amendment was also discussed in the quarterly conference call with tribal representatives held on **(DATE)**.

Massachusetts also engaged in an extensive process to obtain public review and input of its HCBS Transition Plan. The state provided opportunities for public comment as follows:

1. During two 30-day public comment periods:
   - October 15 through November 15, 2014 – on the statewide transition plan; and
   - May 18, 2015 through June 18, 2015 – on the addendum to the statewide transition plan regarding non-residential waiver services.

2. At three public forums:
   - Statewide Transition Plan (STP): November 6, 2014 (Wellesley, MA); November 12, 2014 (Westfield, MA)
   - Non-residential Services Addendum: June 1, 2015 (Worcester, MA)

The public forums were advertised on October 15, 2014 (for the STP) and on May 18, 2015 (for the addendum) in three newspapers each: the Boston Globe, Worcester Telegram and Gazette, and the Springfield Republican. The advertisements in each newspaper directed individuals to the EOHHS website. Information in this link as of October 15, 2014 included a summary of the new federal rule, the draft statewide transition plan, links to the draft DDS, MRC and EOEA agency-specific transition plans, and provided the mailing address and e-mail address for submission of public responses, comments and input to the transition plan. Similarly, materials accessible through this link as of May 18, 2015 included the draft addendum to the statewide transition plan, links to the DDS, MRC and EOEA agency-specific transition plan addenda addressing non-residential service settings, a mailing address and an e-mail address to which public responses, comments and input to the transition plan addendum could be sent.
For both the draft STP and the draft addendum, EOHHS also emailed links to the draft documents as well as information on the public comment periods to several hundred people, including key advocacy organizations and the Native American tribal contacts. The transition plan and the addendum were also discussed during quarterly conference calls with the tribal representatives on October 21, 2014 and July 20, 2015, respectively. Pursuant to CMS's instruction, the newspaper notice, email, and website all provided details for requesting a printed copy of the Non-Residential Services Addendum, and copies of the Non-Residential Services Addenda were made available at the public forum.

In addition, DDS engaged stakeholders in a series of meetings and outreach activities:
   - Initial introduction of the intent of the HCBS rule and the process DDS was going to use with DDS staff, providers, advocacy groups, individuals and families;

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- Ten regional meetings (April – June 2014) with providers and DDS staff to provide more details;
- Formation of a stakeholder group to review and provide input into the draft transition plan. This stakeholder group included representation from several advocacy groups including but not limited to Arc/Massachusetts, Massachusetts Advocates Standing Strong, Disability Law Center, Massachusetts Families Organizing for Change, Massachusetts Developmental Disabilities Council, the Brain Injury Association of Massachusetts, and the Association of Developmental Disability Providers; and
- Information and updates on the DDS website

Prior to submission of its final transition plan to CMS, EOHHS will post the final transition plan, information originally contained in the addendum addressing non-residential service settings as well as revisions based on the previous receipt of public comments, for an additional public notice and comment period.

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Appendix B: Participant Access and Eligibility

Appendix B-5: Post-Eligibility Treatment of Income

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 ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). 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-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

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

b-1. 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**

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*:

DRAFT

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

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.

NOTE: Items B-5-e, B-5-f and B-5-g only apply for the five-year period beginning January 1, 2014. If the waiver is effective during the five-year period beginning January 1, 2014, and if the state indicated in B-5-a that it uses spousal post-eligibility rules under §1924 of the Act before January 1, 2014 or after December 31, 2018, then Items B-5-e, B-5-f and/or B-5-g are not necessary. The state's entries in B-5-b-2, B-5-c-2, and B-5-d, respectively, will apply.

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

e. Regular Post-Eligibility Treatment of Income: SSI State and §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. <u>Allowance for the needs of the waiver participant</u> (*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%.**

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			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. <u>Allowance for the spouse only</u> (*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. <u>Allowance for the family</u> *(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

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	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*:

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. <u>Allowance for the personal needs of the waiver participant</u>

*(select one)***:**

○	**SSI Standard**	
○	**Optional State supplement standard**	
○	**Medically needy income standard**	
○	**The special income level for institutionalized persons**	
○	%	Specify percentage:

DRAFT

○	**The following 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.**

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Appendix C-5: Home and Community-Based Settings

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

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

Note instructions at Module 1, Attachment #2, HCB 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 Intensive Supports Waiver supports both individuals who live in their family home with a comprehensive array of supports, as well as individuals who live in the community in 24-hour residential settings, including: Private, Provider owned or leased, State operated, and Placement Services. The Department of Developmental Services (DDS), an agency within EOHHS that has primary responsibility for day-to-day operation of the Intensive Supports, Adult Supports, and the Community Living waivers, completed systemic and site-specific assessments to ensure compliance of waiver service settings with the new federal requirements as they apply within this waiver.

The DDS systemic 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. Following is a description of the means by which DDS assessed waiver settings' current compliance with HCB settings requirements, a description of the settings that EOHHS has determined fully comply or are near-compliance with the HCB settings requirements as of the time of this submission, and an overview of the mechanisms in place to ensure ongoing compliance.

Where waiver services are provided to individuals living in the community in their family home, these settings are considered fully compliant with the HCB settings requirements.

DDS conducted a review of existing 24-hour residential settings to determine those settings that had a license and certification in good standing. Given the outcomes that are reviewed during the licensure and certification process conducted by DDS surveyors independent of the agency being reviewed, DDS is confident that providers that have received a full license and certification meet the standards established in the Community Rule—with the exception of the requirements for legally enforceable leases/written agreements and locks on bedroom doors, which will be dealt with on a statewide, systemic basis. As a result of this review, these homes were deemed to fall in the category of "The residential setting, with minor changes, will comply," unless specifically identified in the next step of the review process.

Central, Regional, and Area Office DDS staff identified specific 24-hour residential settings as

potentially presumed to have the qualities of an institution. Staff closely followed CMS guidance for this identification, looking at settings that are campus based; are located in a building on the grounds of, or immediately adjacent to a public institution; include a cluster of homes co-located next to one another or that have the effect of isolating individuals from the broader community. Based on this analysis, 14 providers were identified for in-depth review. DDS is engaged with these 14 providers in an ongoing, collaborative process to transition their corresponding 57 settings into compliance by March 2019, as described in the Main Module at Attachment #2.

Based upon the DDS systemic and site-specific assessment, all the 24-hour residential settings serving participants in the Intensive Supports waiver were determined to fall in to the following designations vis-à-vis compliance with the HCB settings requirements:

- The residential setting complies: 1,012 placement services
- The residential setting, with minor changes, will comply: 2,183 private or state-operated settings
- The residential setting, with more substantive changes, will comply: 57 (representing 14 providers
- The residential setting cannot meet the requirements: none

The 24-hour residential setting provider qualifications are reviewed through the DDS licensure and certification process on an on-going basis. The stringent standards and processes specified in DDS regulations ensure that all providers that achieve licensure and/or certification meet all the components consistent with the HCBS community rule. Any modification of these requirements will be determined on an individual participant's needs and situation, and will be incorporated into that participant's Person Centered Plan as outlined in Appendix D.

Providers of 24-hour residential settings were recently the subject of an open bid process and were required to be qualified to provide services and supports. All providers that were qualified were shown to adhere to the requirements for supports to individuals. The RFR that providers responded to outlined critical outcomes with respect to choice, control, privacy, rights, integration and inclusion in community life, consistent with the HCB settings requirements. On an on-going basis, provider qualifications are reviewed through the DDS licensure and certification process described below.

DDS did not have a specific policy in place prior to CMS's issuance of its Community Rule that clearly articulated our position on settings that CMS considers not to meet the criteria for community based settings. Therefore, DDS developed and disseminated a policy (dated September 2, 2014) that spells out the Department's position on future development of settings as well as how existing settings that do not come into compliance with the rule will be addressed. This policy is now in force.

The outcomes identified in the federal HCB settings requirements apply to the following Intensive Supports non-residential waiver services: Center Based Day Supports, Community Based Day Supports (CBDS), Group Supported Employment, and Individual Supported Employment. Based on DDS' systemic and site-specific assessment of these services in the Intensive Supports waiver, DDS--in collaboration with the interagency workgroup and providers--established a timeline for full

compliance (see Main Module Attachment #2). First, Center Based Day Supports settings will be phased out by June 2016. Second, a DDS/provider workgroup meets regularly to address systemic changes that are needed in order to bring all Community Based Day Supports services into compliance with the HCB settings requirements. Such changes may include, without limitation, reforms in provider certification requirements and/or processes, enhanced training and staff development activities, standards for meaningful community integration in the context of CBDS programs, provider technical assistance to enhance program design and operation, and contract-based incentives related to outcome goals in the Community Rule.

The licensure and certification process is the basis for qualifying providers doing business with the Department. The process applies to all public and private providers of residential, work/day, site-based respite and individualized home support services. The system measures important indicators relating to health, personal safety, environmental safety, communication, human rights, staff competency, and goal development and implementation for purposes of licensure, as well as specific programmatic outcomes related to community integration, support for developing and maintaining relationships, exercise of choice and control of daily routines and major life decisions, and support for finding and maintaining employment and/or meaningful day activities. DDS survey teams review provider performance through on-site reviews on a prescribed cycle. Providers are required to make corrections when indicators are not met, and are subject to follow-up by surveyor staff. These indicators are supportive of and fully in compliance with the HCB settings requirements. The licensure and certification tool is in the process of being revised to clarify expectations and even more closely and strongly align the tool with the critical elements of the HCB settings requirements in terms of both residential and non-residential settings.

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Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

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 seclusion is allowed by DDS regulations (115 CMR 5.11), 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 the state's Disabled Persons Protection Commission (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 Program Development and Services Oversight Coordinators with information that is used to detect any use of 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 in the specification 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 H: Quality Improvement Strategy

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.

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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 QIS* 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 QMS 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.

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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 Department's quality management and improvement system (QMIS) is robust and involves individuals in all levels of the Department as well as providers, self-advocates, families, and important stakeholders.

The QMIS system is designed to assure that essential safeguards are met with respect to health, safety and quality of life for waiver participants as well as to use data and information to inform systemic quality improvement efforts. While it is a very robust system, the QMIS system continues to evolve and improve.

The Quality Improvement Strategy specified in this waiver is consistent with the QIS for MA.0826 (Community Living Waiver) and MA.0828 (Adult Supports Waiver). With this amendment, DDS is proposing to consolidate reporting for all three Adult Waivers. Please see the explanation at the end of Appendix H.

The quality management and improvement system is designed and implemented based upon the following key principles:

1. The system creates a continuous loop of quality including the identification of issues, correction, follow- up, analysis of patterns of trends and service improvement activities.
2. Quality is imbedded in all activities of the Department and involves everyone.
3. The measurement of quality is based upon a set of outcomes in peoples' lives agreed upon with stakeholders.
4. The system involves active participation from individuals, families and other key stakeholders.
5. The system rigorously measures health, safety and human rights, and other quality of life domains
6. The system integrates data and information from a variety of different sources.
7. The system collects, aggregates and analyzes data to identify patterns and trends to inform service improvement activities.
8. Service improvement targets are tracked to allow for measurement of progress over time.

Quality is approached from three perspectives: the individual, the provider and the system. On each tier, the focus is on discovery of issues, remediation and service improvement. Information gathered on the individual and provider level is used not only to remedy situations on those levels, but also to inform overall system performance efforts.

Systems level improvement efforts are organizationally structured to occur on essentially two levels – the regional level and the statewide level. DDS is divided into 23 separate area offices, each overseen by an Area Director. In turn, there are four Regional Offices 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. Area Offices work most closely with the individuals the Department serves and their providers through the service planning and oversight processes.

On a statewide level, the Office of Quality Management maintains overall responsibility for designing and overseeing the Department's QMIS and assuring that appropriate data is collected, disseminated, reviewed and service improvement targets established for both waiver and non-waiver DDS clients. The Assistant Commissioner for Quality Management reports in a direct line to the Commissioner, in order to maintain independence from the Operational Services Division. The Waiver Unit functions within the Operational Services Division. Its primary function is to oversee the implementation of the various components of the Waiver. In addition, specific staff in the Central Office/DDS function as "subject leaders" and take responsibility for discrete data sets and their analyses. For example, the Director of Health Services is responsible for reviewing and analyzing all data relating to medication occurrences, health care records and deaths, the Director of Human Rights reviews all restraint reports and the Director of Risk Management reviews data regarding risk management plans.

Processes for trending, prioritizing and implementing system improvements

DDS has a variety of databases that enable it to collect information on important outcomes related to the six assurances under the waiver. These include the Meditech system, which collects data on level of care, plans of care, enrollment, expenditures for waiver participants and risk management plans; the Home and Community Services Information System (HCSIS) which collects information regarding the development and oversight of Individual Service Plans, incidents, restraints, medication occurrences, investigations, health status, and deaths; and the Survey and Certification database, which collects information on both outcomes for individuals served by the Department as well as provider performance.
In addition to reports previously mentioned in the other appendices, there are a number of additional ways in which data is aggregated, reported, and reviewed that specifically facilitate the analysis of patterns and trends and the development of service improvement targets. As a starting point, the Department has two major standards groups that are responsible for overseeing the quality and integrity of the data the Department collects. The groups are composed of internal and external users of the two primary data systems (Meditech and the Home and Community Services Information System, 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.

Up until a few years ago the Department published an Annual Quality Assurance Report

that derived data from all of the different databases maintained. Based on input received from the Quality Council and other stakeholders using the report, the format was changed. In lieu of one report detailing all outcomes reported on, DDS moved to QA Reports that focus on specific subject areas, e.g. rights, health, safety. The reports present information in a user-friendly manner, relying on easy to use graphs and arrows delineating both positive and negative change. The report compares outcomes year to year and allows for a clear analysis of patterns and trends over time. Statewide Quality Council has the specific responsibility to review this report and other data and make recommendations to the Commissioner and other DDS staff for service improvement targets. The Quality Council is comprised of DDS staff, self-advocates, family members, and providers, and is supported by staff from the Center for Developmental Disabilities Evaluation and Research (CDDER) from the University of Massachusetts Medical School. The Council's sole function is to review and analyze the different analyses and reports that are generated with respect to systemic performance, to make recommendations for service improvement and to track progress towards achievement of service improvement targets. Since DDS submitted the initial waiver applications, the composition of the Councils has been modified. In lieu of four separate Regional Councils there is now one Statewide Council that draws representation from each of the former regional councils.

In addition to the Quality Councils, there is a Statewide Incident Review Committee (SIRC), composed of staff from investigations, human rights, survey and certification, risk management, health services, and operations. The committee reviews the analyses that are generated from HCSIS. With the research support of the University of Massachusetts Medical School/Center for Developmental Disabilities Evaluation and Research, aggregate reports analyzing specific incident types are generated. The reports are reviewed by the committee and form the basis of service improvement targets. Reports generated from the risk management committee are also reviewed by the Quality Council and mutually agreed upon service improvement targets are developed.

Since March 2008, area, region and provider specific aggregate data on incidents began to be disseminated quarterly (for frequently occurring incidents) and annually (for less frequently occurring incidents). These reports show data on incidents by both number and rate that enable comparison between an area to a region to the state. Data from month to month is shown and fluctuations below and above 25% are noted. Field staff (i.e. Area Office staff) analyze patterns and trends in their respective locations. In addition to individual incident reports, Area Offices receive monthly reports on individuals who have reached a threshold of specifically designated incidents that then trigger a review on an area level. 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 and enter follow up notes to assure that individuals who may be at risk have been identified and followed up on. 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 follow up actions were taken and whether the actions were consistent with the issues identified.

The Department also publishes an independently developed Annual Mortality Report by

CDDER that details the numbers of deaths, the age, gender, and residential status of individuals, and the causes of death. The report is reviewed by the Quality Council as well as the Regional and Statewide Mortality Review Committees. Data from this report also informs the development of quality improvement activities. In addition to the abovementioned reports, DDS publishes a "Quality is No Accident" (QINA) Brief. The QINA briefs focus in on one particular area per publication and combine data derived from the Incident Management System and other data sources, with practical information regarding risk prevention and mitigation activities. Examples of subjects covered in the past include healthy sexuality, oral health care, preventive health care, Alzheimer's/dementia, and missing persons.

As mentioned earlier, each "subject leader", e.g., Director of Health Services, Director of Human Rights, is responsible for the detailed review and analysis of data for their specific area of responsibility. Data is typically reviewed on a monthly basis and patterns and trends identified. Subject leaders will then work directly with field staff and others on areas that have been identified for improvement.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of monitoring and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify:
	Semi-annually

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 Quality Management and senior management staff of the Department have 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. As an example, the Quality Council

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established an increase in real employment for individuals in the Department as a statewide service improvement target. Regional employment solutions teams were established to develop strategies. Providers were required to submit specific plans and target numbers for increasing individual employment options. This was followed by the development and publication of the "Blueprint for Employment," which called for the transformation of all sheltered workshop settings. Progress in this area shows that by June 2016, all remaining workshops will have been closed.

Reviews of the effectiveness of other service improvement targets are also conducted by the Center for Developmental Disabilities Evaluation and Research (CDDER) of the University of Massachusetts Medical School. As an independent research and policy support to the Department, CDDER has conducted several formative and summative evaluations of specific service improvement initiatives. Methods have included focus groups, surveys and evaluation of specific indicators related to the service improvement target. An example of CDDER's role was its evaluation of the Department's Health Promotion and Coordination Initiative.

More targeted service improvement efforts may involve a discrete number of individuals who have specific responsibility in the subject of the effort. For example, the Director of the Office of Human Rights disseminates quarterly reports to Regional Directors regarding the use of restraints. A service improvement target to reduce the number of restraints for "high utilizers" was identified and worked on with the specific areas and providers involved. Change was tracked by the Office of Human Rights and noted.

The Department shares most statewide quality assurance and service improvement data with a host of internal and external stakeholders. The Quality Assurance Reports the Annual Mortality Report, analyses of HCSIS incident data, and provider licensure/certification reports are all posted on the Department's web site as well as distributed in hard copy. Individuals, families and providers are also active members of the Statewide Quality Council, area Citizen Advisory Boards, and statewide committees. In this capacity, all quality improvement data and reports are shared, discussed and reviewed with them.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The effectiveness of the Quality Management system is reviewed through the following mechanisms:

The Office of Quality Management (OQM) has primary day to day responsibility for assuring that the Department has an effective and robust quality management system in place for both HCBS waiver and non- waiver services. OQM works with internal and

external stakeholders and makes recommendations regarding enhancements to the QMIS system on an on-going basis.
As part of its responsibility, the Statewide Quality Council reviews outcomes and indicators measured and make recommendations to the Department regarding the need to add, change or amend the quality indicators. The council, because of its broad representation from internal and external stakeholders is in a unique position to reflect upon the Department's QMS system.
The Department works with the Center for Developmental Disabilities Evaluation and Research (CDDER) of the University of Massachusetts Medical School. CDDER has and will continue to assist the Department to evaluate the effectiveness of its QMS system and to make recommendations for improvements.

As part of the evaluation of the Quality Improvement Strategy that OOM and DDS 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 this waiver together with MA.0826 (Community Living Waiver) and MA.0828 (Adult Supports Waiver). 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 three 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 3 (2015/2016).

This waiver, MA.0826 (Community Living Waiver) and MA.0828 (Adult Supports Waiver) operate on the same waiver cycles and will be reported on with the same frequency.