CONTRACTING WITH THE DEPARTMENT OF DEVELOPMENTAL SERVICES GENERAL OVERVIEW

Summary of Key Contracting Procedures

(See the specialized units of this manual for detailed instructions on these items.)

USEFUL HYPERLINKS

There are several hyperlinks to websites that may be useful to the provider. Many of these hyperlinks appear in the relevant sections of this Manual. In addition, as a convenience to the reader the hyperlinks to the most useful forms/instructions are located below:

Department of Developmental Services website:
http://www.mass.gov/dds

List of DDS Area Offices:
http://www.mass.gov/eohhs/consumer/disability-services/services-by-type/intellectual-disability/newsroom/about/developmental-services-offices-of-the-department.html

EOHHS Website for Contracting
http://www.mass.gov/eohhs/ (Type "Contracts" in Search)

Secretary of the Commonwealth Corporations Division:
http://www.state.ma.us/sec/cor/coridx.htm

COMMBUYS:
https://www.commbuys.com/bso/

Office of the State Comptroller (OSC):

http://www.mass.gov/comptroller/

Operational Services Division (OSD):
http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/osd

EOHHS Regulated Rates
http://www.mass.gov/eohhs/gov/laws-regs/hhs/purchase-of-service-rates-for-social-services.html

Vendor Web
http://www.mass.gov/osc/guidance-for-vendors/

Request for Verification of Taxation Reporting Information: (Massachusetts Substitute W-9 Format):
http://www.mass.gov/comptroller/docs/forms/vendorcustomer/newmass-w9.pdf

Electronic Funds Transfer Form (Must be completed on-line.)
http://www.mass.gov/eohhs/docs/masshealth/provider-services/forms/eft-1.pdf

I. BECOMING A PROVIDER

Individuals, corporations, or partnerships interested in becoming a provider of services to any of the departments under the *Executive Office of Health and Human Services (EOHHS)* should first go the EOHHS Internet Website for Contracting with EOHHS for required forms and instructions through the following link:
http://www.mass.gov/eohhs/provider/contracting/

The main page has the following links:

- How the State Purchases;
- Potential New Purchase of Service (POS) Providers;
- Existing POS Providers;
- Provider Qualification Process;
- EOHHS Provider Qualification – Agency Contacts/Liaisons; and
- Doing Business with Health and Human Service Agencies.

It is important to note that this process only signifies that a provider is financially qualified to do business with EOHHS agencies; it does not entitle a provider to any level of business with any state agency. Actual contract awards must generally be made on the basis of a competitive bid process. Active bids for services are listed on the Commonwealth Buys System (COMMBUYS) at: https://www.commbuys.com/bso/

II. PROVIDER QUALIFICATION

Each new fiscal year, prior to contracting with any of the departments under the Executive Office of Health and Human Services (EOHHS), providers must undergo a Financial and Programmatic Qualification Process. This annual provider qualification review process is performed for the following reasons:

1. To minimize financial and administrative risk to the Commonwealth and the people served through the POS system;
2. To promote familiarization and enforce compliance with applicable state and federal regulations; and
3. To maintain current, accurate information on POS organizations, including contact names, addresses, and other information critical to the effective and efficient management of the POS system.

Often, provider organizations render services to multiple EOHHS state agencies; however, the organization is qualified by only one agency. The State agency within the EOHHS Secretariat that provides the most POS funding to a state provider during a fiscal year is considered the Principal Purchasing Agency (PPA) and is required to qualify their providers annually. (See the link above to Policies & Procedures on Provider Qualification).

III. COMMBUYS (formerly Comm-PASS)

(COMMONWEALTH BUYS SYSTEM)

In order to determine what programs DDS has to offer for contracted direct care services to developmentally disabled individuals the provider has an obligation to check the listings on the Commonwealth's web site called "COMMBUYS." This web site lists all current Requests for Responses (RFR's) open for provider bids. To view open DDS RFR's navigate the website as follows:

- https://www.commbuys.com/bso/
- From main COMMBUYS page, select "Contract and Bid Search"
- On next page, select "bids"
- For search fields, select DDS
- Select the bid opening date, if you know it, or select "Dorothy Cooper" as the purchaser

- Select the "find" button
- Select from the array shown

To be notified automatically regarding new RFR's, it is recommended that providers register with COMMBUYS.

IV. NEW RFR'S TO BE ISSUED FOR FY2017.

UPCOMING RFR's

A. NEW RFR'S TO BE ISSUED FOR FY2017

During FY2017 DDS is scheduled to issue several new RFR's for the following services:

1. Activity Code 3170 – Clinical Team
2. Activity Code 3274 – Corporate Rep Payee
3. Activity Code 3202 – Medical Services
4. Activity Code 7100 – Autism Coaching

Activity Code 7100 RFR was issued on 4/1/2016. The issuance dates of the other new RFR's have not yet been determined.

B. RFR's OPEN FOR INITIAL QUALIFICATION OR ADDING SERVICES

1. EMP-DAY-09 (Employment and Day Supports Qualification)
   All employment and day services except CIES (activity code 3180)
   CIES: EOHHS normally reopens once per year to identify new providers
2. ALTR-14 (Adult Long Term Residential Services)
3. PS-15 (placement Services)
   Shared Living
   Incentive/Startup Funding
4. ANSS-15 (As-Needed Support Services)
   Temporary support for individuals or programs (LUSA)
5. DESE/DDS (Qualifying List for Self-Directed Services Options)
6. SSQUAL-10 (Support Services Qualifying List)
   Updated to incorporate changes as a result of COMMBUYS, Chapter 257, forms, etc.
   Various individuals and family supports
7. HIS-16 (In Home Supports)
   Supports for individuals in home, family home or in the community
   Start date of new contracts: April 1, 2016

SERVICES THAT WERE PLACED ON AN RFR IN COMM-PASS BEGINNING WITH FY2011

NOTE: Because of a restructuring of Family Support services and the introduction of Agency With Choice services beginning in FY 2011 there were a number of new activity codes for these services.

	Contract Effective Date	RFR Status
QUALIFYING LIST FOR FAMILY SUPPORT PROGRAMS **Please see the Activity Code Definitions, Forms & Instructions unit of this Manual for a short description of these activity codes. Complete descriptions of these activity codes can be found in COMMBUYS in the contract posting "Support Services- Qualifying List" (SSQUAL-10).**	**7/1/2010**	**RFR open until 6/30/2022. Providers may respond at any time up to 6/15/2022.**
QUALIFYING LIST FOR AGENCY WITH CHOICE SERVICES **Please see the Activity Code Definitions, Forms & Instructions unit of this Manual for a short description of these activity codes. Complete descriptions of these activity codes can be found in COMMBUYS in the contract posting "Qualifying List for Self-Directed Service Options: Agency With Choice Services" (SDQUAL-10-AWC).**	**7/1/2010**	**RFR currently closed.**
QUALIFYING LIST FOR DESE/DDS PROGRAMS **Please see the Activity Code Definitions, Forms & Instructions unit of this Manual for a short description of these activity codes. Complete descriptions of these activity codes can be found in COMMBUYS in the contract posting "Qualifying List for Self-Directed Service Options: DESE/DDS Programs" (SDQUAL-10-DESE-DDS).**	**7/1/2010**	**RFR open until 6/30/2018**
FAMILY SUPPORT DESIGNATED PROGRAMS **Please see the Activity Code Definitions, Forms & Instructions unit of this Manual for a short description of these activity codes. Complete descriptions of these activity codes can be found in COMMBUYS in the contract posting "Family Support Services- Designated Programs" (FSS-10).**	**7/1/2010**	**RFR currently closed.**
QUALIFYING LIST FOR EMPLOYMENT PROGRAMS **Please see the Activity Code Definitions, Forms & Instructions unit of this Manual for a short description of these activity codes. All employment and day services except CIES (activity code 3180).** **CIES: EOHHS normally reopens once per year to identify new providers.** **Complete descriptions of these activity codes can be found in COMMBUYS in the contract posting "Employment and Day Supports Qualification" (EMP_DAY_09)**	**7/1/2010**	**RFR open until 6/30/2020**

	Contract Effective Date	***Contract End Date/ RFR Status***
QUALIFYING LIST FOR ADULT LONG TERM RESIDENTIAL SERVICES ACTIVITY CODE 3153	***04/01/2014***	***6/30/2024/ Open***

Please see the Activity Code Definitions, Forms & Instructions unit of this Manual for a short description of this activity code. A complete description of this activity code can be found in COMMBUYS in the contract posting "Adult Long Term Residential Services" (ALTR-14).

	Contract Effective Date	***Contract End Date/ RFR Status***
QUALIFYING LIST FOR PLACEMENT SERVICES ACTIVITY CODE 3150	***10/1/2014***	***6/30/2024/ Open***

Please see the Activity Code Definitions, Forms & Instructions unit of this Manual for a short description of this activity code. A complete description of this activity code can be found in COMMBUYS in the contract posting "Placement Services" (PS-15).

	Contract Effective Date	***Contract End Date/ RFR Status***
QUALIFYING LIST FOR LUSA SUPPORT SERVICES ACTIVITY CODE 3174	**07/01/2014**	**06/30/2024/ Open**

Please see the Activity Code Definitions, Forms & Instructions unit of this Manual for a short description of this activity code. A complete description of this activity code can be found in COMMBUYS in the contract posting "As Needed Support Services" (ANSS-15).

QUALIFYING LIST FOR IN-HOME SUPPORTS PROGRAMS Includes Activity Codes 3798. Please see the Activity Code Definitions, Forms & Instructions unit of this Manual for a short description of this activity code. (IHS-16)	**4/1/2016**	**RFR open until 6/30/2026**

V. REQUEST FOR RESPONSE (RFR)

A. There are two types of a Request for Response.

MOST COMMON DDS RFR

Qualifications Based RFR

An RFR that requests only minimal data from the provider stating his/her organization's basic qualifications to provide the requested services and the organization's desire to be placed on a list of qualified providers from which list providers will be selected to receive a contract for services. RFR's of this type are generally "open" until the posted end date, i.e. a provider may respond to the RFR and have its organization placed on the qualified list at any time until the end date.

INFREQUENT DDS RFR

Designated Program RFR

An RFR containing the details of the specific DDS programs upon which the bidder is making a bid. Unlike the RFR for placement on a qualified providers list the specific services RFR results in the direct selection of provider(s) to deliver the requested services. RFR's of this type generally are closed at the posted end date, i.e. a provider will not be allowed to respond to the RFR after the end date.

B. Submission and details of a Designated Programs RFR

RFR documents must be submitted to the designated DDS office. Although the details of an RFR vary with the program being offered there are several standard sections:

- Summary of Procurement
- Single or multiple contractors
- Single or multiple department participation
- Anticipated duration of contract
- Anticipated expenditures, funding or compensation for expected duration
- Federal Funding availability
- Bid conference opportunity
- Written questions opportunity
- Instructions for submission of responses
- Deadline for responses
- Extensive description of the program being offered including any relevant forms

(Note: The submission requirements for a Qualifications Based RFR are greatly reduced from the requirements of submission of a Designated Programs RFR.)

VI. PROPOSALS – (For providers responding to a Designated Program RFR)
Once a provider selects an RFR upon which it desires to make a bid, it must prepare and submit a proposal in accordance with the instructions in the RFR. The proposal must include the required RFR forms found on COMMBUYS. After an RFR is issued, but before the proposal is due, the purchasing agency may, at its discretion, convene a bidder's conference at which all potential bidders have an opportunity to appear and present any questions relating to the RFR. The details of this bidder's conference will be clearly stated in the RFR itself. **(Note: Proposals may, or may not, be required from providers who are selected to deliver services from a Qualifications RFR, at the discretion of DDS.)**

VII. CONTRACT NEGOTIATIONS – Once awarded a contract, the bidder must enter negotiations with DDS staff. The negotiation process consists of finalizing the following details:

- Services to be delivered
- Number and needs of the Consumers
- Estimated total cost of the contract
- Program Objectives
- Funding sources

The provider completes and signs the contract after negotiations are complete and the contract is sent to the Regional Contract Staff for technical review. (NOTE: Contract negotiations must be limited to minor adjustments to the conditions of the award as outlined in the RFR. Significant changes are not allowed at this point in the process.)

VIII. ENROLLING AS A PROVIDER WITH THE OFFICE OF THE STATE COMPTROLLER New providers who have never conducted business directly with the Commonwealth of Massachusetts, must be enrolled on the Massachusetts Management, Accounting and Reporting System (MMARS) to facilitate payment. The following required documentation must be submitted to the Office of the State Comptroller (OSC):

A. The Commonwealth of Massachusetts Request for Verification of Taxation Reporting Information (Massachusetts Substitute W-9 Format)
B. (1) Commonwealth Terms and Conditions (for Individuals and Non-Social Services)
OR
(2) Commonwealth Terms and Conditions for Human and Social Services (for Corporations and Partnerships)
C. Electronic Funds Transfer Form (EFT) (Optional but recommended for direct deposit)

The above listed forms are required to be filed **only once**, unless there is a subsequent change in the provider's legal name, legal address, or Tax Identification Number (TIN) in which case a new set of forms must be filed. Once filed, The Office of the State Comptroller will assign a vendor Customer Code to the provider. Providers who currently receive payment from the Commonwealth for services usually do not have to enroll again, except when changes occur as noted.
These forms are available on the Operational Services Division (OSD) web site using the

following link: http://www.state.ma.us/osd/pos/dps.htm. However, forms taken from this web site cannot be completed on screen but must be downloaded via Word Document or pdf format and completed off screen. (The submission of these forms may be done independently or as part of the Prequalification/Requalification process; see Section II above).

IX. REQUIRED FORMS

PREQUALIFICATION/REQUALIFICATION CERTIFICATION FORM

This form is limited for use only by new providers and providers making material changes in their original prequalification submissions.
The Prequalification/Requalification Certification Form is located at the site listed below:
http://www.mass.gov/eohhs/provider/contracting/pos-new-prov/

X. CONTRACT DOCUMENTS

A. If a provider is entering into contract negotiations pursuant to winning an award through the RFR process or through some other approved awarding process the contract document required for use is the Commonwealth of Massachusetts Standard Contract Form.

B. **IMPORTANT: The approved start date of the contract is the date of signature of the provider or the date of signature of the DDS authorized signatory authority, whichever is later, notwithstanding the start date entered on the contract. However, should a provider incur obligations prior to the effective date of the contract and these obligations are considered necessary and reimbursable by the DDS authority these obligations will be considered a final Settlement and Release and a one-time payment for these obligations will be allowed.**

(N.B.: The following discussion pertains to contracts or amendments with corporations or partnerships. Contracts or amendments with individuals are covered in section XVII.)

XI. COMPLETION OF THE STANDARD CONTRACT FORM

A. IMPORTANT:

1. Contracts will contain one program in one activity code only. Multiple programs in the same contract are not allowed.

2. Contract ID Numbering System

DDS adopted a contract ID numbering that supports multi-year contracting and at the same time introduces more useful information into the ID number. In order to implement this system all contracts (regardless of whether they are for multi-year contracts, single year contracts, or single year renewal amendments) will use this ID numbering system. Once established for this multi-year contracts the ID number will remain unchanged throughout the life of the contract.

The system employs 20 characters to be created as follows:

Characters 1 and 2: The two digit fiscal year designation representing the original start date of the contract, e.g. "17" for a contract beginning in FY2017; "16" for contracts begun in FY2016 or being renewed into FY2017 from FY2016.

Characters 3 through 6: These characters are used at the discretion of the Regional Office. Their use will vary from region to region.

Characters 7 through 12: These characters represent the core of the "old" contract ID numbering system. They are essential to DDS' ability to track contracts through its automated systems. As such these numbers must be unique, i.e. no two contracts may have the same characters 7 through 12.
Character 7 = Region identifier;
Character 8 = Area identifier;
Character 9 = Area identifier or special character; *
Characters 10 – 12 = characters chosen by the Region. **

*** Special Alphabetical Designations for the 9th character:**
The 9th character will be alphabetical under the following circumstances:
"R" for an activity code 3153 contract
"W" for an activity code 3150 contract
"S" for an activity code 3798 contract
A letter in the range of "A" to "G" indicating the rate in a multi-rate contract in an activity code 3163 contract

**** Special Alphabetical Designation for the 12th character:**
The 12th character will be assigned for an activity code 3798 contract as follows: A number is used to indicate a contract with a single rate;
A letter in the range of "A" to "K" is used to indicate the rate in a multi-rate contract.

Examples of ID numbers for contracts started in previous fiscal years:

153320 32W333 DDS 3150 D

146670 67R280 DDS 3153 D

145520 52D365 DDS 3163 H

161110 11S658 DDS 3798 H (example of a single rate contract)

Characters 13 through 15: Always "DDS"

Characters 16 – 19: The four digit Activity Code number

Character 20: The letter code indicating the allowable payment method for that activity code, e.g. "D" (day), "H" (hour – Note: hours are billed in 15 minute units), "M" (month), "T" (trip), "V" (visit) or "C" (cost reimbursement or capital budgets)

Examples of ID numbers using special characters:

16 1110 110604 DDS 3163 H

16 1110 11R604 DDS 3153 D

16 1110 11S60A DDS 3798 H

Cost reimbursement contracts that are written in activity codes where DDS collects attendance for federal billing purposes must be completed with the Unit Type code for the relevant activity code as character 20 in the ID number (see the Matrix in the Manual unit "POS Activity Code List" for a listing of Unit Types used on ID#'s.) In such situations the letter code "C" cannot be used. The letter "C" can only be used for contracts in activity codes that where attendance for federal billing is not collected. If a contract is written as a cost reimbursement contract in an activity code where attendance is collected for federal billing purposes (e.g. "H" for day activity codes or "D" for residential activity codes) the letter code of the cost reimbursement contract must agree with attendance measure.

Example of the proper way to use the final letter code to indicate the contract reimbursement method:

A cost reimbursement contract for a residential service awarded in FY2015 would look like this:

15 xxxx 110300 DDS 3153 D (note the "D". Even though this particular contract is cost reimbursement, attendance in this activity code is collected for federal

billing. ;
However, a cost reimbursement contract in a clinical team service would be 15 xxxx 110300 DDS 3170 C (since attendance is not collected in clinical team services for federal billing).

1. Required Unit Rate Definitions:

In order to insure that all DDS services are eligible for federal reimbursement under the new federal waiver regulations it is important that services delivered under DDS Activity Codes covered by these regulations be delivered under programs with unit rates calculated with acceptable definitions of the unit rate, i.e. DAYS, HOUR, TRIP, MONTH, VISIT. The practice of combining programs that are written for different unit rate definitions in the same contract has been discontinued.

The following chart lists the acceptable unit rate definitions for federally reimbursable Activity Codes:

Placement Services	3150	DAYS
Adult Long Term Residential Services	3153	DAYS
ABI Residential Habilitation	3751	DAYS
ABI Shared Living	3752	DAYS
Community Based Day Services	3163	HOUR
Individual Supported Employment	3168	HOUR
Competitive Integrated Employment Service	3180	HOUR
Group Supported Employment	3181	HOUR
Transportation Services	3196	TRIP
Day Habilitation Supplement	3285	HOUR
Activity Codes for former Family Support Services (Italics)		
Emergency Stabilization Residence	*3182*	*DAYS*
Physical Therapy	*3240*	*VISIT*
Occupational Therapy	*3243*	*VISIT*
Speech & Hearing Therapy	*3245*	*VISIT*

Assistive Technology (Not a code for standard contracts. Contact the Central Office Contract Office for guidance if this code is to be used)	*3283*	*TBD*
Transitional Assistance (Not a code for standard contracts. Contact the Central Office Contract Office for guidance if this code is to be used))	*3284*	*TBD*
Family Support Navigation	*3700*	*HOUR*
Family Support Navigation AWC	*6700*	*HOUR*
Respite in Recipient's Home	*3701*	*DAYS*
Respite in Recipient's Home AWC	*6701*	*DAYS*
Respite in Care Giver's Home	*3702*	*DAYS*
Individualized Home Supports	*3703*	*HOUR*
Individualized Home Supports AWC	*6703*	*HOUR*
Individualized Day Supports AWC	*6704*	*HOUR*
Adult Companion	*3707*	*HOUR*
Adult Companion AWC	*6707*	*HOUR*
Community Family Training/Residential Family Training	*3709*	*HOUR*
Community Family Training/Residential Family Training AWC	*6709*	*HOUR*
Behavioral Supports & Consultation	*3710*	*HOUR*
Emergency Stabilization in Caregiver's Home	*3712*	*DAYS*
Community Peer Support/ Residential Peer Support	*3716*	*HOUR*

Community Peer Support/ Residential Peer Support AWC	*6716*	*HOUR*
Homemaker	*3722*	*HOUR*
Homemaker AWC	*6722*	*HOUR*
Chore	*3725*	*HOUR*
Chore AWC	*6725*	*HOUR*
Individual Supports and Community Habilitation (split of 3798)	*3749*	*HOUR*
Agency w/ Choice Processing Fee	*6753*	*MNTH*
Site Based Respite Facility (formerly Emergency Residence)	*3759*	*DAYS*
Individual Community Supports	*3798*	*HOUR*

B. COMMONWEALTH OF MASSACHUSETTS STANDARD CONTRACT FORM

Please Note: Only the Standard Contract Form dated 3/21/14 is acceptable.

THE CURRENT APPROVED VERSION OF THE STANDARD CONTRACT FORM

The version that now appears on the OSC web site is dated **3/21/2014**. Please use this version of the form.

- Please note the following clarification for completing required sections:
  Anticipated Start Date:

Check Option 1 when the amendment is effective upon the latest signature date and services haven't been provided nor any costs incurred prior to the effective date of the amendment. (Used when services are anticipated to begin on the latest signature date.)

Special Situation for Option 1: If an amendment includes a one-time "lump sum" adjustment for reimbursement of services that fall **within the original scope of the contract** and such services were provided **prior to** the effective date of the amendment the correct Option to be checked on the Standard Contract Form is **Option 1**. While this exception appears counter-intuitive to the language on the Standard Contract Form in Option 3 it is approved by the Comptroller's Office. So, while lump sum adjustments remain rare please note that if you should have the need for this type of amendment the correct option is Option 1.

Check Option 2 when a future effective date not determined by the signature dates is desired and services haven't been delivered nor costs incurred prior to the effective date of the amendment. (This line is best used for most DDS contracts/amendments.)

Check Option 3 when services and obligations have been incurred **prior** to the latest signature date on the contract or amendment and such services and obligations **fall outside of the original scope of the contract.** Use of this option constitutes a Settlement of Payments. **THIS OPTION CANNOT BE USED UNLESS PRIOR AGREEMENT WITH THE RELEVANT REGIONAL DDS**

CONTRACT OFFICE HAS BEEN REACHED. It is intended to be used rarely and only under special circumstances. If approved for use by DDS the provider must clearly spell out in the brief description section of the Standard Contract Form or in an attachment, the time period of the settlement, amount of the settlement, and what the monies were spent on.

This form will serve as the one and only form to be used for new contracts, renewal amendments that extend a contract across a fiscal year and standard amendments that amend a contract within a fiscal year. This Standard Contract Form consists of one (1) page required for processing and four (4) pages of instructions. Only the first of these pages requires completion by the provider. The remaining four (4) pages contain instructions, regulations, provisions, and web site references which, when clicked on a computer, bring the user to the relevant web site. Although the provider completes and submits only the first page of the Standard Contract Form the provider acknowledges all responsibilities contained in the remaining four pages and is legally obligated to conform to them. INCLUDED IN THESE FOUR PAGES ARE SECTIONS COVERING THE NORTHERN IRELAND NOTICE AND CERTIFICATION FORM AND EXECUTIVE ORDER 481 – CONTRACTOR CERTIFICATION PROHIBITING THE USE OF UNDOCUMENTED WORKERS ON STATE CONTRACTS. This form is available on the Operational Services Division (OSD) web site using the following link: http://www.mass.gov/osc/docs/forms/contracts/standard-contract-frm.doc.
When completing the Standard Contract Form for the purpose of starting a new contract the provider must complete the form as indicated choosing to complete the section on the form entitled "New Contract".

C. CONTRACT ATTACHMENTS – All contracts written on the Standard Contract Form are required by either DDS or the Office of the State Comptroller regulations to contain the following legal documents:

- Attachment C – Statement of Applicable Statutes, Regulations, Manuals, Policies and Procedures (This document is subject to change on a yearly basis.)
- Attachment C – Special Provisions (An addendum to the Attachment C) containing:
  1. Critical Services Procurement language (applies to DDS residential services only)
  2. PCA Services instructions
  3. Provisions for the Use of Virtual Gateway Business Services
  4. Chapter 257
  5. Provision for the Management of Certain Federal, Capital, and/or Trust Accounts
- Contractor Authorized Signatory Listing (CASL)
  The CASL may be an original signature copy or a photocopy. Dates of signature **must be handwritten**, not typed or stamped. Page 2 is not required, but is recommended.

XII. DOCUMENT PROCESSING

A. STANDARD PROCESSING

Standard Contracts, Renewal Amendments, and Standard Amendments essentially follow the same path to approval after the final negotiations are complete and the document is signed and dated by both the provider and the DDS authorized signatory. Documents that have a total value (including the value of the current fiscal year and all previous fiscal years) of $500,000.00 or less are approved on MMARS under DDS delegated authority; documents that have a value

greater than $500,000.00 (except documents processed under a Master Agreement (SEE BELOW) must be forwarded by the Regional Office to the Office of the State Comptroller where they are approved under OSC authority; copies of approved documents are sent to the provider for the provider's records.

NOTE: At any point, DDS Regional Office or the Office of the State Comptroller may reject a document if errors are encountered. In such cases the document will be held pending contact with the provider and corrections made, or returned to the provider for correction. In any such case the provider will be contacted at the earliest possible moment.

B. THE STANDARD CONTRACT AS "MASTER AGREEMENT" FOR REGULATED RATE CONTRACTS

As DDS moves toward multi-year contracts and unit rates established under the auspices of Chapter 257 its use of the Standard Contract Form will evolve. For all contracts in activity codes not covered by Chapter 257 regulated rates the Standard Contract Form will continue to be used on an individual basis for each individual contract as it has been used for many years. However, for contracts issued pursuant to the RFR's noted above the Standard Contract Form will be issued as a "Master Agreement." A Master Agreement is a contract document that covers all programs in an activity code operated by a provider. The document is written as a Rate Agreement and therefore contains no maximum obligation. Legal documents associated with the contract are attached to the Standard Contract Form but there is no description of services and no budget. The description of services for each program covered by the Master Agreement is contained in the submission to the RFR provided by the provider and incorporated as such into the contract.

For contracts awarded pursuant to RFR ALTR-14 and RFR PS-15 the service and budget specifications will be contained in a "Statement of Work" (SOW). For contracts under Master Agreements awarded pursuant to all other services covered by rates under chapter 257 the budget specifications will be contained in a Service Summary Form (SSF).

PROCESS: The Standard Contract Form as a Master Agreement is submitted as part of a provider's RFR submission to the Central Office of DDS. Once an RFR has been deemed acceptable by the review committee of DDS the Master Agreement becomes effective. Individual program services provided under the auspices of the Master Agreement must be determined in negotiations between the provider and DDS area staff.

C. PROCESSING CONTRACTS AWARDED PURSUANT TO THE RFR's FOR ADULT RESIDENTIAL SERVICES AND PLACEMENT SERVICES QUALIFYING LIST,

The Standard Contract cover page submitted by the provider in response to an RFR for any services in the following activity codes is a Master Agreement that is filed in Central Office and covers any and all programs that are written in these activity codes. Once approved for a program in the activity code the provider will complete a Service Authorization Form for each program and submit this form to the Regional Office. Individual rates and funds will be listed on a Statement of Work (SOW). (See the Activity Code Definitions, Forms, & Instructions unit of this manual for complete definitions of these programs.)

Residential/Placement Services

3150 – Placement Services
3153 - Adult Long Term Residential Services (ALTR)
3753 – Occupancy for ALTR Services
3713 – Occupancy ABI (Acquired Brain Injury) Services

3751 – ABI Residential Habilitation
3752 – ABI Shared Living

New Residential Services subject to EOHHS standard rates

a. Beginning with programs approved pursuant to the RFR for Adult Long Term Residential Services in FY2014 (RFR ALTR-14) the approved EOHHS rates for each site will be "blended" into one reimbursable blended unit rate for reimbursement to the provider.

b. Beginning with programs approved pursuant to the RFR for Placement Services in FY2015 (RFR PS-15) the approved EOHHS rates for each consumer will be "blended" into one reimbursable blended unit rate for reimbursement to the provider.

D. PROCESSING CONTRACTS AWARDED PURSUANT TO THE RFR FOR DAY AND EMPLOYMENT SERVICES

The Standard Contract Form cover page submitted by the provider in response to the RFR for Day and Employment services is a Master Agreement that is filed in Central Office and covers any and all programs that are written in the following activity codes:
3163 – Community Based Day Supports
3165 – Adult Day Services
3168 – Individual Supported Employment
3180 – Competitive Integrated Employment Services (CIES)
3181 – Group Employment
3285 – Day Habilitation Supplement
3664 – Day Habilitation Services
3681 – DDS/Group Supported Employment Partnership
3764 – Facility Day Habilitation
Once approved for a program in one or more of the activity codes listed above the provider will complete a Service Authorization and submit it to the Regional Office. Individual rates and funds will be listed on a Service Summary Form (SSF). (See the Activity Code Definitions, Forms, & Instructions unit of this manual for complete definitions of these programs.)

E. PROCESSING CONTRACTS AWARDED PURSUANT TO THE RFR FOR THE SUPPORT SERVICES QUALIFYING LIST,

The Standard Contract cover page submitted by the provider in response to the RFR for any services in the activity codes awarded under RFR SSQUAL-10 and the updated version of SSQUAL-10 posted in FY2016 is a Master Agreement that is filed in Central Office and covers any and all programs that are written in the following activity codes:
3700 – Family Support Navigation
3701 - Respite In Recipient's Home-Day
3702 - Respite In Care Giver's Home - Level 1
3703 - Individualized Home Supports
3705 - Children's Respite In Care Giver's Home-Day
3707 - Adult Companion
3709 - Community Family Training/Residential Family Trng.
3710 - Behavioral Supports and Consultation

3712 - Emergency Stabilization in Caregiver's Home
3716 - Community Peer Support/ Residential Peer Support
3731 - Respite in Recipient's Home- Hourly
3735 - Children's Respite in Care Giver's Home-Hourly
3738 – DDS/DESE Direct Support Services
3759 – Site Based Respite (Planned, for adults)
3775 – Planned Facility-Based Respite Programs for Children
Once approved for a program in one or more of the activity codes listed above the provider will complete a Service Authorization Form for each program and submit this form to the Regional Office. . Individual rates and funds will be listed on a Service Summary Form (SSF). (See the Activity Code Definitions, Forms, & Instructions unit of this manual for complete definitions of these programs.)

F. PROCESSING CONTRACTS NOT SUBJECT TO REGULATED RATES

DDS is moving most of its contracts to regulated rate contracts subject to the provisions of chapter 257. However, there still remain a number of services that will need to be contracted under the long standing procedures of negotiated unit rate maximum obligation contracts, rate contracts, or accommodation purchase contracts. The procedures for contracting such services are as follows:

BUDGET FORMS (Non-Master Agreement contracts) – Before completing budget forms the provider and DDS staff must decide upon the method of reimbursement for services. Program budgets may be written in either of two reimbursement methodologies:

a. UNIT RATE BUDGETS (Includes Unit Rate Maximum Obligation contracts, Negotiated Rate contracts and Accommodation Rate contracts) – A unit rate budget is designed to reimburse the provider a specified amount of money for the delivery of a unit of service. A unit of service is most commonly defined as one day of service to one individual, one hour of service to one individual, or one month of service to a group of individuals. (In rare cases other unit arrangements are possible.)

DIFFERENCES BETWEEN UNIT RATE MAXIMUM OBLIGATION CONTRACTS, RATE CONTRACTS (excluding Master Agreement contracts), ACCOMMODATION RATE CONTRACTS AND CAPITAL BUDGET CONTRACTS:
A Unit Rate Maximum Obligation contract program budgets contain a line item specific budget (Attachment 3: Fiscal Year Program Budget) negotiated by the provider and DDS staff as well as unit rate calculation budget (Attachment 4) that shows both a unit rate and a maximum obligation calculated as a result of the number of units purchased by DDS multiplied by the unit rate. In this type of program budget the maximum obligation, the number of units, and the unit rate are specified and become fixed at the start of the contract, requiring an amendment to change the maximum obligation, the number of units, and/or the unit rate, if a change is later necessary**.**

A Rate Contract program budget shows the calculation of the unit rate in the same manner as a Unit Rate Maximum Obligation program budget but does NOT specify a maximum obligation nor specify a maximum number of units available to the provider during the life of the contract. The unit rate is fixed at the start of the program, requiring an amendment to change it if a change is later necessary. However, both the maximum obligation and the number of units remain "variable" during the life of the program.

An Accommodation Rate program budget is defined by the Operational Services Division (OSD) as follows: “The accommodation rate defines the unit in terms of its availability rather than actual delivery. An example is a shelter bed where its availability is the critical factor.” For use in DDS program budgets Accommodation Rate budgets are designed to reimburse the provider for being open and available to provide essential services at all times during the period of the contract regardless of actual usage by consumers. Examples of such services are Emergency Stabilization Services and Family Support Centers. Reimbursement for Accommodation Rate contracts occurs on a monthly basis with a payment of 1/12 the contract maximum obligation for a full year contract.
Depending on the service attendance reporting may be required even though payment is not based on the delivery of a set number of units of service.

A Capital Budget is used when a provider is purchasing furnishings and/or equipment which, either individually, or in the aggregate for like items purchased together, total an amount exceeding the capitalization level determined by the provider organization in keeping with OSD regulations and generally accepted accounting principles. Capital budget contracts must contain the Attachment 6: Capital Budget Form. (See the discussion in section 3. below.)

Except where otherwise indicated the provider must complete the following documents for a unit rate program budget of each type:
a. Attachment 1:Program Cover Page (Use form dated 11/1/2005) (Check Option 3:Unit Rate.
Also, see the special instructions in the STANDARD CONTRACT FORM & INSTRUCTIONS unit of this manual for completing the Attachment 1 for a contract renewal amendment that extends past the end date of the awarding RFR and is subject to Chapter 257.) Please Note: Only the Attachment 1 Form dated 11/01/05 is acceptable.
PROGRAM ROSTERS
Although not an integrated part of the contract document FY2017 program “Rosters” of consumer names and allocations must be submitted for all programs where enrollments are collected at the same time that contracts are submitted or as directed by the Area Office. Such rosters must not be included in the contract package but must accompany the contract as a separate submission or as directed by the Area Office. Regions have the discretion to withhold the processing of contracts that are not accompanied by program rosters.
b. Attachment 3: Fiscal Year Program Budget (Use form dated 6/19/2007) – Complete as instructed in the STANDARD CONTRACT FORM & INSTRUCTIONS unit of this Manual.
c. Attachment 4:Rate Calculation/Maximum Obligation Calculation Page (Use form dated 11/1/2005) - NOTE: Except in the case of a Class Rate program budget DDS Unit Rates are calculated on the basis of a negotiated “Utilization Factor” (in no case lower than 85%). The option of using a Utilization Factor other than 100% is made available to providers who are running stable day or residential programs that incur fixed operating costs and can reasonably anticipate absences to occur during the period that the program is in effect. By multiplying the number of units that the program has to offer by the Utilization Factor the DDS reimbursable unit rate is adjusted upwards.
d. Attachment 5:Non-Reimburseable Cost Program Offset Page (Use form dated 11/1/2005) (complete only if applicable)

b. COST REIMBURSEMENT BUDGETS – A cost reimbursement budget is designed to reimburse the provider a sum of money based upon the line item values contained in the budget. Unlike a unit rate budget, the reimbursement is not directly based upon the delivery of a specified number of units (although acceptable delivery of services is a factor in reimbursement), but, rather, on the actual incurrence by the provider of costs specified in the budget. The provider must complete the following documents for a cost reimbursement budget:

1. Attachment 1:Program Cover Page (Use form dated 11/1/2005) (check Option 3:Cost Reimbursement. *Also, see the special instructions in the* STANDARD CONTRACT FORM & INSTRUCTIONS *unit of this manual for completing the Attachment 1 for a contract renewal amendment that extends past the end date of the awarding RFR and is subject to Chapter 257.)*
2. Attachment 3:Fiscal Year Program Budget (Use form dated 6/19/2007) - Complete as instructed in the STANDARD CONTRACT FORM & INSTRUCTIONS unit of this Manual.
3. Attachment 4:Rate Calculation/Maximum Obligation Calculation Page (Use form dated 11/1/2005) (lines 11 – 15 ONLY!)
4. Attachment 5:Non-Reimburseable Cost Program Offset Page (Use form dated 11/1/2005) (complete only if applicable)

c. ATTACHMENT 6: CAPITAL BUDGET (Use form dated 11/1/2005)

The capital budget is a special budget form that must be constructed as a stand-alone budget. A capital budget must be created as a separate unique contract with its own DDS contract ID number and a reference placed in the description of service that shows the contract to which the capital budget is related. The capital budget is used when a provider is purchasing furnishings and/or equipment which, either individually, or in the aggregate for like items, total an amount exceeding the capitalization level determined by the provider organization in keeping with OSD regulations and generally accepted accounting principles. Such items are specified on the Capital Budget form along with a statement of the provider's capitalization level. OSD has issued a policy for the purchase of capital items, which is available on the OSD website. DDS will generally be using Option 3 of the OSD policy for its capital purchases (funding through a capital budget; the provider owns the furnishings). (If a DDS Region wishes to use one of the other two options in a particular instance it will need to get prior approval from central office.)

Option 3 procedures are as follows:

1**.** The provider owns the furnishings or equipment, not the Department. This approach contains specific inventory requirements as well as special considerations under which DDS retains some control over the assets if the program is terminated before the F&E has been fully depreciated (3 years). The details are contained in the OSD policy memo referenced 22 above. This means that whenever a program is terminated a review must be made of whether any capital purchases are less than three years old.

2**.** EOAF regulations state that a capital item is "an asset or group of assets…which equals or exceeds the capitalization level established and certified by the Contractor in accordance with generally accepted accounting principles…" The provider must state its capitalization level on the Capital Budget Form so that when an F&E purchase is going to be made it will be clear that it should be contracted for as a capital item and not included as supplies with a onetime increase to the unit rate. Once the capitalization level is set, under these regulations, it must be followed. The Department and the provider would not be permitted to use the capital

budget to purchase an F&E type item that is below that level.
3**.** Option 3 should generally only be used within the last three years of the life of an award with the prior approval of the DDS Assistant Commissioner for Management and Finance. If the Regional Office wishes to make a purchase for a contract with fewer than three years remaining, the following information should be sent in a letter from the Regional Director to the DDS Assistant Commissioner for Management and Finance.
☐Provider Name
☐Contract ID Number
☐Amount
☐Items(s) to be purchased
☐An assessment of the likelihood that the program itself will continue after the award expires (is it an on-going program that is going to be re-bid?) and that the provider will continue to operate it.
NOTE: In programs not yet assigned class rates by EOHHS DDS generally prefers Unit Rate program budgets to Cost Reimbursement program budgets. However, in certain circumstances the cost reimbursement program budget is a preferred choice. DDS staff has the right to determine the methodology appropriate to the program budget.
These forms can also be obtained at the OSD web site
http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/osd/
Forms taken from the OSD web site cannot be completed on screen but must be downloaded via Word Document or pdf format and completed off screen.

XIII. SUBCONTRACTS

A. DEFINITIONS – A subcontract is defined as the purchase of an organized program of direct services from a secondary provider by the primary provider. The primary provider will be held responsible for the performance of any subcontractor.
B. BOUNDARIES - Subcontracts that involve a commitment of $10,000 or more or amount to 25% or more of the total contract, whichever is less, are subject to competitive procurement policies by the primary provider. Subcontracts amounting to the lesser of $10,000 or 25% of the total contract need **not** be competitively bid. Sub-purchases (e.g. supplies, consultants) that are not purchases of organized programs of direct services are not considered subcontracts.
C. PROCESS – All subcontracts must receive the prior written approval of DDS. Written approval during the selection process by DDS of the subcontracts proposed by a primary provider is considered to be prior written approval.
D. CONDITIONS– A provider with an approved contract with DDS may enter into a subcontract agreement with a secondary provider under certain conditions:
☐The subcontract arrangement is programmatically sound and necessary as determined by DDS;
☐The subcontract arrangement is approved, in advance, and in writing by the DDS authorized signatory;
☐Procurement standards must be applied where applicable to subcontracts executed by providers;
☐A written agreement stating the terms of the subcontract are signed by the DDS authorized signatory and the provider prior to the commencement of the subcontract. This agreement must contain, at a minimum, the following information:

1. A statement of the parties involved
2. The type of service
3. The terms of the services
4. The subcontractor qualifications
☐A copy of this subcontract must be kept on file at the provider's office with the contract and a copy must be sent to the DDS Regional Office.

XIV. CONTRACTOR CHANGE IN IDENTITY FORM

In certain limited situations where a change in provider identity occurs (e.g. legal name, organizational structure, tax identification number (TIN), vendor code, merger, or other change in a provider from what was presented in the provider's response to a procurement) a special provider Change in Identity Form must be used in place of a Standard Contract Form or Standard Contract Amendment Form. **IMPORTANT**: **When anticipating a change in identity the provider must contact the DDS Regional Office as soon as possible. A provider has no independent authority to assign a contract to a new entity so it is imperative that DDS is notified well in advance of any identity change.**

XV. PAYMENT REIMBURSEMENT

The provider has available two methods for reimbursement for services rendered, Regular Payment or Ready Payment. The provider has the right to request the Ready Payment option; however, DDS staff reserves the right to make the final decision. The Ready Payment option is available for both unit rate and cost reimbursement programs.

A. REGULAR PAYMENT – In the Regular Payment methodology the provider submits a standard invoice with any required documentation at the conclusion of each month for payment.

B. READY PAYMENT - For many years, providers have benefited from the cash flow enhancements provided by the Commonwealth's Ready Payment system. This system allows providers to choose a reimbursement system that provides periodic automatic payments, in amounts up to 1/24 of contracted maximum obligation levels that are later reconciled to actual contract billings through the traditional Payment Voucher submission process. These periodic payments, which begin during the middle of July, smooth the reimbursement process and provide "bridge" funding at the beginning of a new fiscal year.

NOTE: FOR FY2017 THE READY PAYMENT AMOUNT WILL BE ADJUSTED TO A MAXIMUM OF 80% OF THE 1/24 VALUE IN ORDER TO REDUCE THE INCIDENTS OF OVERPAYMENT.

The Ready Payment methodology provides for an automatic check to be sent to the provider on a prescribed schedule with a reconciliation invoice required from the provider at the end of the month. DDS contracts typically use the Ready Payment schedule listed below:

- **Semi-Monthly** – The semi-monthly methodology provides that automatic checks are sent to the provider approximately twice a month with a maximum base payment of **80% of 1/24th** of the document total.

Process – the Ready Payment methodology will issue the first automatic check at approximately the second week in July (for July 1st start contracts.) The final check issuance will vary based upon the level of spending versus the estimated total spending level. Therefore, it is possible that the last check may be issued prior to the end of the fiscal year.

CAUTION: DDS has the right to remove a provider from the Ready Payment method (for procedural reasons) if there is insufficient billing by the provider as demonstrated on the reconciliation payment vouchers.

C. UTILIZATION FACTORS

1. Residential Service contracts (Chapter 257 rates) will be reimbursed using a 95% utilization factor.
2. Day/Employment Services contracts (Chapter 257 rates) will be reimbursed using an 87% utilization factor.
3. Non-Regulated Unit Rate contracts will be reimbursed using an 85% or higher utilization factor.
4. ABI service contracts do not have a utilization factor.

D. VENDOR WEB

VendorWeb is a common access point for Commonwealth providers from which they may get their payment information easily.
The website for Vendor Web is http://www.mass.gov/osc/guidance-for-vendors/
Once you are at the site follow instructions below:
Click on – Vendor Web Login
Enter your Vendor Code Number and the last four digits of your federal ID number and click the Login button.
From the Vendor Web Home Page, click on one of the views on the left side of the page:
SCHEDULED PAYMENTS for payments that have been approved in MMARS but not yet issued;

OR

PAYMENT HISTORY for payments already paid to you.
On these pages scroll down to make your selections from the dialog boxes.

XVI. DDS APPROVED ABSENCE POLICY

Approved Absences

Approved absences must be applied for by submitting to DDS the "Consumer Absence Request/Approval Form."

Approved Long Term Illness:

Residential Services

The Approved Absence Policy for Residential Services has been revised for FY2017.
At the start of each residential contract the number of available units calculated under the Utilization Factor (UF) of 95% will be identified. Each month the number of Utilization Factor units will be decreased by the number of absences in the contract. When the number of UF units available to the contract reaches zero or below the provider will be permitted to request additional units under the AAP. Detailed instructions on implementing the absence policy can be found in the Payment Reimbursement section of this manual.

Non-Residential Services

If an individual requires an absence from a non-residential program because of illness beyond two weeks of regular authorized hours, the Area Director may approve a continuation of the absence with

reimbursement for certain periods. An Area Director's signature-approval is necessary in order for the Service Provider to bill from the third and fourth week absent from non-residential programs. For non-residential programs, allowable billing must be based on the regular weekly level authorized for the individual. If the absence continues beyond four weeks in a non-residential program, both the Area Director's and Regional Director's signature- approvals are necessary for the Service Provider to bill for further reimbursement. The dual approval covers billing up to eight weeks absent from a non-residential program.

After eight weeks absent from a non-residential program, a decision must be made as to the advisability of continuing the individual in the program. In no case may reimbursement continue after the eighth consecutive week for non-residential services. All other sick days are not billable, and must be assumed under the Utilization Factor.

In the case of non-residential programs, the decision to permit billing for absences may limit allowable billing for absences to amounts that will not exceed the applicable utilization factor used to establish the billing rate.

ABI Services

ABI services fall under the authority of Mass. Health regulations. Mass. Health regulations contain no provisions for reimbursing absences. Therefore, any absences in ABI programs are not reimbursable**.**

XVII. CONTRACTS WITH INDIVIDUALS

An individual (i.e. not a corporation or partnership) who wishes to provide direct care services to developmentally disabled individuals must become a listed provider on the Commonwealth's MMARS system as described in section I above. However, individuals are not required to undergo the Prequalification/Requalification process as described in section II above. The means of determining services that DDS is purchasing and the proper response to these offerings is the same as for corporations/partnerships (i.e. accessing the **COMMBUYS** web site and submitting a valid proposal consistent with the advertised RFR.) The awarding of a contract to an individual also follows the previously described review and negotiation procedures. The contract package that an individual provider must complete, however, differs from the package required of a corporation/partnership.

A. STANDARD CONTRACT FORM is completed as described above, including the required attachments identified in the revised Standard Contract Form page.

B. DESCRIPTION OF SERVICE must be included

C. BUDGET FORMS – the budget document is informal, created by the provider with, as a minimum, a statement of the conditions of reimbursement (e.g. unit rate, number of units to be delivered maximum obligation) and any special conditions (e.g. timeframes for delivery of services.) The budget document must be acceptable to DDS staff. Most contracts with individuals are written on a unit rate basis; however, in rare instances a cost reimbursement contract is possible. The decision to allow a cost reimbursement contract rests with DDS staff.

D. CONTRACT ATTACHMENTS

- **Contractor Authorized Signatory Listing (not required if doing a Renewal Amendment)** Resume or qualifications to provide service

XVIII. LIMITED UNIT SERVICE AGREEMENT (LUSA)

DDS has established a distinct and limited contract methodology for purchasing intermittent or as-needed services for developmentally disabled individuals needing limited time placements. The purpose of LUSA's is to allow providers the opportunity to place on file with DDS a contract that can be accessed at any time during its life when an unexpected or limited time service is agreed upon by both the provider and DDS. LUSA's are not funded unless and until DDS and the provider agree on a service to be delivered.

See the section of this Manual named LIMITED UNIT RATE SERVICE AGREEMENTS (LUSA's) for detailed instructions on properly completing a LUSA and processing it for approval.

PROPER (AND IMPROPER) USE OF THE LIMITED UNIT SERVICE AGREEMENT

The Limited Unit Rate Service Agreement ("LUSA") is established to provide payment to providers for "intermittent, as-needed services on a limited short term basis". The LUSA is a unit rate contracting mechanism to be employed only when a service meets the definition stated above and an amendment to an existing contract is not feasible or appropriate. The LUSA is not now, nor has ever been, an acceptable alternative to a proper contract or amendment.

Some examples of the proper use of a LUSA:

1. A consumer in need requires one-to-one attention for a period of time. The need for this service was not anticipated in the original contract. The service is limited in nature and an amendment to the contract would be inappropriate because the basic service funded in the program is not changing.
2. An Area Office is evaluating the proper placement for a new consumer. The consumer is placed in a program for a short time to evaluate his/her needs. Due to the nature of the evaluation an amendment is to the existing program is not desirable.
3. A consumer presents with an "emergency" circumstance such that an immediate placement in an existing program is necessary. The intent is for the consumer to remain in the program only for the period of time of the emergency at which time a permanent solution will be found and a proper amendment prepared.
4. After the annual encumbrance deadline (typically mid-May) a consumer(s) requires an *immediate* placement in a program. If the funding for the consumer(s) is $25,000.00 or more an amendment to an existing contract is not allowed. Absent the ability to amend a contract the LUSA may be used until the amendment process is again made available.
5. A consumer requires short term placements in several programs for short periods of time such that no one program has permanent control over his/her services. Amendments would not be appropriate in this situation.
6. A consumer is initially placed in a program with the intent of moving him/her to another more appropriate program as soon as such program can be identified. The period of time spent in the

initial program is undetermined so a LUSA may be employed for the placement. However, in this case the LUSA funding must end as soon a permanent placement can be found and in any case cannot exceed one year. (Exceptional cases may be referred to the Regional Director and Deputy Commissioner of DDS for approval of services beyond one year.)

7. A LUSA may be used as a "bridge" authorization prior to the completion and approval of a formal contract amendment. In this case the LUSA funding is limited to no more than one month

Some examples of the improper use of a LUSA:

1. Funding for a consumer in excess of one year (unless expressly authorized by the Deputy Commissioner for an extraordinary situation.)
2. Paying for any add-on service (e.g. one-to-one supervision) from a LUSA using the unit rate established for the entire program. (The add-on service should have its own unit rate.)
3. Paying for any capital equipment. A LUSA is, by definition, a unit rate agreement constructed for the purpose of providing services. Capital equipment cannot be purchased as a unit of service.
4. Paying for any individually specific line items in a program. A LUSA must only be used for a service(s) on a unit rate basis to one or more consumers.
5. Using the LUSA at the end of the fiscal year to pay for services previously performed in an attempt to "spend out" fiscal year funds. (An exception to this principle is described in line 4 in the above section on proper use of a LUSA.)
6. Using a LUSA to provide a new service without undergoing a required procurement process.
7. Payment to a provider by means of a LUSA for services delivered without the required prior authorization from DDS for such services to be delivered.
8. In general, using the LUSA as a matter of convenience to provide regular services within a program where a proper amendment to the contract is appropriate.

Like any Standard Contract, LUSA's are effective upon the latest of the provider's signature date or the DDS authorized signatory's signature date. Payments for services delivered under a LUSA are NOT retroactive.

Also, in order to deliver services and be reimbursed under a LUSA a provider must be prequalified for the fiscal year.

A. TYPES OF LUSA's

Support Services (RFR ANSS-15), (Activity Code 3174). **NOTE: Activity code 3174 is the only acceptable activity code for LUSA Support Services.**

N.B. Effective 7/1/2009 all Day and Employment Services paid under a LUSA agreement will require a provider to be qualified under the RFR "EMP_DAY_09" found on COMMBUYS. A provider who is qualified under this RFR will automatically be qualified to provide short term as-needed services as appropriate for its qualifications.

Effective 4/1/2014 LUSA's for Residential Services are no longer be allowed. The Master Agreement for residential services will cover any needed services that formerly met the definition of a LUSA service.

B. UNIT RATES

- LUSA's can only be established on a unit rate basis. Cost Reimbursement programs are not allowed.
- Unit rates may be established as a range of rates with a low rate and a high rate. Any rate falling within the range is considered to be an approved rate. (This concept of "range of rates" is unique to LUSA's. It is not available to programs in Standard Contracts.)
- Unit rates are allowed on a day, hour, month, trip, or unit basis, depending on the service type.

C. LUSA PREPARATION

LUSA's are prepared on the Standard Contract Form. Attachments to LUSA's are the same as attachments for Standard Contracts, i.e.:

- Description of Service (Standard language for each of the four LUSA types)
- Unit Rate Budget Pages
- Contractor Authorized Signatory Listing (CASL)
- Attachment C
- Attachment C - Special Provisions

See the unit of this manual Limited Unit Rate Service Agreements (LUSA's) for detailed instructions on completing the LUSA documents.

D. AMENDING LUSA's

LUSA's may be amended to change an existing rate or add a new rate. The proper form to amend a LUSA is the Standard Contract form.

See the unit of this manual Limited Unit Rate Service Agreement (LUSA's) for detailed instructions on amending LUSA documents.

A. EFFECTIVE DATES

New LUSA's and amendments to LUSA's are effective upon the latest of the two signature dates (provider signature and DDS authorized signatory signature.)

F. LUSA PROCESS

Unlike Standard Contracts, Renewal Amendments, and Standard Amendments, LUSA's and LUSA amendments are processed directly by DDS Central Office. After a provider accesses and completes the required LUSA forms it must send the LUSA's directly to the DDS Central Office contract office for processing. Once approved the DDS Central Office contract office will send a fully approved copy of the LUSA/LUSA amendment to the provider for its records. Receipt of the LUSA/LUSA amendment will be the signal that the provider may begin billing for services rendered as approved by DDS staff.

G. LUSA AUTHORIZATION PROCESS

Whenever possible, services that are properly deliverable by means of a LUSA must be authorized by DDS prior to the service being delivered (or no later than three business days following the start of services in cases of immediate need). Ideally payment should be made to the provider at the time of the completion of the service. However, it is recognized that there are occasions where services must be performed and the funds for reimbursement are not immediately available. In such cases it is recommended that the following procedures be followed:

1. The Area Director must submit to the Regional Director a reason why the service is necessary, why an amendment is not possible or feasible, and why the LUSA is appropriate for reimbursement.

2. The Regional Director must approve in writing the request for a LUSA and identify where the future funds for reimbursement are anticipated.

3. After Regional Director approval the Area Director must send an authorization for services under the LUSA to the provider prior to the delivery of services. The authorization must contain language stating that payment for services may be delayed. The provider must agree to this language.

4. Payment for these services must be made as soon as funds are available, but in no case may payment come after the close of accounts payable.

5. Region staff have the obligation to assure that funds are in the appropriate lines in MMARS by the end of the allowable amendment period (usually mid-May) in order to pay for services reimbursed by means of the LUSA.

6. After Regional Office review LUSA requests are forwarded to the DDS Central Office for a final review. At that time Central Office staff has the option to allow the LUSA to be processed for approval, reject the LUSA request outright, or request further information/justification from the provider in order to make a decision.