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. **Proposed Effective Date:** 01/01/2023

Approved Effective Date *(CMS Use):*

II. Purpose(s) of Amendment

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

The purpose of the amendment is to remove Day Habilitation Supplement from the waiver effective January 1, 2023. The Day Habilitation Supplement service is transitioning to a component of the Day Habilitation (DH) state plan service to provide a more streamlined and structured service for members and DH providers.

The Department of Developmental Services (DDS, or "the Department"), the state agency within the Executive Office of Health and Human Services responsible for providing supports to adults with intellectual disabilities (ID), is the lead agency tasked with the day-to-day operation of this waiver. The Executive Office of Health and Human Services, the single State Medicaid Agency (MassHealth), oversees the Department's operation of the waiver. MassHealth also operates the Medicaid state plan, which includes the DH program. The Day Habilitation Supplement service allows individuals with substantial clinical needs to access and benefit from DH services and participate in the community. Incorporating the Day Habilitation Supplement service into the DH program will streamline the administration and will make the service available to all eligible MassHealth members, not only those enrolled in one of the DDS Adult ID waivers.

MassHealth and DDS are working collaboratively to transition the Day Habilitation Supplement service, renamed Individualized Staffing Supports (ISS), from the DDS Adult ID waivers to the state plan. This will streamline and modernize the rate structure of the DH state plan service to include ISS, effective October 1, 2022. MassHealth and DDS have worked closely on policies and procedures to ensure that current recipients of Day Habilitation Supplement will continue to receive the service in the same amount and duration through this transition.

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	
☐	Appendix A – Waiver Administration and Operation	
☐	Appendix B – Participant Access and Eligibility	
x	Appendix C – Participant Services	C-3
☐	Appendix D – Participant Centered Service Planning and Delivery	
☐	Appendix E – Participant Direction of Services	
☐	Appendix F – Participant Rights	
☐	Appendix G – Participant Safeguards	
☐	Appendix I – Financial Accountability	
x	Appendix J – Cost-Neutrality Demonstration	J-1/J-2

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
x	Add/delete services
☐	Revise service specifications
☐	Revise provider qualifications
☐	Increase/decrease number of participants
x	Revise cost neutrality demonstration
☐	Add participant-direction of services
☐	Other (specify):

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

☐	**Hospital** *(select applicable level of care)*	
	☐	**Hospital as defined in 42 CFR §440.10**

		If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:
	○	**Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160**
☐	**Nursing Facility** *(select applicable level of care)*	
	☐	**Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155** If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:
	○	**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
■	**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)** If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID facility level of care:	

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

Select one:

■	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

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

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:*
☐	**A program authorized under §1915(i) of the Act.**
☐	**A program authorized under §1915(j) of the Act.**
☐	**A program authorized under §1115 of the Act.** *Specify the program:*

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Purpose:
The purpose of this Waiver is to provide flexible and necessary supports and services to adults 22 years and older eligible for services through the Department of Developmental Services (DDS, or "the Department") who meet the ICF-ID level of care and are determined through an assessment process to require supervision and support 24 hours, 7 days per week to avoid institutionalization. Based on the severity of their functional impairments these individuals require a comprehensive level of support. These individuals may reside in out–of-home settings or in their family home with a comprehensive array of supports. Individuals in this waiver have a high level of support needs due to significant behavioral, medical, and/or physical support needs. Individuals have access to all state plan services. Individuals in this waiver need 24/7 support either in an out of home placement or with additional supports and supervision in the family home. For individuals who reside in the family home although natural supports and state plan supports are available, they are insufficient to meet the needs of the individual, and therefore the individual needs waiver services and supports. The combination and coordination of waiver services, natural supports, Medicaid State Plan services, generic community resources support the individual to continue to live successfully in the family home. For individuals who cannot and do not have family to provide care for them, the waiver services in combination with Medicaid State Plan services and generic community resources make it possible for them to successfully live in the community.

The population to be served in this waiver includes individuals moving from ICF-IDs, individuals transitioning from nursing facilities to the community, young adults aging out of special education and individuals whose needs and caregiver circumstances have become more complex, requiring additional in home supports and supervision or placement outside of the family home. The participants in this waiver present with a substantial risk for out of home placement due to their extraordinary needs. The Intensive Supports Waiver has no prospective individual budget limit.

Goal:
The goal of this waiver is to provide support to these individuals in their communities to prevent the need for restrictive institutional care.

Organizational Structure:
As the state agency within the Executive Office of Health and Human Services (EOHHS) responsible for providing supports to adults with intellectual disabilities, DDS is the lead agency tasked with the day-to-day operation of this waiver. EOHHS, the single State Medicaid Agency, through MassHealth, oversees the Department's operation of the waiver. DDS is organized into four geographical Regional Offices with 23 Area Offices assigned to the regions. Intake and Eligibility into the system occurs at the regional level through a dedicated group of Waiver Eligibility Teams. These teams collect information and conduct assessments to determine if the individual meets DDS eligibility criteria. If determined eligible, individuals are assigned to the Area Office nearest the city or town where they live. The Area Office builds on the information and assessments collected during the eligibility process to determine prioritization for services, service needs and funding level.

Service Delivery:
DDS operates as an Organized Health Care Delivery System, directly providing some of the services available through this waiver and contracting with other qualified providers for the provision of other services. Services may be participant directed, or purchased through either a Fiscal Employer Agent/Fiscal Management Service or through an Agency with Choice Model.

Services may also be delivered through the traditional provider based system. Participants may choose both the model of service delivery and the provider. DDS makes payments to providers through the Meditech claims processing system. DDS's payments are validated through the state's approved MMIS system through which units of service, approved rates and member eligibility are processed and verified.

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

■	**Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
○	**No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. **Appendix F** specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. **Appendix H** contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

○	**Not Applicable**
○	**No**
■	**Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

■	**No**
○	**Yes**

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

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. *Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

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

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem.

During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

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

Massachusetts outreached broadly to the public and to interested stakeholders to solicit input on the Community Living, Adult Supports and Intensive Supports waiver amendments.

The draft waiver amendment applications and information on how to request a hard copy of the amendment applications were posted to MassHealth's website (https://www.mass.gov/info-details/home-and-community-based-services-waiver-renewal-and-amendment-applications-public). Public notices were issued in multiple newspapers, including: the Boston Globe, Worcester Telegram and Gazette, and the Springfield Republican. In addition, emails were sent on January 14, 2021 to key advocacy organizations as well as the Native American tribal contacts. The newspaper notices and emails provided the link to the MassHealth website, the dates of the public comment period (January 14, 2021 – February 12, 2021), and both email and mailing addresses for the submission of written comments. The state also held a public listening session on January 25, 2021 at which oral comments were received. Participants were able to join the listening session on Webex or by phone. The state received oral and written comments from a total of 8 individuals and organizations. Commenters included advocates, providers and family members of waiver participants.

MassHealth outreached to and communicated with the Tribal governments about the Community Living, Adult Supports and Intensive Supports waiver amendments at the regularly scheduled tribal consultation quarterly meeting on November 18, 2020. This meeting afforded MassHealth the opportunity for direct discussion with Tribal government contacts about the waiver amendments. The Tribal governments did not offer any comments or advice on the waiver amendments.

Based on the public comments received, the state has modified the name of the new Remote Supports service to be Remote Supports and Monitoring in an effort to clarify the purpose of the service. The state reviewed all comments received and determined that no other changes to the waiver applications were required.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name:	Bernstein				
First Name:	Amy				
Title:	Director of HCBS Waiver Administration				
Agency:	MassHealth				
Address :	One Ashburton Place				
Address 2:	5th Floor				
City:	Boston				
State:	Massachusetts				
Zip:	02108				
Phone:	617-573-1751	**Ext:**		☐	**TTY**
Fax:	617-573-1894				
E-mail:	Amy.Bernstein@mass.gov				

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

Last Name:	Pavlova				
First Name:	Rumiana				
Title:	Director of Medicaid Waivers				
Agency:	Department of Developmental Services				
Address:	1000 Washington Street				
Address 2:					
City:	Boston				
State:	Massachusetts				
Zip :	02118				
Phone:	617-312-7917	**Ext:**		☐	**TTY**
Fax:					
E-mail:	Rumiana.R.Pavlova@mass.gov				

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

_____

State Medicaid Director or Designee

Submission Date:	

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

Last Name:	Cassel Kraft				
First Name:	Amanda				
Title:	Assistant Secretary and Director of MassHealth				
Agency:	Executive Office of Health and Human Services				
Address:	One Ashburton Place				
Address 2:	11th Floor				
City:	Boston				
State:	Massachusetts				
Zip:	02108				
Phone:	617-573-1600	**Ext:**		☐	**TTY**
Fax:	617-573-1894				
E-mail:	Amanda.Casselkraft@mass.gov				

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

MassHealth and DDS have worked closely on policies and procedures to ensure that current recipients of Day Habilitation Supplement will continue to receive the service in the same amount and duration through this transition. MassHealth and DDS have reviewed utilization data to identify all participants currently using the Day Habilitation Supplement waiver service. This data review will be conducted several more times prior to October 1, 2022 to identify individuals who have newly accessed the service after the initial data pull. MassHealth is establishing an administrative Prior Authorization to ensure that those individuals who currently receive Day Habilitation Supplement will continue to receive the same level of service through this transition of the service to ISS. Providers and recipients do not need to take action to initiate this process. These administrative Prior Authorizations will be put in place automatically for these individuals and will stay in effect until such time as MassHealth has fully expended funding made available by the American Rescue Plan (ARP) to enhance, expand, and strengthen home- and community-based services (HCBS) for MassHealth members who need long-term services and supports. DDS Service Coordinators will work with waiver participants and their families to reassess needs and access ISS through the MassHealth state plan once the Administrative Prior Authorization ends.

MassHealth and DDS will notify current recipients of Day Habilitation Supplement of this change in a direct mailing that will explain the change and provide reassurance that the current level of service will be uninterrupted. Members and their families will be instructed to talk with their Day Habilitation providers or DDS Service Coordinators if they have questions or concerns. MassHealth and DDS are educating Day Habilitation providers and DDS Service Coordinators about this change and have produced a Factsheet and FAQ to equip staff to respond to questions. MassHealth and DDS are also asking Day Habilitation providers and DDS Service Coordinators to proactively communicate with affected members and families to follow

up on this mailing and provide reassurance that service level will not be impacted by this transition.

Through the person-centered planning process, DDS Service Coordinators will support participants to access ISS through the state plan, and to make other necessary changes to the Plan of Care to ensure participants' needs are met. The state assures that all waiver participants will continue to have access to the Day Habilitation Supplement service, as they will have access to ISS through the state plan.

The state is putting processes in place to prevent any possibility of billing for ISS and Day Habilitation Supplement on the same date of service for the period between October 1, 2022, when ISS will be in the state plan, and January 1, 2023, when Day Habilitation Supplement will be removed from the DDS Adult ID waivers. This three-month transition period is intended as a safety net, to ensure that no participant is left without the needed supports inadvertently. DDS is programming its billing system to reject any claims submitted inappropriately by providers. DH providers will be redirected to submit claims through MMIS. MassHealth will develop and implement an audit process as an additional safeguard against duplicative billing during this three-month period. Payment for any duplicative claims will be recouped by the state.

In parallel to this waiver amendment, MassHealth has developed a state plan amendment to add ISS to the State Plan as part of DH.

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

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

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

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

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

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Massachusetts Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency (MassHealth), convened an interagency workgroup to address how best to comply with the requirements of the federal Home and Community Based settings at 42 CFR 441.301 (c)(4)-(5). The Department of Developmental Services (DDS), an agency within EOHHS that has primary responsibility for day-to-day operation of the 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.

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~~comply 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 HCBS settings requirements, not yet be in compliance with federal HCBS settings requirements but could with minor changes, or not yet in compliance with federal HCBS settings requirements because of the need for more substantial changes. As of the time of the submission of this amendment, all but 2 providers, representing 27 provider-operated residential settings, have demonstrated full compliance with the Community Rule. Of these remaining settings, DDS identified 1 provider with 17 settings as requiring minor changes and 1 provider with 10 settings as requiring substantial changes. ~~, continue to work with~~ DDS will continue to work with these providers~~to plan for and~~ to move toward full compliance. The state expects all providers of waiver services in the Intensive Supports waiver to be in full compliance by or before March 202~~2~~3.

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.

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 onsite and off-site; that many activities are most commonly offered in a group; and that offered activities may be disability-specific as well as involve meaningful engagement with non-disabled people in the broader community. Based upon the review and assessment, the non-residential settings mentioned above fall into the following designations:

- The non-residential setting complies: 508 (these represent ~~group and individual employment~~private and state operated CBDS and supported employment settings)
- The non-residential setting, with minor or more substantive changes, will comply: 20 (these represent private CBDS and supported employment settings)
- The non-residential setting cannot meet the requirements: none

A DDS/provider workgroup meets regularly to address systemic changes that are were needed in order to bring all CBDS services into compliance with federal rules. in a timely manner. 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 engagement of participants with people and activities in their communities in the context of CBDS programs, provider technical assistance to enhance program design and operation, and other mechanisms related to outcome goals in the Final 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 developed updated anticipates development of clear guidelines and standards that define day services, including what constitutes meaningful day activities, and how services and supports can be incorporated into the community more fully. Technical assistance, training and staff development has been and will continue to be provided to assist providers in complying with the HCBS Regulations.

For all settings in which changes are required, DDS 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.

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.

As noted above, all settings in which waiver services are delivered will be fully compliant with the HCBS Regulations no later than March 2022.

The State is committed to transparency during the waiver renewal process as well as in all its activities related to Community Rule compliance planning and implementation in order to fully comply with the HCBS settings requirements by or before March 2022. If, in the course of ongoing monitoring process, DDS along with MassHealth determines that additional changes are necessary for certain providers or settings, MassHealth and DDS will engage in activities to ensure full compliance by the required dates, and in conformance with CMS requirements for public input.

The state assures that the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval

of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Additional Information from Appendix I-2-a – Rate Determination Methods:

Additional information regarding Live In Caregiver (LIC) rates:

The rate calculation is updated every January based upon the previous year's HUD and USDA data. The maximum per diem and monthly rates for LIC are as follows:

Max LIC Monthly Rate=[(HUD FMR for the municipality where individual resides x 1.5)÷2]+ USDA Cost of Food

Max LIC Per Diem Rate=(Max LIC Monthly Rate x 12)÷365

The HUD Fair Market Rates for a 2 bedroom home in MA for Fiscal Year 2018: https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2018_code/2018state_summary.odn

Please note: when using this link, select New State: MA, select Statewide FMRs, the town to town rates are found on the FY2018 MA FMR Local Area Summary table.

The Official USDA Food Plans: Cost of Food at Home at Four Levels, U.S. Average, Nov.2017 moderate food plan costs for an individual (male and female) between the ages of 19-71+ for the month of Nov.2017.
https://www.cnpp.usda.gov/sites/default/files/CostofFoodNov2017.pdf

Below is the state's response to the Informal Request for Additional Information questions received on 1/14/22.

1.In this section of the waiver, please list all waiver services that may be provided via telehealth.

•Family Training

•Peer Support

•Individual Supported Employment

Language has been added to each of the service definitions of the 3 services above: This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a.

•Individualized Day Supports

•Individualized Home Supports

•Group Supported Employment

•Behavioral Supports and Consultation

Language has been added to each of the service definitions of the 4 services above: This service is primarily delivered in person; telehealth may be used to supplement the scheduled in-person service based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a.

•Assistive Technology

Language has been added to the service definition of the service above: The evaluation and training component of this service may be provided remotely via telehealth based on the professional judgement of the evaluator and the needs, preferences, and goals of the participant as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a.

•Home Modifications and Adaptations

Language has been added to the service definition of the service above: The assessment and evaluation component of the home and adaptations service may be provided remotely via telehealth based on the professional judgement of the evaluator and the needs, preferences, and goals of the participant as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a.

•Transitional Assistance

Language has been added to the service definition of the service above: This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process as outlined in Appendix D. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D.

2.In this section of the waiver, please provide answers to the following questions regarding the waiver services that may be provided via telehealth/remotely. If the responses to these questions are the same for all services delivered via telehealth/remotely, the state may provide a combined response to cover them all. If there are different answers for specific services, these differences should be specifically noted. Alternatively, the state may choose to answer these questions within the service definitions for each service that it will allow to be delivered via telehealth/remotely.

a. What is the role of the SMA in ensuring the health and safety of waiver participants in instances when their services are delivered via telehealth/remotely?

DDS and MassHealth have well established processes to ensure the health and safety of waiver participants. The assessment and person-centered planning processes continue to be

the mechanisms by which the health and safety of waiver participants are reviewed. This review will ensure that appropriate considerations for waiver participants' health and safety were part of the person-centered planning process and confirm whether the telehealth delivery of service model can meet their needs and ensure health and safety. The review will also ensure that waiver participants' services were delivered in the same amount, frequency, and duration that was identified in the Individual Support Plan (ISP), regardless of the method of service delivery. Appendix D and Appendix G describe the safeguards that the state has established to assure the health and welfare of waiver participants regardless of the service delivery method.

b. What is the percentage of time telehealth/remote will be the delivery method for the service? Will any in-person visits be required?

The participant's ISP will outline which activities or components of services may be provided via telehealth, depending on the service and the needs and preferences of the waiver participant to support inclusion, community integration, and independence. If the participant chooses telehealth service delivery for some combination of services, the person-centered planning team will ensure that the services are appropriate in amount, frequency, and duration as identified in the participant's ISP and that the services adequately meet the participant's needs and goals for independence and community integration. Certain services may be provided in a remote capacity for certain participants whereas other services may be delivered either as a hybrid approach of some remote and some in-person, or fully in-person. Frequency of face-to-face contact with the participant is based on the participant's individual needs and preferences. While this service may be provided via telehealth, it is within the context of regular contact with the Service Coordinator including at least an annual in-person visit. Service Coordinators review progress notes from providers and maintain regular contact with providers of waiver services, which also serve to inform the frequency of direct in-person contact.

c. How does the telehealth/remote service help the individual to fully integrate in the community and participate in community activities?

The person-centered planning process helps participants fully integrate in the community and identifies which components of integrated services can best be enhanced through the telehealth means of support, as well as those to be provided in person. In person community activities will continue to be a priority for the participant based on the person-centered planning process. A telehealth service will complement and promote community integration. The ISP team members will identify safeguards that are in place to ensure telehealth modalities do not isolate participants from the community, as well as how team members will ensure community integration. This will also be monitored through service coordination contacts/visits. The participant may also have opportunities for integration in the community via other services which the participant receives which are provided in the community.

Frequency of face-to-face contact with the participant is based on the participant's individual needs and preferences. While this service may be provided via telehealth, it is within the

context of regular contact with the Service Coordinator including at least an annual in-person visit. Service Coordinators review progress notes from providers and maintain regular contact with providers of waiver services, which also serve to inform the frequency of direct in-person contact.

d. How will the telehealth/remote service be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Are video cameras/monitors permitted in bedrooms and bathrooms? If the state will permit these to be placed in bedrooms and bathrooms, how will the state ensure that this is determined to be necessary on an individual basis and justified in the person-centered service plan?

The video cameras used for telehealth services would not be installed in bedrooms and bathrooms. Provider will not install any video cameras for the provision of any telehealth service. Participants are in control of their own devices and may choose to use that device from any place in their home. They are in control of starting and stopping the video feed on their devices. Telehealth delivery is not utilized for ADL supports. The telehealth supports ensure the participant's rights of privacy, dignity, and respect. The provider must develop, maintain, and enforce written policies, which address how the provider will ensure the participant’s rights of privacy, dignity, and respect; how the provider will ensure the telehealth supports used meet applicable information security standards; and how the provider will ensure its provision of telehealth complies with applicable laws governing individuals’ right to privacy. Education on cyber safety is available for participants and the need for such training is identified by the person-centered planning team. Participation in such training is not mandatory for participants, but based on assessed need.

e. Does the telehealth/remote service meet HIPAA requirements and is the methodology accepted by the state’s HIPAA compliance officer?

Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant’s protected health information.

DDS/EOHHS relies on the providers’ independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS

officials.

Below is the state’s 5/24/18 response to the Appendix I-2-a questions from the Informal RAI received on 5/3/18. Informal RAI

Waiver #: MA.0827.R02.00

Waiver Name: Intensive Supports 05/03/18

Appendix I

Appendix I-2-a: Rate Determination Methods

11. The State failed to document or insufficiently documented the rate setting methods for each waiver service. The State references multiple State regulations in this Appendix as the basis for a service rate. For each referenced code, the State must provide a summary of what that code entails with regards to rate setting methodology. For instance, the State uses 101 CMR 414.00 as the basis for the "Behavioral Supports and Consultation, Family Training, Peer Support, and Respite Services. The State should provide a brief summary of the rate setting methodology outlined in that State regulation, and each service to which it applies. The State should then do the same for the other 101 CMR references on page 197-198 (including the self-directed services).

a. Provide the rate model for each service paid using a fee-for-service methodology.

All waiver services in this waiver, including those that reference rates established by state regulation, are paid using a fee-for- service methodology. See descriptions below for additional information.

b. For each service using a rate methodology established by State regulation (101 CMR), the State should provide a brief summary of the rate methodology outlined in the regulation along with the associated services.

For waiver services for which there is a comparable EOHHS Purchase of Service (POS) rate, the waiver service rate was established in POS regulation after public hearing pursuant to state statutory requirements for the development and promulgation of health care services rate regulations that apply to rates for health care services paid for by state agencies. See Massachusetts General Laws (MGL) Chapter 118E, Sections 13C Establishment of rates of payment for health care services and 13D Duties of ratemaking authority; criteria for establishing rates.

- The POS rate used for Behavioral Supports and Consultation (see 101 CMR 414.00: Rates for Family Stabilization Services) was developed by using data from the most recent available UFR and averaging each line item across providers of the service. Specifically, the line items incorporated into this rate analysis are: the salary based on degree level (bachelor, master, and doctorate levels), tax and fringe, other direct costs, and administrative allocation. A cost adjustment factor (CAF) of 2.72% was applied. This analysis also applies to the self-directed service rate maximum for this service.

- The POS rates used for Family Training, Peer Support, and Respite (in the participant's home) (see 101 CMR 414.00: Rates for Family Stabilization Services) were developed by using data from the most recent available UFR and averaging each line item across providers of these services. Specifically, the line items incorporated into this rate analysis are: salaries of direct care workers and an allocation of director/manager salaries, tax and fringe, other direct costs, and administrative allocation. A cost adjustment factor (CAF) of 2.72% was applied. This analysis also applies to the self-directed service rate maximum for these services.

- The POS rate used for Respite (in the caregiver's home) (see 101 CMR 414.00: Rates for Family Stabilization Services) was developed by using data from the most recent available UFR and averaging each line item across providers of these services.

Specifically, the line items incorporated into this rate analysis are: stipend level for the caregiver and an allocation of director/manager salaries, tax and fringe, other direct costs, and administrative allocation. A cost adjustment factor (CAF) of 2.72% was applied. This analysis also applies to the self-directed service rate maximum for these services.

- The POS rate used for Respite (site-based) (see 101 CMR 414.00: Rates for Family Stabilization Services) was developed by using data from the most recent available UFR and averaging each line item across providers of these services. Specifically, the line items incorporated into this rate analysis are: salaries of direct care workers, nurses, and an allocation of director/manager salaries, tax and fringe, occupancy, other direct costs, and administrative allocation. A cost adjustment factor (CAF) of 2.72% was applied. This analysis also applies to the self-directed service rate maximum for these services.

- The POS rates used for Community Based Day Supports (set in accordance with 101 CMR 415.00: Rates for Community- Based Day Support Services) were developed by using data from the most recent available UFR and averaging each line item across providers of these services. Specifically, the line items incorporated into this rate analysis are: salaries of direct care workers, support staff, and an allocation of director/manager salaries, as well as tax and fringe, office space/program location expenses, consultant/temporary help, direct client expense, supplies, other direct expenses and direct administrative expenses, transportation, and administrative allocation. A cost adjustment factor (CAF) of 2.72% was applied.

- The POS rates used for Group Supported Employment and Individual Supported Employment (set in accordance with 101 CMR 419: Rates for Supported Employment Services) were developed by using data from the most recent available UFR and averaging each line item across providers of these services. Specifically, the line items incorporated into this rate analysis are: salaries of direct care staff and an allocation of support staff and director/manager salaries, as well as tax and fringe, office space/program location expense, other direct care and program expenses and administrative allocation. In addition, for Individual Supported Employment alone, an allocation of salaries for clinical/medical/specialized consultants was included. A cost adjustment factor (CAF) of 2.72% was applied. This analysis also applies to the self-directed service rate maximum for these services.

- The POS rate for Day Habilitation Supplement (set in accordance with 101 CMR 424.00: Rates for Certain Developmental and Support Services) was developed by using data from the most recent available UFR and averaging each line item across providers of these services. Specifically, the line items incorporated into this rate analysis are: salaries of direct care workers and nurses, and tax and fringe. A cost adjustment factor (CAF) of 2.62% was applied.

- The POS rates for Individualized Home Supports (set in accordance with 101 CMR 423.00: Rates for Certain In-Home Basic Living Supports) were developed by using data from the most recent available UFR and averaging each line item across providers of these services. Specifically, the line items incorporated into this rate analysis are: salaries of program staff (including direct care staff, cultural facilitator, support navigator, clinical supervisor, community support worker, and counselor) and an allocation of manager salaries, as well as tax and fringe, staff training and mileage, clinical consultant, program support, office space, and administrative allocation. A cost adjustment factor (CAF) of 2.62% was applied. This analysis also applies to the self-directed service rate maximum for these services.

- The POS rates for Residential Habilitation (set in accordance with 101 CMR 420.00: Rates for Adult Long-Term Residential Services) were developed by using data from the most recent available UFR and averaging each line item across providers of these services. Specifically, the line items incorporated into this rate analysis are: salaries of direct care workers (based on specialization and experience level), supervisor salaries, and an allocation of director/manager salaries, tax and fringe, consultant services (including RNs, clinicians, and psychologists and psychiatrists), staff mileage, transportation, direct administration, other expenses, and administrative allocation. In addition, the rates take into account the number of participants living in the home. A cost adjustment factor (CAF) of 2.39% was applied.

- The POS rates for respite Stabilization (set in accordance with 101 CMR 412.00: Rates for Family Transitional Support Services) were developed by using data from the most recent available UFR and averaging each line item across providers of these services. Specifically, the line items incorporated into this rate analysis are: salaries of direct care workers and an allocation of director/manager and clinical staff salaries, tax and fringe, consultant services, occupancy, other expenses, direct administrative, and staff training, and administrative allocation. A cost adjustment factor (CAF) of 2.62% was applied.

- The POS rate used for 24-Hour Self Directed Home Sharing Support (see 101 CMR 411.00: Rates for Certain Placement, Support, and Shared Living Services) was developed by using data from the most recent available UFR and averaging each line item across providers of these services. Specifically, the line items incorporated into this rate analysis are: an allocation of salaries of director/manager, placement specialist and caregiver relief staff, stipend level for the caregiver, tax and fringe, clinical consultants, other direct administrative, training, mileage, program supplies, other direct costs and administrative allocation. A cost adjustment factor (CAF) of 1.87% was applied. This analysis results in the maximum rate for this service.

For waiver services for which there is no comparable Medicaid state plan or EOHHS Purchase of Service (POS) rate, the waiver service rate was established in state regulation after public hearing pursuant to state statutory requirements for the development and promulgation of health care services rate regulations that apply to rates for health care

services paid for by state agencies. See Massachusetts General Laws (MGL) Chapter 118E, Sections 13C Establishment of rates of payment for health care services and 13D Duties of ratemaking authority; criteria for establishing rates. This approach applies to rates for Adult Companion and Chore, which are set in accordance with 101 CMR 359.00: Rates for Home and Community Based Services Waivers, and were established based on data for comparable services provided through the Executive Office of Elder Affairs (EOEA) Home Care Program, which is the largest purchaser of these services. The most current data for SFY 2016 was used, and rates were adjusted to the median rate paid for each of these services under the Home Care Program. In developing the rate for Chore services the rates was adjusted to the median after excluding outliers. Outliers were removed for any pricing in the database for Chore services that was 2 standard deviations away from the mean for that service. The exclusion of outliers in the development of the median for Adult Companion, however, was not utilized, as the exclusion yielded a median slightly lower than the previously established rate for Adult Companion, and therefore the previous Adult Companion rate was maintained. The methodology and data sources used in this 2016 analysis were consistent with the method used previously in past analysis. The calculation of the median and exclusion of outliers were performed using SAS statistical software.

12. The State provides Assistive Technology, Home Modifications, Individual Goods and Services, Specialized Medical Equipment and Supplies, Transitional Assistance, Transportation (transit passes only) and Vehicle Modifications at the cost of goods sold. The State does not describe whether there is a negotiation process, a maximum allowable cost, or a minimum bid requirement for any of these services.

a. How does the State maintain oversight over costs paid for Assistive Technology, Home Modifications, Individual Goods and Services, Specialized Medical Equipment and Supplies, Transitional Assistance, Transportation (transit passes only) and Vehicle Modifications?

The waiver services identified above are participant-directed services and are paid using the State's contracted Financial Management Services (FMS), Public Partnerships Limited (PPL). As indicated in Appendix E-2-b-v, PPL utilizes a web-based electronic information system to track and monitor billing and reimbursements and issue monthly reports to DDS. This system also applies strict budgetary limits. The system allows for individual service rates and authorization caps, limits based on waiver type, and incompatible service listings. Payments that do not conform to program rules will be pended and reviewed by DDS and will not be paid without DDS approval. PPL issues payments to authorized providers and individuals upon receipt of accurate paper and electronic invoices.

Goods and services are not paid in full until the appropriate documentation is received, the expenditures are validated, and confirmation is made that the purchased items have been delivered and have met the specifications identified in the participant's individual service plan.

b. Does the State have a negotiation requirement, maximum allowable cost, or minimum number of bids required prior to purchase?

Items under Assistive Technology, Individual Goods and Services, Specialized Medical Equipment and Supplies, and Transportation (transit passes-only) are not subject to negotiation or bidding. The cost of the services is subject to an area office review, and upon approval is compensated at the current market price.

Individual Goods and Services will be subject to the maximum of $3,000 per participant per waiver year.

As outlined in the service definition, Home Modifications require a minimum of three bids to be included with the service proposal which is submitted to the Area Director and Regional Director for approval prior to commencement of the service. Vehicle Modifications do not require multiple bids, but are subject to the Area and Regional Director approval prior to commencement of the service. Home Modification and Vehicle Modification are each set at a maximum $15,000 for a five-year period.

Items under Assistive Technology must meet an identified assessed need, must not be available under the State Plan and are subject to the Area Office approval.

Transportation passes are paid at rates established by the Regional Transit Authority.

13. The State failed to document or insufficiently documented how the Medicaid agency solicits public comments on rate determination methods. The State is required by statute to complete a public process when proposing rate changes. The State issues a notice of the proposed rates with an opportunity for the public to provide written comment, and they are required to hold a public hearing to provide opportunity for the public to provide oral comment. The State references MGL Chapter 118E Section 13D and MGL Chapter 30A Section 2 as the basis for their public comment requirements. The State does not describe how the public is made aware of rate updates following a rate change. Describe how the public is informed of a rate change. Does this only happen when the participant is meeting with the service coordinator to develop / review their service plan?

EOHHS establishes rates in regulation pursuant to state statutes that set out requirements for the development and promulgation of health care services rate regulations establishing rates to be paid to providers for health care services by state agencies. MGL Chapter 118E, Section 13D (Duties of ratemaking authority; criteria for establishing rates) requires EOHHS to establish rates by regulation after public hearing. MGL Chapter 30A, Section 2 (Regulations requiring hearings) provides the requirements for regulations after public hearing. The requirements for regulations promulgated after public hearing include that there be public notice of the proposed regulation published in a newspaper and in the Massachusetts Register, that the public hearing be held in a specific timeframe, and that there be a separate method to provide written comment. After public hearing, EOHHS considers all public testimony submitted at the hearing and in writing through the written comment period, and makes a final determination of the rates. The final rates are

promulgated as part of the final regulation and published in the Massachusetts Register as well as on the EOHHS website.

Information about payment rates is available on the DDS website and is shared by service coordinators with waiver participants at the time of the service planning meeting.

Appendix A: Waiver Administration and Operation

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

■	The waiver is operated by the state Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one)*:		
	○	The Medical Assistance Unit *(specify the unit name) (Do not complete Item A-2*)	
	■	Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit. Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (*Complete item A-2-a)*	Department of Developmental Services; While DDS is organized under EOHHS and subject to its oversight authority, it is a separate agency established by and subject to its own enabling legislation.
○	The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency. Specify the division/unit name:		
	In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b).*		

2. Oversight of Performance.

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

a) MassHealth and DDS have entered into an Interagency Service Agreement which outlines the responsibilities of the parties. DDS performs functions related to operation of the waiver, including case management, clinical eligibility determinations, needs assessments, service plan development, service authorization, and reimbursing waiver service providers with which it contracts. DDS will ensure that waiver providers with which it contracts adhere to the contractual obligations imposed on them, will work with the contractors regarding their performance of waiver functions, and will collect and report information on waiver enrollees' utilization and experience with waiver enrollment. b) DDS has entered into an Interagency Service Agreement with MassHealth to document the responsibility for performing and reporting on these functions. c) MassHealth will

meet routinely with DDS staff regarding the performance of these activities as well as collect and report data and other information collected from DDS to CMS.

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

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

■	**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).** Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	For those individuals who participate in participant-direction, Financial Management Services are furnished as an administrative activity under a contract between the Department of Developmental Services and its Fiscal Employer Agent/Fiscal Management Service (FEA/FMS), Public Partnerships Limited (PPL). The agreement between PPL and DDS provides for a Financial Management Services fee per member per month as well as transaction fees based upon budget authority services. PPL reports budget status to the Department of Developmental Services and to participants on a monthly basis. PPL executes individual contracts with each waiver participant for Financial Management Services and with the participant and the provider of direct services and supports.
○	**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

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

■	**Not applicable**
○	**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:

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

DDS is responsible for assessing the performance of the contracted entities.

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

The Department of Developmental Services is responsible under its competitive procurement and negotiated contract to manage the performance of the FEA/FMS. The Department has established performance metrics and requires the FEA/FMS to meet them and has established a process of remediation if they do not achieve them. These benchmarks and required reports are reviewed in regular meetings. Between these meetings there is ongoing contact with the FEA/FMS to address any issues that might arise. Assessment is ongoing.

The FEA/FMS maintains monthly individual budgets on a management information system and provides monthly financial reports to both the participants and the Department. Monthly invoices contain specific line items identifying the disbursements made on behalf of participants. Monthly FEA/FMS reports reconcile expenditures for a participant with that participant's approved budget.

The FEA/FMS configures data so as to produce reports of performance measures, and to develop a unified format both for utilization and financial reporting and reporting pursuant to the Real Lives Statute. The Real Lives Statute, Chapter 255 of the Acts of 2014, codified at Massachusetts General Law Chapter 19B, Section 19, was enacted to further enhance participant direction within the Commonwealth of Massachusetts and DDS. The FEA/FMS is responsible for providing data and reports for DDS QA measures and waiver assurances. The Department includes individuals using the FEA/FMS in its National Core Indicator Consumer Sample.

Quarterly reports by the FEA/FMS analyze expenditures by 1) types of goods and services purchased, 2) similar categories of supports and service plans and reconciliation reports. There are also reports that analyze accuracy and timeliness of payments to providers and accurate and timely invoicing for goods. Reports examine the monthly spending and track this against the participant's allocation.

The FEA/FMS executes Provider Agreements on behalf of the Department and only does so for individuals engaged in participant-direction. The FEA/FMS maintains a good-to-provide list which it regularly scans and updates for changes in provider qualifications. DDS also reviews the provider list regularly and alerts the FEA/FMS to changes needed in it.
For additional descriptions please refer to Appendix E.

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	■	☐	☐	☐
Waiver enrollment managed against approved limits	■	☐	☐	☐
Waiver expenditures managed against approved levels	■	☐	■	☐
Level of care evaluation	■	☐	☐	☐
Review of Participant service plans	■	☐	☐	☐
Prior authorization of waiver services	■	☐	☐	☐
Utilization management	■	☐	■	☐
Qualified provider enrollment	■	☐	■	☐

Execution of Medicaid provider agreements	■	☐	■	☐
Establishment of a statewide rate methodology	■	☐	☐	☐
Rules, policies, procedures and information development governing the waiver program	■	☐	☐	☐
Quality assurance and quality improvement activities	■	☐	■	☐

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:	AA 2. MassHealth/DDS work collaboratively to improve quality of services, by, in part, ensuring that service provider oversight is conducted in accordance with policies and procedures. Numerator: Number of service provider reviews conducted in accordance with waiver policies and procedures. Denominator: Total number of service provider reviews due during the period
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify: FMS Reports	

	Responsible Party for data collection/generation	***Frequency of data collection/generation:***	***Sampling Approach*** *(check each that applies)*

	(check each that applies)	*(check each that applies)*	
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☒ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	AA 1. MassHealth, DDS and the Financial Management Service Agency (FEA/FMS) work collaboratively to ensure systematic and continuous data collection and analysis of the FEA/FMS entity functions and systems, as evidenced by the timely and appropriate submission of required data reports. (Num: # of FEA/FMS reports submitted to DDS on time and in the correct format. Denom: # of FEA/FMS reports due.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☑ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☐ *Annually*	
	Financial Management Service Agency	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	AA 4. Participants are supported by competent and qualified case managers. Numerator: Number of case manager evaluations completed as required. Denominator: Number of case managers due for performance evaluation.
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☒ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	AA 3. Percent of individuals who have an annual LOC re-assessment. Numerator: Number of individuals who have an LOC re-assessment within 12 months of their initial assessment or of their last re-assessment. Denominator: Number of individuals enrolled in the waiver.
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☑ *Other Specify:*
	Semi-annually

Add another Performance measure (button to prompt another performance measure)

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

b. Methods for Remediation/Fixing Individual Problems

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

The State Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by DDS. In the event problems are discovered with the management of the waiver program processes at waiver service providers or DDS Area Offices, DDS and MassHealth are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Further, MassHealth and DDS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
[redacted]	■ *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other Specify:*	☐ *Annually*
		■ *Continuously and Ongoing*
		☐ *Other Specify:*

c. Timelines

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

■	**No**
○	**Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Select one Waiver Target Group		Target Group/Subgroup	Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
☐	**Aged or Disabled, or Both - General**				
	☐	Aged (age 65 and older)			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
■	**Intellectual Disability or Developmental Disability, or Both**				
	☐	Autism			☐
	☐	Developmental Disability			☐
	■	Intellectual Disability	22		■
☐	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Individuals age 22 and older with intellectual disability as defined by DDS who meet the ICF-ID level of care and are determined through an assessment process to require supervision and support for 24 hours, 7 days per week to avoid institutionalization. Based on the severity of their functional, behavioral, and/or medical impairments these individuals require an intensive level of support over 24 hours; their needs for supervision and support cannot be met by the services that are contained in the Adult Supports Waiver or the Community Living Waiver. These individuals may reside in out- of-home settings or in their family home with a robust array of supports. Individuals must be able to be safely served within the terms of the Waiver. Individuals who are authorized to receive Behavior Modification interventions classified as Level III interventions (as defined in 115 CMR 5.14A) are not enrolled in the waiver. Additionally, individuals receiving

services in provider settings in which the provider is authorized to provide and/or perform Level III interventions are not enrolled in the waiver. An individual cannot be enrolled in, or receive services from more than one Home and Community Based Services (HCBS) waiver at a time.

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

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

Appendix B-2: Individual Cost Limit

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

■ **No Cost Limit**. The state does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c*. The limit specified by the state is *(select one)*:

- ○ **%** — A level higher than 100% of the institutional average. Specify the percentage:
- ○ Other *(specify)*:

○ **Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.

○ **Cost Limit Lower Than Institutional Costs**. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c*.

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

- ○ **The following dollar amount**: Specify dollar amount:

The dollar amount *(select one)*:

- ○ **Is adjusted each year that the waiver is in effect by applying the following formula:** Specify the formula:
- ○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

	○	**The following percentage that is less than 100% of the institutional average:**		
	○	**Other:** *Specify:*		

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

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

☐	**The participant is referred to another waiver that can accommodate the individual's needs.**
☐	**Additional services in excess of the individual cost limit may be authorized.** Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	**Other safeguard(s)** *(Specify)*:

Appendix B-3: Number of Individuals Served

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

Table: B-3-a	
Waiver Year	**Unduplicated Number of Participants**
Year 1	10118
Year 2	10468
Year 3	10818
Year 4 (only appears if applicable based on Item 1-C)	11168
Year 5 (only appears if applicable based on Item 1-C)	11518

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

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

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

Table B-3-b	
Waiver Year	**Maximum Number of Participants Served At Any Point During the Year**
Year 1	
Year 2	
Year 3	
Year 4 (only appears if applicable based on Item 1-C)	
Year 5 (only appears if applicable based on Item 1-C)	

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

○ **Not applicable**. **The state does not reserve capacity.**

■ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for: Emergencies and Changing Needs, Priority Status, Turning 22 (T-22) Students – Transitioning from Special Education

Table B-3-c

	Purpose (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):
	Emergencies and Changing Needs	Priority Status	Turning 22 (T-22) Students - Transitioning from Special Education	Intermediate Care Facility for the Intellectually Disabled	Nursing Home Transitioning to Community
	Purpose (describe):	**Purpose** (describe):	**Purpose** (describe):	**Purpose** (describe):	**Purpose** (describe):
Waiver Year	The state reserves capacity for individuals who require waiver supports as determined through an assessment process. Specificall	The state reserves capacity for individuals who require waiver supports as determined through an assessment process, specificall	The state reserves capacity for individuals who require waiver supports as determined through an assessment process, specificall	The state reserves capacity for individuals who require waiver supports as determined through an assessment process, specificall	The state reserves capacity for individuals who require waiver supports as determined through an assessment process. Specificall

		y, individuals in emergency situations and those with changing needs. The state will set aside capacity for these individuals who are a priority for enrollment. All participants enrolled in the waiver will have comparable access to all services offered in the waiver.	y individuals who are a Priority 1 for Community Living Supports as defined in 115 CMR 6.0. First Priority means the provision, purchase, or arrangement of supports available through the Department is necessary to protect the health or safety of the individual or others. For individuals who are Priority 1, the Department through its planning process with individuals attempts to secure services within 90 days or less from the date of the	y, transitioning students from Special Education who are assessed as a high priority for needing Community Living Supports. The state will set aside capacity for these individuals who are priority for enrollment. All participants enrolled in the waiver will have comparable access to all services offered in the waiver.	y transitioning individuals from ICF-ID facilities to the community. All participants in the waiver will have comparable access to all services offered in this waiver.	y, individuals placed from a skilled nursing facility to the community. The state will set aside capacity for these individuals who are a priority for enrollment. All participants enrolled in the waiver will have comparable access to all services offered in the waiver.

			prioritization letter. The state will set aside capacity for these individuals who are a priority for enrollment. All participants enrolled in the waiver will have comparable access to all services offered in the waiver.			
		Describe how the amount of reserved capacity was determined:	**Describe how the amount of reserved capacity was determined:**	**Describe how the amount of reserved capacity was determined:**	**Describe how the amount of reserved capacity was determined:**	**Describe how the amount of reserved capacity was determined:**
		The reserved capacity is based on the Department's experience of managing emergencies and	The reserved capacity is based on the Department's experience of providing services to its Priority	The reserved capacity is based on a legislative appropriation for the T-22 class. The Department has historical	The Department has two ICF-ID facilities open and reserved capacity is based upon the Department's	The reserved capacity is based on the Department's experience with transitioning individual

		changing needs.	1 individuals	information and an assessment and prioritization system which informs the Department about the number of T-22 students who will need the level of service on this waiver.	experience of transitioning individuals out of ICF-IDs.	s from Nursing Homes.
		Capacity Reserved	**Capacity Reserved**	**Capacity Reserved**		
	Year 1	100	5	100	5	5
	Year 2	100	5	100	5	5
	Year 3	100	5	100	5	5
	Year 4 (only if applicable based on Item 1-C)	100	5	100	5	5
	Year 5 (only if applicable based	100	5	100	5	5

	on Item 1-C)					

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

When an application for waiver enrollment is made to the Central Waiver Unit, the Waiver Unit confirms that the individual meets the basic requirements for Medicaid eligibility and the level of care for the waiver. The Waiver unit confirms that the Choice form has been signed as well. The Central Office Waiver unit maintains a statewide date- stamped log, organized by the DDS regions, of completed waiver applications. Based on the administration of the MASSCAP the individual is prioritized for services and a determination is made as to which waiver's target group criteria the individual meets. Participants prioritized for services must also be assessed as needing the service within 30 days. The Department requires that all adult individuals seeking waiver services apply for and maintain Medicaid eligibility. The Central Office Waiver Unit confirms that there is available capacity in the waiver and that the individual's needs for health and safety can be met. Based on the individual's priority status an offer of enrollment is made. Those individuals who cannot be enrolled because of lack of capacity will be denied entry based upon slot capacity and provided with appeal rights. When new resources are allocated by the Legislature for specific target groups there will be reserved capacity set aside for them. Individuals in emergency situations who meet the criteria for enrollment are not subject to the process outlined above. If assigned waiver resources are available an individual is expected to enroll in the waiver. The State will utilize the total slots estimated in the application.

B-3: Number of Individuals Served - Attachment #1

Waiver Phase-In/Phase Out Schedule

Based on Waiver Proposed Effective Date:

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Phase-In/Phase-Out Time Schedule.** Complete the following table:

Beginning (base) number of Participants:

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	**Base Number of Participants**	**Change in Number of Participants**	**Participant Limit**

c. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

d. Phase-In/Phase-Out Time Period. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

■	§1634 State
○	SSI Criteria State
○	209(b) State

2. Miller Trust State.

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

■	No
○	Yes

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☐	Low income families with children as provided in §1931 of the Act		
■	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
■	Optional state supplement recipients		
■	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	■	100% of the Federal poverty level (FPL)	
	○ %	of FPL, which is lower than 100% of FPL Specify percentage:	
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	Medically needy in 209(b) States (42 CFR §435.330)		
■	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) *specify*:		

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

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

■ **Yes**. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*

- ○ All individuals in the special home and community-based waiver group under 42 CFR §435.217
- ■ Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:
  - ■ A special income level equal to (select one):
    - ■ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % A percentage of FBR, which is lower than 300% (42 CFR §435.236)

      Specify percentage:
    - ○ $ A dollar amount which is lower than 300%

      Specify percentage:
  - ☐ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
  - ☐ Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
  - ☐ Medically needy without spend down in 209(b) States (42 CFR §435.330)
  - ☐ Aged and disabled individuals who have income at: *(select one)*
    - ○ 100% of FPL
    - ○ % of FPL, which is lower than 100%
  - ☐ Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) *specify*:

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 September 30, 2019 (or other date as required by law).*

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.

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*:

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

c-1. Regular Post-Eligibility Treatment of Income: 209(B) State. The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts 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)*
  - ○ The following standard under 42 CFR §435.121
    Specify:
  - ○ 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 percentage:
    - ○ $ A dollar amount which is less than 300% of the FBR
      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 (see instructions)
- ○ The following standard under 42 CFR §435.121
  Specify:
- ○ 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 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 §435.735:

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 checked.*
○	The state does not establish reasonable limits.
○	The state establishes the following reasonable limits *(specify)*:

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.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- ○ The following standard included under the state plan
  (Select one):
  - ○ **SSI standard**
  - ○ **Optional state supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**
    (select one):
    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ ____ % **A percentage of the FBR, which is less than 300%**
      Specify the percentage:
    - ○ $ ____ **A dollar amount which is less than 300%.**
      Specify dollar amount:
  - ○ ____ % **A percentage of the Federal poverty level**
    Specify percentage:
  - ○ **Other standard included under the state Plan**
    Specify:
- ○ **The following dollar amount**
  Specify dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:**
  Specify:
- ○ **Other**
  Specify:

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

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

Specify the amount of the allowance (*select one*):

○	**SSI standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

iii. <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 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 time periods before January 1, 2014 or after December 31, 2018.

c-2. Regular Post-Eligibility Treatment of Income: 209(B) State. The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 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 amounts 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):*
  - ○ **The following standard under 42 CFR §435.121:** *Specify:*
  - ○ **Optional state supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons** *(select one):*
    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ ____ % **A percentage of the FBR, which is less than 300%** Specify the percentage:
    - ○ $ ____ **A dollar amount which is less than 300%.** Specify dollar amount:
  - ○ ____ % **A percentage of the Federal poverty level** Specify percentage:
  - ○ **Other standard included under the state Plan** Specify:
- ○ **The following dollar amount** Specify dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:** Specify:
- ○ **Other** *Specify:*

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

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

	Specify:

Specify the amount of the allowance (*select one*):			
○	**The following standard under 42 CFR §435.121:** *Specify:*		
○	**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 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 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).

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:	
○	**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***:**		
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.**

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

- ○ The following standard included under the state plan
  (Select one):
  - ○ **SSI standard**
  - ○ **Optional state supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**
    (select one):
    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ ____ % **A percentage of the FBR, which is less than 300%**
      Specify the percentage:
    - ○ $ ____ **A dollar amount which is less than 300%.**
      Specify dollar amount:
  - ○ ____ % **A percentage of the Federal poverty level**
    Specify percentage:
  - ○ **Other standard included under the state Plan**
    Specify:
- ○ **The following dollar amount** Specify dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:**
  Specify:
- ○ **Other**
  Specify:

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

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

Specify the amount of the allowance (*select one*):

- ○ **SSI standard**

○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

iii. <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 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.

f. Regular Post-Eligibility: 209(b) State – 2014 through 2018. The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 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 amounts 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):
- ○ **The following standard under 42 CFR §435.121:**
  Specify:
- ○ **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** $ ____ If this amount changes, this item will be revised.
  Specify dollar amount:
- ○ **The following formula is used to determine the needs allowance:**
  Specify:
- ○ **Other**
  Specify:

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

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

Specify the amount of the allowance (*select one*):

○	**The following standard under 42 CFR §435.121:** *Specify:*		
○	**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 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. Allowance for the personal needs of the waiver participant

*(select one)***:**

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

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

Select one:

○	**Allowance is the same**
○	**Allowance is different.** *Explanation of difference:*

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

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

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

○	**The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B-6: Evaluation / Reevaluation of Level of Care

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

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for waiver services:

i. Minimum number of services.

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

1

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

○ **The provision of waiver services at least monthly**

■ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

Waiver services must be scheduled on at least a monthly basis. The Service Coordinator will be responsible for monitoring on at least a monthly basis when the participant doesn't receive scheduled services for longer than one month (for example when absent from the home due to hospitalization). Monitoring includes in- person, telephone, video-conferencing, text messaging, e-mail contacts, and/or other electronic modalities with the participant, guardian, or other family member designated by the participant as a contact for monitoring purposes. Monitoring may also include collateral contact with service providers or informal supports. Guardians and other family members designated by the participant as will be documented in their electronic record by the Service Coordinator. Every participant has direct in-person contact at least annually. Contact requires a response from the participant, guardian or other specified family member in order to be considered monitoring.

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

■ **Directly by the Medicaid agency**

○ **By the operating agency specified in Appendix A**

○ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

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

○ **Other**

Specify:

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

Information necessary for making the initial evaluation of level of care (LOC) for waiver applicants is collected by the State's Regional Intake and Waiver Eligibility Teams (see B-6-d). Each team includes state waiver eligibility specialists and licensed doctoral level psychologists who supervise the eligibility team members' administration of the level of care for the waiver applicant. Team members include state social worker(s), and state eligibility specialists. Their qualifications are as follows:

Psychologist IV
Applicants must have at least three years of full-time or equivalent part-time, professional experience as a Licensed Psychologist in the application of psychological principles and techniques in a recognized agency providing psychological services or treatment, of which at least one year must have included supervision over Postdoctoral Psychologists-in-training and/or Psychological Assistants.

Clinical Social Worker
Required work experience: At least two years of full-time or equivalent part-time, professional experience as a clinical social worker after earning a Master's degree in social work.
Substitutions:
-A Doctorate in social work, psychology, sociology, counseling, counseling education, or human services may be substituted for the required experience on the basis of two years of education for one year of experience.
-One year of education equals 30 semester hours. Education toward a degree will be prorated on the basis of the proportion of the requirements actually completed.
Required education: A Master's or higher degree in social work is required. Licenses:
-Licensure as a Licensed Certified Social Worker by the Massachusetts Board of Registration in Social Work is required

State Eligibility Specialists
State Service Coordinators; State Eligibility Specialists
Applicants must have at least (A) three years of full-time or equivalent part-time, professional experience in human services; (B) of which at least one year must have been spent working with people with disabilities (intellectual disability; developmental disabilities;) or (C) any equivalent combination of the required experience and the substitution below.
Substitutions:
1.A Bachelor's degree with a major in social work, social casework, psychology, sociology, counseling, counselor education, rehabilitation counseling may be substituted for a maximum of one year of the required (A) experience.*
2.A Master's degree with a concentration in social work, psychology, sociology, counseling, counselor education, rehabilitation counseling may be substituted for a maximum of two years of the required (A) experience. Applicants who meet all federal requirements for Qualified Intellectual Disability Professional may substitute those requirements for three years of the required combined (A) and (B) experience.
*Education toward such a degree will be prorated on the basis of the proportion of the requirements actually completed.

Service Coordinators

Applicants must have at least (A) three years of full-time or equivalent part-time, professional experience in human services; (B) of which at least one year must have been spent working with people with disabilities (intellectual disability; developmental disabilities; deafness; blindness; multi-handicapped) or (C) any equivalent combination of the required experience and the substitution below.
Substitutions:
1.A Bachelor's degree with a major in social work, social casework, psychology, sociology, counseling, counselor education, rehabilitation counseling may be substituted for a maximum of one year of the required (A) experience.*
2.A Master's degree with a concentration in social work, psychology, sociology, counseling, counselor education, rehabilitation counseling may be substituted for a maximum of two years of the required (A) experience. Applicants who meet all federal requirements for Qualified Intellectual Disability Professional may substitute those requirements for three years of the required combined (A) and (B) experience.
*Education toward such a degree will be prorated on the basis of the proportion of the requirements actually completed.

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

The Vineland III (or another valid and reliable measure of adaptive functioning as determined by a DDS licensed Psychologist, such as the Adaptive Behavior Assessment Scale Revised may be substituted), is administered at the time of eligibility assessment to determine the functional impairments of the individual. The initial evaluation of level of care is based on the MASSCAP process which consists of an assessment of the individual's need for supervision and support and an assessment of the specialized characteristics of the individual and the capacity of the caregiver to provide care. The Individual Client and Agency Planning (ICAP), the Consumer and Caregiver Assessment (CCA) in conjunction with the Vineland III or the Adaptive Behavior Assessment Scale, Revised constitute the MASSCAP process. The ICAP is an automated, standardized and validated tool that assesses an individual's adaptive functioning. The domains assessed by the ICAP include motor skills, social and communication skills, personal living skills and community living skills. The ICAP also assesses maladaptive behavior. Other reliable information that is evaluated in making this determination includes, but is not limited to, psychological or behavior assessments, additional functional and adaptive assessments, educational, health, mobility, safety and risk assessments. The CCA process further amplifies the specialized needs of the individual and assesses the caregiver's capacity to provide care. The CCA is designed to more fully articulate the caregiver's strengths and needs to provide care in the home for the waiver participant. Factors such as the age, health status, mental acuity, ability of the caregiver to drive and the potential impact of these factors on the waiver participant are reviewed.

Annually, as part of the care planning process, a reevaluation of level of care is done using DDS's tool which is a shortened version of the MASSCAP. The MASSCAP and all other available assessments are considered if there is a question about whether the participant continues to meet the level of care for the waiver. If at any time during the year the participant has experienced significant changes in their life, the MASSCAP will be administered to determine if there is a changing need which warrants a change in level of care or services.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

■	**The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
○	**A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.** Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

The Regional Eligibility Teams (RET) across the state conduct the initial evaluations of all new applicants for the Department's services. This team is comprised of a doctoral level licensed psychologist, a social worker, eligibility specialists, and a team manager. The eligibility process includes administration of the MASSCAP. The Service Coordinator participates in the initial evaluation process as part of the team.

Subsequent to the initial level of care determination, level of care is reevaluated annually by the participant's Service Coordinator at each of the participant's annual supports planning meetings. This reevaluation is conducted using a shortened version of the MASSCAP. If there is a question as to whether the participant continues to meet the level of care, the MASSCAP is administered. The re-evaluation process would be identical to original evaluation process if at any time during the year, it is determined that the participant has changing needs or circumstances that might impact their level of care, and the MASSCAP is administered. The Service Coordinator would also be part of that evaluation team/process.

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

○	**Every three months**
○	**Every six months**
■	**Every twelve months**
○	**Other schedule** *Specify* the other schedule:

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

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

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

The state ensures timely reevaluations of level of care through the use of its automated information system. The system tracks an individual's level of care score and also the date the next reevaluation is due. Through the use of management reports each Area Director is provided with the data needed to ensure the timely completion of the reevaluations. Reports of overdue LOCS are reviewed for correction within 30 days.

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

Determinations of level of care are maintained in electronic records as part of the DMRIS Management Information System. Paper records are maintained for each waiver participant at the departmental Area Office in accordance with 115 CMR 4.00.

Quality Improvement: Level of Care

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

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

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

i. Sub-assurances:

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

i. Performance Measures

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

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

Performance Measure:	LOC a1. Percent of applicants who received an initial LOC assessment within 90 days of the individual's application to participate in the waiver. (Number of individuals who received an initial LOC assessment within 90

	days of their application to participate in the waiver/Number of individuals who received an initial LOC assessment.)
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
DMRIS Consumer Database	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☒ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☒ *Other Specify:*
	Semi-annually

Add another Performance measure (button to prompt another performance measure)

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

i. Performance Measures

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

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

Performance Measure:	No longer needed in new QM system

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☒ *Other Specify:*	☐ *Annually*	
	No longer needed	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☒ *Other Specify:*	
		No longer needed	☒ *Other Specify:*
			No longer needed

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*

☐ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
■ *Other Specify:*	☐ *Annually*
No longer needed	☐ *Continuously and Ongoing*
	■ *Other Specify:*
	No longer needed

Add another Performance measure (button to prompt another performance measure)

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

i. Performance Measures

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

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

Performance Measure:	LOC c1. Percent of initial level of care assessments completed that were applied appropriately and according to the DDS policies and procedures. (Number of exception reports completed by licensed psychologists of level of care instruments that are returned for cause/Total number of initial level of care assessments administered.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	■ *State Medicaid Agency*	☐ *Weekly*	■ *100% Review*

	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☒ *Other Specify:*
	Semi-annually

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

b. Methods for Remediation/Fixing Individual Problems

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

The State Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by DDS. In the event problems are discovered with the management of the waiver program processes at waiver service providers or DDS Area Offices, DDS and MassHealth are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Further, MassHealth and DDS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii Remediation Data Aggregation

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

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☑ *Annually*
		☐ *Continuously and Ongoing*
		☐ *Other: Specify:*

c. Timelines

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

■	**No**
○	**Yes**

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

Appendix B-7: Freedom of Choice

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

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

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

As part of the eligibility process the eligibility team begins the process of determining whether the individual meets clinical eligibility criteria for waiver enrollment. The Team conducts the MASSCAP to assess whether the individual meets the ICF-ID LOC requirement for entrance into the Waiver. Based on both the individual's clinical eligibility status and the level of care, the Intake and Eligibility Specialist gives the individual a brief oral explanation along with a printed brochure regarding waiver services.
The area office to which the newly DDS-eligible individual is assigned meets with the individual, shares information about the waiver program, provides the Choice form/application, and offers assistance to the individual or legally responsible person in completing the Choice form/application. Once the Choice form/application is completed, the individual or legally responsible person submits it to the area office. The area office forwards the Choice form/application to the Waiver Management Unit for review and determination of compliance with the first level of criteria for waiver enrollment: choice of community services as a feasible alternative to institutional services. The appropriate Area Office receives notice from the Waiver Management Unit about the status of the waiver application

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

A copy of the "Waiver Choice Assurance Form" is maintained by the Targeted Case Manager (Service Coordinator) in the legal section of the participant's record for a minimum of three years

Appendix B-8: Access to Services by Limited English Proficient Persons

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

The Department has developed multiple approaches to promote and help ensure access to the waiver for Limited English Proficient persons. To help ensure access for individuals and families documents are typically translated into nine languages, which are most commonly spoken by residents in Massachusetts. This includes Spanish, Haitian Creole, Portuguese, Chinese, Russian, Vietnamese, French, Arabic and Khmer. The demographics of the state are routinely reviewed to insure that translation of documents reflects the current Massachusetts population. DDS through a state procurement has selected translation and interpretation agencies to provide both oral and written translations. The state has also selected a telephonic interpretation service which is available statewide for DDS staff to use. All of the translation and interpretation contractors as well as the telephonic service have a roster of translators and interpreters for multiple languages so that DDS can respond to the need of families who speak languages beyond those listed previously, such as Swahili or Amharic. In addition to providing translated information, interpreters are made available when needed to enable individuals and family members to fully participate in planning meetings. These interpreters can be made available through providers under state contract.

DDS has also developed a Language Access Plan to support the Targeted Case Managers (Service Coordinators) and other DDS staff who interact with families.

There are a number of key junctures where DDS offers individuals and families the opportunity to request additional supports. Interpretation is available at any time during the individual's or family's interaction with the Department. Additionally, all public documents are available in multiple languages.

Another important method the Department utilizes to promote access to Waiver services is by working to build capacity among service providers to become more culturally responsive in their delivery of services. One central effort involves building in contractual requirements stipulating that providers must be responsive to the specific ethnic, cultural, and linguistic needs of families in the geographic area they serve. It is expected that this is addressed in multiple ways including outreach efforts, hiring of bi-lingual and bi-cultural staff, providing information in the primary languages of the individuals and families receiving services, and developing working relationships with other multi-cultural community organizations in their communities.
The Department is committed to continue to develop and enhance efforts to provide meaningful access to services by individuals with Limited English Proficiency.

Appendix C: Participant Services

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

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

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Individualized Home Supports	■	
Home Health Aide	☐	
Personal Care	☐	
Adult Day Health	☐	
Habilitation	☐	
Residential Habilitation	■	
Day Habilitation	☐	
Prevocational Services	☐	
Group Supported Employment	■	
Education	☐	
Respite	■	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	■	

Other Services *(select one)*	
○	Not applicable
■	As provided in 42 CFR §440.180(b)(9), the state requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	24-Hour Self Directed Home Sharing Support

b.	Adult Companion
c.	Assistive Technology
d.	Behavioral Supports and Consultation
e.	Chore
f.	Community Based Day Supports (CBDS)
g.	Family Training
h.	Home Modification and Adaptations
i.	Individual Goods and Services
j.	Individual Supported Employment
k.	Individual Day Supports
l.	Peer Support
m.	Specialized Medical Equipment and Supplies
n.	Stabilization
o.	Transitional Assistance Services
p.	Transportation
q.	Vehicle Modification
r.	Remote Supports and Monitoring

Extended State Plan Services *(select one)*

○	Not applicable
■	The following extended state plan services are provided *(list each extended state plan service by service title)*:
a.	Day Habilitation Supplement
b.	
c.	

Supports for Participant Direction *(check each that applies))*

☐	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
☐	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.
■	Not applicable

Support	Included	Alternate Service Title (if any)

Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	
Other Supports for Participant Direction *(list each support by service title)*:		
a.		
b.		
c.		

C-1/C-3: Service Specification

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

Service Specification

Service Type: ■ Statutory ☐ Extended State Plan ☐ Other

Service Name: Group Supported Employment

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Group Supported employment services consist of the ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need support to perform in a regular work setting. The outcome of the service is sustained paid employment and work experience leading to further career development and individual integrated community employment for which the participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefit paid by the employer for the same or similar work performed by individuals without disabilities. Small group supported employment are services and training activities provided in regular business, industry and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile work crews, enclaves and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Services must be provided in a manner that promotes engagement in the workplace and interaction between participants and people without disabilities including co-workers, customers, and supervisors. Group supported employment may include any combination of the following services: job-related discovery or assessment, assisting the participants to locate a job or develop a job on behalf of the participants, job analysis, training and systematic instruction, job coaching, negotiation with prospective employers, and benefits support. Typically group supported employment consists of 2-8 participants, working in the community under the supervision of a provider agency. The participants are generally considered employees of the provider agency and are paid and receive benefits from that agency. Group supported employment includes activities needed to sustain paid work by participants including supervision and training and may include transportation if not available through another source. Transportation between the participants' place of residence and the employment site or between the provider site and the group employment site may be provided.

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

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

When supported employment services are provided at work sites where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required for participants receiving the waiver service as a result of their disabilities but does not include payment for supervisory

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

Group supported employment does not include volunteer work or vocational services provided in facility based work settings.

This service is primarily delivered in person; telehealth may be used to supplement the scheduled in-person service based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a.

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

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Work/Day Non Profit, For Profit and State Provider Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Work/Day Non Profit, For Profit and State Provider Agencies	115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and	High School diploma, GED or relevant equivalencies or competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Massachusetts Criminal Offender Record Information (CORI) and National Criminal Background check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their

	Enforcement Regulations)		disability and other characteristics will be delineated in the Support Plan by the Team. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Work/Day Non Profit, For Profit and State Provider Agencies	DDS Office of Quality Enhancement, Survey and Certification staff.	Every two years

Service Specification

Service Type: ■ Statutory ☐ Extended State Plan ☐ Other

Service Name: Individualized Home Supports

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Individualized Home Supports consists of services and supports in a variety of activities that may be provided regularly but that are less than 24 hours per day that are determined necessary to allow a participant to successfully live in the community as opposed to an institutional setting. This service provides the support and supervision necessary for the participant to establish, live in and maintain on an on-going basis a household of their choosing, in a personal home or the family home to meet their habilitative needs. These services assist and support the waiver participant and may include teaching and fostering the acquisition, retention or improvement of skills related to personal finance, health, shopping, use of community resources, community

safety, and other social and adaptive skills to live in the community as specified in the Plan of Care. It may include training and education in self- determination, self-advocacy to enable the participant to acquire skills to exercise control and responsibility over the services and supports they receive to become more independent, engaged and productive in their communities. The service includes elements of community habilitation and personal assistance. This service excludes room and board, or the cost of facility upkeep, and maintenance. An assessment is conducted and a Plan of Care is developed based on that assessment. The service is limited to the amount specified in the waiver participant's Plan of Care. The assistance of locating appropriate housing may be included as part of this service. No individual provision duplicates services provided under Targeted Case Management. This service may not be provided at the same time as Respite, Group or Individual Supported Employment, Community Based Day Supports, Individualized Day Supports, Individualized Goods and Services, or Adult Companion or when other services that include care and supervision are provided.

This service may be self-directed through either the Fiscal Intermediary or Agency with Choice.

This service may be delivered in a participant's own home, or a family home, or in the community, or via telehealth. This service is primarily delivered in person; telehealth may be used to supplement the scheduled in-person service based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a. When participants are also receiving Remote Supports and Monitoring, providers of both services will share services plans and schedules, so that Remote Supports and Monitoring timing and activities will not overlap with the provision of Individualized Home Supports. This service may not be delivered via telehealth to any participant who is also receiving Remote Supports and Monitoring.

Purchase of devices used for such remote/telehealth delivery is not covered by this service.

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

This service is 23 hours or less per day. This service is not available to participants who receive residential habilitation or receive 24-Hour Self Directed Home Sharing Supports. A participant can be enrolled in both Individualized Home Supports and Remote Supports and Monitoring but cannot receive both simultaneously. Participants who receive both services must receive their IHS in person, not via telehealth.

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E			■	Provider managed
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Qualified Individual Providers		Residential/Work/Day Individual or Family Support Provider and State Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Qualified Individual Providers		High School diploma, GED, or relevant equivalencies or competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in

			an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.
Residential/Work/Day Individual or Family Support Provider and State Agencies	115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)	High School diploma, GED or relevant equivalencies or competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other

			characteristics will be delineated in the Support Plan by the Team. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Qualified Individual Providers	DDS	Every two years
Residential/Work/Day Individual or Family Support Provider and State Agencies	DDS Office of Quality Enhancement, Survey and Certification staff.	Every two years

Service Specification
Service Type: ■ Statutory ☐ Extended State Plan ☐ Other
Service: Live-in Caregiver (42 CFR §441.303(f)(8)
■ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☐ Service is not included in approved waiver.
Service Definition (Scope)**:**
The payment for the additional costs of rent and food that can reasonably be attributed to a live-in personal caregiver who resides in the same household as the waiver participant. Payments for live-in caregiver services are made to the waiver participant. Payment will not be made when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. The live-in caregiver may provide up to 40 hours per week of direct service including self-directed adult companion, self-directed individualized home support self-directed individual supported employment or individualized day support. The live-in

caregiver service must be self-directed, paid through the Fiscal Intermediary. The live-in caregiver may not be related by blood or marriage to any degree. The live-in caregiver can not be employed by a provider of waiver services							
Specify applicable (if any) limits on the amount, frequency, or duration of this service:							
Live-in caregiver can not provide more than 40 hours of direct service per week.							
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E		☐	Provider managed		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian	

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	☐	Agency. List the types of agencies:
	Individual Live-in Caregiver			

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Live-in Caregiver		High School Diploma, GED, equivalencies, or relevant competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Live-in Caregiver	Department of Developmental Services	Annually or prior to utilization of service.

Service Specification

Service Type: ■ Statutory ☐ Extended State Plan ☐ Other

Service: Residential Habilitation

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Residential habilitation consists of ongoing services and supports by paid staff that are designed to assist participants to acquire, maintain, or improve the skills necessary to live in a non-institutional setting. Residential habilitation is available to participants who need daily staff intervention with care, supervision and skills training in activities of daily living, home management and community involvement and live in a certified or licensed home with 24 hour staffing. Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, support for meaningful involvement in the community, transportation, adult educational supports such as safety sign recognition and money management, social and leisure skill development, that assist the participant to reside in the least restrictive setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision 24 hours a day.

This service may also include the provision of medical and health care services that are integral to meeting the daily needs of the participants. Transportation between the participant's place of residence and other service sites or places in the community may be provided as a component of residential habilitation services and included in the rate paid to providers of residential habilitation services. Settings where residential habilitation services are furnished are compliant with the Americans with Disabilities Act.

The types of residential habilitation are Provider or State Operated Group Residences where residential habilitation is delivered with 24 hour paid staff in a licensed home with other individuals receiving supports and Placement Services where residential habilitation is delivered through a support agency which provides placement, guidance and oversight for individuals with 24 hour paid supports who live in the home of a care provider or live in their own homes with a care provider who lives with them. The care provider is unrelated to the participant and is not an employee of the support agency.

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

Residential habilitation provided in a provider licensed Group Residence cannot be self-directed. Participants residing in licensed group residences may however, choose to direct other services in this waiver. Participants cannot receive both Residential Habilitation and 24-Hour Self Directed Home Sharing Support or Live-in Caregiver services. Only one residential support is permitted.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■	Agency. List the types of agencies:
				Residential Habilitation Providers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Residential Habilitation Providers	115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations) or 104 CMR Chapter 28 (Department of Mental Health regulations governing Licensing and Operational Standards for Community Programs).	High School diploma, GED or relevant equivalencies or competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Residential Habilitation Providers	DDS Office of Quality Enhancement, Survey and Certification staff.	Every two years.

Service Specification
Service Type: ■ Statutory ☐ Extended State Plan ☐ Other
Service: Respite

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Services are provided in either: a) licensed respite facility, b) in the home of the participant, c) in the family home, or d) in the home of an individual family provider to waiver participants who are unable to care for themselves. Services are provided on a short-term overnight basis where there is an absence or need for relief of those persons who normally provide care for the participant or due to the needs of the waiver participant. Respite care may be made available to participants who receive other services on the same day, such as Group or Individual Supported Employment, or adult day-care, however, payment will not be made for respite at the same time when other services that include care and supervision are provided.

Respite may not be provided at the same time as Individualized Goods and Services, when a service rather than a good is being provided.

Facility-based respite cannot be participant-directed. Others forms of respite may be self-directed. The choice of the type of respite is dependent on the waiver participant's living situation.

Federal financial participation will only be claimed for the cost of room and board when provided as part of respite care furnished in a facility licensed by the state.

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

Respite may be provided up to 30 days per year and is reflected in the Individual Service Plan based on assessed need.

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Individual Respite Provider		Respite Provider Agency and State Provider Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Respite Provider Agency and State Provider Agencies	115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and	High School Diploma, GED, or equivalencies or relevant competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language

	Enforcement Regulations		and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team.
Individual Respite Provider		High School Diploma, GED, or equivalencies or relevant competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Respite Provider Agency and State Provider Agencies	DDS Office of Quality Enhancement, Survey and Certification staff.	Every 2 years
Individual Respite Provider	Department of Developmental Services	Every 2 years

Service Specification
Service Type: ☐ Statutory ■ Extended State Plan ☐ Other
Service: Day Habilitation Supplement

☐ ■ Service is included in approved waiver. There is no change in service specifications.

■ ☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

This service will no longer be included as a waiver service effective January 1, 2023.
Day Habilitation Supplement consists of supplemental services that are provided at free-standing Day Habilitation program sites and is not available to waiver participants in any other program, setting or site. These supplemental services are not otherwise available under the Medicaid State plan, and are services which the Department of Developmental Services has determined are necessary to enable the participant to participate in a day habilitation program. The supplemental services consist of focused one-to-one assistance for participants who have significant support needs who are either medically fragile with issues such as dysphasia, aspiration, and repositioning and/or exhibit extreme behavioral actions such as serious self-injurious behavior or injurious behavior directed at others such as pica, severe head-banging, pulling out fingernails and toenails, biting and other forms of aggression. The one-to-one assistance insures that the health and safety issues of both the participant and others who participate in the Day Habilitation program are met. Many of the participants have severe intellectual disability and are fully dependent on caregivers for risk management and protection. The scope and nature of these services do not otherwise differ from day habilitation services furnished under the State plan. Transportation between the participant's place of residence and the day habilitation site is not provided as a component of the day habilitation supplement; meals are not provided as a component of the Day Habilitation Supplement. The provider qualifications specified in the State plan apply. This service cannot be self- directed.

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

This service is limited to 5 days per week and no more than 6 hours per day based on assessed need of the waiver participant.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				MassHealth Certified Providers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
MassHealth Certified Providers	130 CMR 419.401 (MassHealth Day Habilitation Center Services Regulations).	Committee for Accreditation of Rehabilitation Facilities (CARF).	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
MassHealth Certified Providers	Committee for Accreditation of Rehabilitation Facilities (CARF).	One to three years, depending on level of certification.

Service Specification
Service Type: ☐ Statutory ■ Extended State Plan ☐ Other
Service: 24-Hour Self Directed Home Sharing Support
■ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☐ Service is not included in approved waiver.
Service Definition (Scope)**:**
24-Hour Self-Directed Home Sharing Support consists of ongoing services and supports by paid care giver(s) that is designed to assist individuals to acquire, maintain, or improve the skills necessary to live in a noninstitutional setting. The service is available to individuals who need daily staff intervention with care, supervision and skills training in activities of daily living, home management and community integration and live in a home of their own or live in the home of a care provider identified by the waiver participant or the legally responsible individual. The care provider is identified and supervised directly by the waiver participant or the legally responsible individual. Unlike Placement Services in Residential Habilitation, there is no support agency involved in the 24-Hour Self-Directed Home Sharing Support. Like placement services there is an assessment to determine the intensity of the need of the individual in relation to the daily payment rate for the care provider. There are three levels of intensity in the model. 24-Hour Self-Directed Home Sharing Support means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, recognition and money management, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. 24-Hour Self-Directed Home Sharing Support also includes personal care and protective oversight and supervision 24 hours a day. This service may also include the provision of medical and health care services that are integral to meeting the daily needs of the participants or arranging and assisting individuals to access the health care system. Transportation between the participant's place of residence and other service sites or places in the community may be provided as a component of 24-Hour Self-Directed Home Sharing Support and is included in the individual's participant budget. 24-Hour Self-Directed Home Sharing Support must be purchased through a self-directed budget. This service may not be provided at the same time as Respite, Individualized Home Supports, or Adult Companion or when other services that include care and supervision are provided. 24-Hour Self-Directed Home Sharing Support services are not available to individuals who live with their parent or spouse unless that individual is also eligible for the Department's supports. Family members who are either the legal guardian or legal representative or spouse can not provide 24-Hour Self-Directed Home Sharing Support. Other family members such as siblings or cousins, aunts, uncles may provide these services. These services may be arranged and organized by a family member or legally responsible individual. Payment is not made for the cost of room and board including the cost of building maintenance, upkeep and improvements. The method by which room and board are excluded from payment for residential habilitation is specified in Appendix I. Payment is not made directly or indirectly to members of the individual's immediate family except as provided in Appendix C-2. 24-Hour Self-Directed Home Sharing Support can not be provided in a provider licensed Group Residence or staffed by a provider agency. The physical site is either owned or leased directly by the waiver participant or the direct care provider and not by the provider agency. 24-Hour Self-Directed Home Sharing Support services can only be self-directed through an individual budget and paid through a fiscal management service. 24-Hour Self-Directed Home Sharing Support is limited to one individual in the same site. Licensed providers may not act as the employer of the care provider and may not provide services in one of their licensed settings.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐ Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Individual Qualified Self-Directed 24 Hour Support Provider

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Qualified Self-Directed 24 Hour Support Provider		High School diploma, GED or relevant equivalencies or competencies.	Possess appropriate qualifications as evidenced by interviews, two personal or professional references and a CORI, Age 18 years or older, be knowledgeable about what to do in an emergency, be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, must maintain confidentiality and privacy of consumer information, must be respectful and accept different values, nationalities, races, religions, cultures, and standards of living, specific competencies needed by an individual provider to meet support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Qualified Self-Directed 24 Hour Support Provider	Department of Developmental Services	Annually or prior to utilization of service.

Service Specification
Service Type: ☐ Statutory ☐Extended State Plan ■ Other
Service: Adult Companion
■ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☐ Service is not included in approved waiver.
Service Definition (Scope)**:**

Non-medical care, supervision and socialization provided to an adult. Services may include assistance with meals and basic activities of daily living such as shopping, laundry, meal preparation, routine household care incidental to the support and supervision of the participant. The service is provided to carry out personal outcomes identified in the individual plan that support the participant to successfully reside in his/her home or in the family home. Adult companion may also be provided when the caregiver regularly responsible for these activities is temporarily absent or unable to manage the home and care. Adult companion services are also available for a participant in his/her own residence who requires assistance with general household tasks.

This service does not entail hands on nursing care. Provision of services is limited to the person's own home, family home, or in the community. This service may not be provided at the same time as Chore, Individualized Home Support, Respite, Group or Individual Supported Employment, Individualized Day Supports, Community Based Day or when other services that include care and supervision are provided. This service may be self-directed.

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

This service is 23 hours or less per day. This service is not available to participants who receive residential habilitation including those who reside in 24 hour licensed group settings or placement settings or who receive 24- Hour Self Directed Home Sharing Support. It is only available to participants who live in their family home or in a home of their own.

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Qualified Individual Provider		Residential/Work/Day Individual or Family Support Provider

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Residential/Work/Day Individual or Family Support Provider	115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)	High School diploma, GED or relevant equivalencies or competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the

			participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team.
Qualified Individual Provider		High School diploma, GED, or relevant equivalencies or competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Residential/Work/Day Individual or Family Support Provider	DDS Office of Quality Enhancement, Survey and Certification Staff.	Every 2 years
Qualified Individual Provider	Department of Developmental Services	Every 2 years

Service Type: ☐ Statutory ☐Extended State Plan ■ Other

Service Name: Assistive Technology

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

This service has two components: Assistive Technology devices and Assistive Technology evaluation and training. These components are defined as follows:

Assistive Technology devices - an item, piece of equipment, or product system that is used to develop, increase, maintain, or improve functional capabilities of participants, and to support the participant to achieve outcomes identified in their Individual Support Plan. Assistive Technology devices can be used to enable the participant to engage in telehealth. Assistive Technology devices can be acquired commercially or modified, customized, engineered or otherwise adapted to meet the individual's specific needs, including design and fabrication. In addition to the cost of Assistive Technology device purchase, lease, or other acquisition costs, this service component covers maintenance and repair of Assistive Technology devices and rental of substitute Assistive Technology devices during periods of repair. This service includes device installation and setup costs but excludes installation and set-up and ongoing provision fees related to internet service.

Assistive Technology evaluation and training – the evaluation of the Assistive Technology needs of the participant, i.e. functional evaluation of the impact of the provision of appropriate Assistive Technology devices and services to the participant in the customary environment of the participant; the selection, customization and acquisition of Assistive Technology devices for participants; selection, design, fitting, customization, adaption, maintenance, repair, and/or replacement of Assistive Technology devices; coordination and use of necessary therapies, interventions, or services with Assistive Technology devices that are associated with other services contained in the Individual Support Plan; training and technical assistance for the participant, and, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants. Assistive Technology must be authorized by the Service Coordinator as part of the Individual Support Plan. The Service Coordinator will explore with the participant/legal guardian the use of the Medicaid State Plan. Waiver funding shall only be used for assistive technology that is specifically related to the functional limitation(s) caused by the participant's disability. The evaluation and training component of this service may be provided remotely via telehealth based on the professional judgement of the evaluator and the needs, preferences, and goals of the participant as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a.

Assistive Technology must meet the Underwriter's Laboratory and/or Federal Communications Commission requirements, where applicable, for design, safety, and utility.

There must be documentation that the item purchased is appropriate to the participant's needs.

Any Assistive Technology item that is available through the State Plan must be purchased through the State Plan; only items not covered by the State Plan may be purchased through the Waiver.

This service includes purchase, lease, or other acquisition costs of cell phones, tablets, computers, and ancillary equipment necessary for the operation of the Assistive Technology devices that enable the individual to participate in telehealth. These devices are not intended for purely diversional/recreational purposes.

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

Participants may not receive duplicative devices through both the Transitional Assistance Service and the Assistive Technology Service. The Assistive Technology evaluation includes identification of technology already available and assesses whether technology modifications or a new device is appropriate based on demonstrated need.

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐ Legal Guardian

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Individual Qualified contractors authorized to sell this equipment or make adaptations		Qualified Contractors authorized to sell this equipment or make adaptations	
	Individual Qualified AT Evaluation, Training, and Device Provider		Non-profit, for-profit provider, state operated AT Evaluation, Training, and Device Provider Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Qualified Contractors authorized to sell this equipment or make adaptations			The Individual Qualified Contractor must hold a license in occupational therapy or physical therapy or speech-language pathology issued in accordance with 259 CMR 2.00 or 260 CMR 2.00, or a certified Assistive Technology Professional (ATP) or a certified Rehabilitation Engineering Technologist (RET) and an active member of the Rehabilitation Engineering Society of North America (RESNA). Individual Qualified Contractors must meet or purchase from entities that meet state requirements to sell, lease, maintain or modify equipment. They must hold a valid tax payer ID number. Payment for services is made only to providers who meet the following requirements: (1) agree to accept assignment of rates developed by the Executive Office of Health and Human Services (EOHHS) for all products and services provided; (2) primarily engage in the business of providing assistive technology equipment, assistive technology repair services, or medical supplies to the public; (3) meet all applicable federal, state, and local requirements, certifications, and registrations governing assistive technology business practice; and (4) demonstrate compliance with state and national criminal

			history background checks in accordance with 101 CMR 15.00: Criminal Offender Record Check and 115 CMR 12.00: National Criminal Background Checks on all employees or subcontractors where the employee or subcontractor may have the potential for unsupervised contact with a waiver participant such as where the employee or subcontractor delivers or sets up equipment in the participant's home.
Qualified Contractors authorized to sell this equipment or make adaptations			Qualified contractors authorized to or that purchase from entities that are authorized to sell this equipment or make adaptations and that meet state requirements to sell, lease, maintain or modify equipment. Qualified contractors providing assistive technology and or assistive technology services for persons with intellectual disabilities that are covered by Medicare or Medicaid, or Qualified contractors qualified by Medicare/Medicaid as a multi-specialty clinic providing assistive technology services. They must hold a valid tax payer ID number. Payment for services is made only to providers who meet the following requirements: (1) agree to accept assignment of rates developed by the Executive Office of Health and Human Services (EOHHS) for all products and services provided; (2) have a primary business telephone number listed in the name of the business; (3) engage in the business of providing assistive technology equipment, assistive technology repair services, or medical supplies to the public; (4) meet all applicable federal, state, and local requirements, certifications, and registrations governing assistive technology business practice; and (5) demonstrate compliance with state and national criminal history background checks in accordance with 101 CMR 15.00: Criminal Offender Record Check 115 CMR 12.00: National Criminal Background Checks on all employees or subcontractors where the employee or subcontractor may have the potential for unsupervised contact with a waiver participant such as where the employee or subcontractor delivers or sets up equipment in the participant's home.

Individual Qualified AT Evaluation, Training, and Device Provider			The Individual Qualified AT Evaluation, Training, and Device Provider must hold a license in occupational therapy or physical therapy or speech-language pathology issued in accordance with 259 CMR 2.00 or 260 CMR 2.00, or a certified Assistive Technology Professional (ATP) or a certified Rehabilitation Engineering Technologist (RET) and an active member of the Rehabilitation Engineering Society of North America (RESNA). Individual Qualified Contractors must meet or purchase from entities that meet state requirements to sell, lease, maintain or modify equipment. They must hold a valid tax payer ID number. Payment for services is made only to providers who meet the following requirements: (1) agree to accept assignment of rates developed by the Executive Office of Health and Human Services (EOHHS)for all products and services provided; (2) primarily engage in the business of evaluating the need for providing Assistive Technology and training on its use, assistive technology repair services, or medical supplies to the public; (3) meet all applicable federal, state, and local requirements, certifications, and registrations governing assistive technology business practice; (4) demonstrate compliance with state and national criminal history background checks in accordance with 101 CMR 15.00: Criminal Offender Record Check and 115 CMR 12.00: National Criminal Background Checks on all employees or subcontractors where the employee or subcontractor may have the potential for unsupervised contact with a waiver participant such as where the employee or subcontractor delivers or sets up equipment in the participant's home. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996

			(HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.
Non-profit, for-profit provider, state operated AT Evaluation, Training, and Device Provider Agencies			The evaluator/trainer or leader of the evaluation/training team must be a professional who holds a license in occupational therapy or physical therapy or speech-language pathology issued in accordance with 259 CMR 2.00 or 260 CMR 2.00, or a certified Assistive Technology Professional (ATP) or a certified Rehabilitation Engineering Technologist (RET) and an active member of the Rehabilitation Engineering Society of North America (RESNA). Qualified agency providers must meet state requirements to sell, lease, maintain or modify equipment. They must hold a valid tax payer ID number. Payment for services is made only to providers who meet the following requirements: (1) agree to accept assignment of rates developed by the Executive Office of Health and Human Services (EOHHS)for all products and services provided; (2) have experience in evaluating the need for, providing Assistive Technology and training on its use, assistive technology repair services, or medical supplies to the public; (3) meet all applicable federal, state, and local requirements, certifications, and registrations governing assistive

			technology business practice; (4) demonstrate compliance with state and national criminal history background checks in accordance with 101 CMR 15.00: Criminal Offender Record Check and 115 CMR 12.00: National Criminal Background Checks on all employees or subcontractors where the employee or subcontractor may have the potential for unsupervised contact with a waiver participant such as where the employee or subcontractor delivers or sets up equipment in the participant's home. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Qualified Contractors authorized to sell this equipment or make adaptations	DDS	Every two years.
Qualified Contractors authorized to sell this equipment or make adaptations	DDS	Every two years.
Individual Qualified AT Evaluation,	DDS	Every two years.

Training, and Device Provider		
Non-profit, for-profit provider, state operated AT Evaluation, Training, and Device Provider Agencies	DDS	Every two years.

Service Specification
Service Type: ☐ Statutory ☐Extended State Plan ■ Other
Service Name: Behavioral Supports and Consultation
■ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☐ Service is not included in approved waiver.
Service Definition (Scope)**:**
Behavioral supports and consultative services are clinical and therapeutic services and that are necessary to improve the participant's independence and meaningful participation in their home or in their community. This service is available to waiver participants and is designed to remediate identified challenging behaviors or to acquire socially appropriate behaviors. Behavioral supports and consultation are provided by professionals in the fields of psychology, mental health, or special education. The service may include a a) functional assessment by a trained clinician, b) the development of a positive behavior support plan which includes the teaching of new skills for increasing new adaptive replacement behaviors, decreasing challenging behavior(s) in the participant's natural environments, c) intervention strategies, d) implementation of the positive behavior support plan and associated documentation and data analysis, and e) monitoring of the effectiveness of the plan. Monitoring of the plan will occur at least monthly or more frequently as needed. The service will include any change to the positive behavior support plan when necessary and the professional(s) shall be available to provide recommendations to the ISP team and the Targeted Case Manager including making referral recommendations to community physicians and other clinical professionals that support the assessment findings. In order to carry out supports to Waiver Participants, training, consultation and technical assistance to paid and unpaid caregivers may be provided to enable them to understand and implement the positive behavioral plan at home. This service does not provide direct services to either paid or unpaid caregivers. The behavioral supports and consultation must be consistent with the DDS regulations. Access to this service is only permissible by prior authorization through the Area Office Psychologist or the Area Director. This service is available in the waiver participant's home or in the community. This service is primarily delivered in person; telehealth may be used to supplement the scheduled in-person service based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a. Behavioral Supports and Consultation does not include any service covered by the Medicaid State Plan including individual, group, or family counseling or under private insurance including benefits under ARICA. If the waiver participant has a co-occurring mental health diagnosis those services must be accessed through the Medicaid State Plan. Providers must first access behavioral supports and consultation through their own agency. This service may be self-directed through the Fiscal Intermediary.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:							
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E			■	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Individual Qualified Behavioral Health Provider		Non-profit, for-profit provider, state operated Behavioral Support agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Qualified Behavioral Health Provider	Doctoral degree in psychology, education, medicine or related discipline, and any state licensure required for the discipline.	For mental health professionals, such as family therapists and rehabilitation counselors, necessary certification requirements must be met for those disciplines.	1500 hours of relevant training, including course work in principles of development, learning theory, behavior analysis and positive behavioral supports. Knowledge and experience in a range of interventions for adults with intellectual disability. The relevant training may be part of an advanced degree program. Two years of relevant experience in assuming the lead role in designing and implementing behavioral supports and consultation. Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks) if working directly with the waiver participant. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these

			requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.
Non-profit, for-profit provider, state operated Behavioral Support agencies	If the agency employs individuals to provide behavioral support and consultation, staff must meet all relevant state and federal licensure requirements in their discipline. Doctoral degrees in psychology, education, medicine, or related discipline, any related state licensure required for the discipline.	For mental health professionals, such as family therapists and rehabilitation counselors, necessary certification requirements must be met for those disciplines.	1500 hours of relevant training, including course work in principles of development, learning theory, behavior analysis and positive behavioral supports. Knowledge and experience in a range of interventions for adults with intellectual disability. The relevant training may be part of an advanced degree program. Two years of relevant experience in assuming the lead role in designing and implementing behavioral supports and consultation. Individuals with less than the highest advance degree for the discipline can offer the service under the supervision of a licensed individual per state requirements. All applicants and providers must conduct Criminal Offender Record Information (CORI) checks and National Criminal Background Check: 115 CMR 12.00 (National Criminal Background Checks) on all employees working directly with the waiver participant. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA

			compliance officer. This methodology is accepted by DDS and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Qualified Behavioral Health Provider	DDS	Every two years
Non-profit, for-profit provider, state operated Behavioral Support agencies	DDS	Every two years

Service Specification						
Service Type: ☐ Statutory ☐Extended State Plan ■ Other						
Service: Chore						
■ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☐ Service is not included in approved waiver.						
Service Definition (Scope)**:**						
Services needed to maintain the home in a clean, sanitary, and safe environment. This service includes minor home repairs, general housekeeping and heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, moving heavy furniture in order to provide safe egress and access. These services are only provided when neither the participant nor anyone else in the household is capable of performing or financially providing for them and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of the service. Service is not available in a provider operated setting. Chore service must be paid through a self-directed budget through the Fiscal Intermediary.						
Specify applicable (if any) limits on the amount, frequency, or duration of this service:						
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	☐	Provider managed		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian
Provider Specifications						
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:		
	Individual Qualified Chore Provider		Chore Providers			
Provider Qualifications						

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Qualified Chore Provider			Taxpayer identification number required, 18 years or older, must have a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), have two personal or professional references, Must maintain confidentiality and privacy of participant information, must be respectful and accept different values, nationalities, races, religions, cultures and standards of living.
Chore Providers			Taxpayer identification number required, 18 years or older, must have a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), have two personal or professional references, Must maintain confidentiality and privacy of participant information, must be respectful and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Qualified Chore Provider	Department of Developmental Services	Every 2 years
Chore Providers	Department of Developmental Services	Every 2 years

Service Specification
Service Type: ☐ Statutory ☐Extended State Plan ■ Other
Service: Community Based Day Supports
■ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☐ Service is not included in approved waiver.
Service Definition (Scope)**:**
This program of supports is designed to enable a participant to enrich his or her life and enjoy a full range of (community) activities in a community setting by providing opportunities for developing, enhancing, and

maintaining competency in personal, social and community activities. The service may include career exploration, including assessment of interests through volunteer experiences or situational assessments; community experiences to support fuller participation in community life; development and support of activities of daily living and independent living skills, socialization experiences and enhancement of interpersonal skills and pursuit of personal interests and hobbies. The service is intended for participants of working age who may be on a pathway to employment, a supplemental service for participants who are employed part-time and need a structured and supervised program of services during the time that they are not working, and for participants who are of retirement age. Community based day supports provides a structured and supervised program of services and supports in a group setting which promotes socialization and peer interaction and development of habilitative skills and achieve habilitative goals.

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

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Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Non-profit or for profit Center Based Day Support Providers and State Provider Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Non-profit or for profit Center Based Day Support Providers and State Provider Agencies	115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)	High School diploma, GED or relevant equivalencies or competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Non-profit or for profit Center Based Day Support Providers and State Provider Agencies	DDS Office of Quality Enhancement, Survey and Certification Staff	Every 2 years

Service Specification

Service Type: ☐ Statutory ☐Extended State Plan ■ Other

Service Name: Family Training

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Family Training is designed to provide training and instruction about the treatment regimes, behavior plans, and the use of specialized equipment that supports the waiver participant to participate in the community. Family Training may also include training in family leadership, support of self-advocacy, and independence for their family member. The service enhances the skill of the family to assist the waiver participant to function in the community and at home when the waiver participant visits the family home. Documentation in the participant's record demonstrates the benefit to the participant. For the purposes of this service "family" is defined as the persons who live with or provide care to a waiver participant and may include a parent or other relative. Family Training may be provided in small group format or the Family Trainer may provide individual instruction to a specific family based on the needs of the family to understand the specialized needs of their family member. The one to one family training is instructional; it is not counseling. Family does not include individuals who are employed to care for the participant. This service may be self-directed. This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a.

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

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E				■	Provider managed
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐		Legal Guardian

Provider Specifications

	■	Individual. List types:	■	Agency. List the types of agencies:

Provider Category(s) *(check one or both)*:	Qualified Individual Family Training Provider	Family Training Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Qualified Individual Family Training Provider	Individuals who meet all relevant state and federal licensure or certification requirements for their discipline.	Relevant competencies and experiences in Family Training.	Applicants must possess appropriate qualifications to serve as staff as evidenced by interviews, two personal or professional references, a Criminal Offender Record Information (CORI) and National Criminal Background Check: 115 CMR 12.00 (National Criminal Background Checks). The applicant must have the ability to communicate effectively in the language and communication style of the family to whom they are providing training. The applicant must have experience in providing family leadership, self-advocacy, and skills in training in independence. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.
Family Training Agencies	Agency needs to employ individuals who meet all relevant state and federal licensure of certification	If the agency is providing activities where certification is necessary, the applicant will have the necessary certifications.	Must possess appropriate qualifications to serve as staff as evidenced by interviews, two personal or professional references, a Criminal Offender Record Information (CORI) and National Criminal Background Check: 115 CMR 12.00 (National Criminal Background Checks).

	requirements in their discipline.	For mental health professionals such as Family Therapists, Rehabilitation Counselors, Social Workers, necessary certification requirements for those disciplines must be met.	Agency needs to employ individuals who must be able to effectively communicate in the language and communication style of the participant or family for whom they are providing the training. They must have experience in promoting independence and in family leadership. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Qualified Individual Family Training Provider	DDS	Every two years
Family Training Agencies	DDS	Every two years

Service Specification

Service Type: ☐ Statutory ☐Extended State Plan ■ Other

Service Name: Home Modifications and Adaptations

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Those physical adaptations to the private residence of the participant, required by the participant's service plan, that are necessary to ensure the health, welfare, and safety of the participant, or that enable the participant to function with greater independence in the home. Service includes the assessment and evaluation of home safety modifications. The assessment and evaluation component of the home and

adaptations service may be provided remotely via telehealth based on the professional judgement of the evaluator and the needs, preferences, and goals of the participant as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a. Adaptations can only be provided to the participant's primary residence. Such adaptations include but are not limited to:

- Installation of ramps and grab-bars
- Widening of doorways/hallways
- Modifications of bathroom facilities
- Lifts: porch or stair lifts
- Installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies, and which are necessary for the welfare of the participant
- Installation of specialized flooring to improve mobility and sanitation
- Specialized accessibility/safety adaptations/additions
- Automatic door openers/door bells
- Voice activated, light activated, motion activated and electronic devices
- Door and window alarm and lock systems
- Air filtering devices and cooling adaptations and devices
- Specialized non-breakable windows

All services shall be provided in accordance with State or Local Building codes.

Excluded are those adaptations or improvements to the home that are of general utility, and which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation. General household repairs are not included in this service.

Any use of Waiver funds for home adaptation requests must be submitted and approved in advance following the process outlined below.

The Service Coordinator will explore with the participant and family when relevant, utilization of appropriate modifications that are portable to accommodate changes in residence, size of the participant, and changes in equipment and needs. In addition, all proposals for home adaptations shall plan for the reuse of portable accommodations.

a) Waiver funding shall only be used for renovations that will allow the participant to remain in his/her home (primary residence), and must specifically relate to the functional limitation(s) caused by the participant's disability. It is not available to participants who visit home periodically but who otherwise reside elsewhere.

b) The following steps to request approval for funding must be followed.

- The Service Coordinator must receive for his/her review and recommendation the following information: a proposal detailing the request for funding, and the completed Vehicle/Home Adaptations Funding Request Form. The participant's Individual Support Plan that clearly defines and explains the need for a home adaptation must be attached to this information.
- If the DDS Service Coordinator recommends the proposal for funding, the request is then forwarded to the Area and then the Regional Director for review and recommendation of funding.
- If a home adaptation request is approved, the participant/family must submit, at a minimum, 3 bids that contain costs and a work agreement, to the Department.

c) All payments for Home Adaptations must be made through the Fiscal Management

Service and purchased through a self-directed budget. This service must be an identified need and documented in the service plan. The Home Adaptations must be purchased through a self -directed budget through the Fiscal Intermediary.
Funding for Home Adaptations is not available for use in any state operated or provider residence, or in the home of a home sharing care provider. No permanent adaptations to the structure will be made to property rented or leased by the participant, guardian or legal representative.

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

Not to exceed $15,000 in a five-year period. Only available to participants who live in the family home or in a home of their own.

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	☐	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Individual Qualified Home Adaptation provider		Home Modification Agencies/Assistive Technology Centers	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Qualified Home Adaptation provider	Contractors for home adaptations must be licensed to do business in the Commonwealth and meet applicable qualifications and be insured.		Individual providers must produce a Criminal Offender Record Information (CORI) check and National Criminal Background Check: 115 CMR 12.00 (National Criminal Background Checks), if working directly with the waiver participant. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is

			not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.
Home Modification Agencies/Assistive Technology Centers	Contractors for home modifications must be licensed to do business in the Commonwealth and meet applicable qualifications and be insured.		Providers shall ensure that individual workers employed by the agency have been CORI checked and National Criminal Background Check: 115 CMR 12.00 (National Criminal Background Checks) and are able to perform assigned duties and responsibilities, if working directly with the waiver participant. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Qualified Home Adaptation provider	DDS	Every two years
Home Modification Agencies/Assistive Technology Centers	DDS	Every two years

Service Specification
Service Type: ☐ Statutory ☐Extended State Plan ■ Other
Service: Individual Goods and Services
■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Individual Goods and Services are services, equipment or supplies that will provide direct benefit and support specific outcomes that are identified in the waiver participant's service plan. The Individual Goods and Services are not provided through either other waiver services or the Medicaid State Plan. The Individual Goods and Services promote community involvement and engagement, or provide resources to expand opportunities for self-advocacy, or decrease the need for other Medicaid services, or reduce the reliance on paid support, or are directly related to the health and safety of the waiver participant in his/her home or community. Individual Goods and Services are used when the waiver participant does not have the funds to purchase the item or service from any other source.

Examples of allowable Individual Goods and Services include:

Enrollment fees, dues, membership costs associated with the participant's participation in community habilitation, training, preventative veterinary care and maintenance of service dogs, supplies and materials that promote skill development and increased independence for the participant with a disability in accessing and using community resources. The Individual Goods and Services must be purchased through a self-directed budget. This service must be pre-approved by the Team and subject to DDS rules and must be an identified need and documented in the service plan. Experimental and prohibited treatments are excluded. The Individual Goods and Services may not be provided at the same time as respite, or any employment or day activity program. Individual Goods and Services excludes all services and supplies provided under specialized medical equipment and supplies or assistive technology. This service must be self-directed paid through the Fiscal Intermediary.

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

This service is limited to $3,000 per waiver year.

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	☐	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Individual Qualified Community Vendor		Vendor agency meeting industry standards in the community according to the goods, services and supports needed

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Vendor agency meeting industry standards in the community according to the goods, services and supports needed			Services, supports, or goods can be purchased from typical vendors in the community. Vendors must meet industry standards in the community.
Individual Qualified Community Vendor			Services, supports, or goods can be purchased from typical

			vendors in the community. Vendors must meet industry standards in the community.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Vendor agency meeting industry standards in the community according to the goods, services and supports needed	Department of Developmental Services	Every 2 years
Individual Qualified Community Vendor	Department of Developmental Services	Every 2 years

Service Specification

Service Type: ☐ Statutory ☐Extended State Plan ■ Other

Service Name: Individual Supported Employment

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Individual supported employment services consist of ongoing supports that enable a participant, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of his/her disabilities, need support to perform in a regular work setting. Individual supported employment may include assisting the participants to locate a job or develop a job on behalf of the participant. Individual supported employment is conducted in a variety of settings, particularly typical work sites where persons without disabilities are employed. Emphasis is on work in an environment with the opportunity for participants to have contact with co-workers, customers, supervisors and others without disabilities. In individual supported employment the participant has a job based on his/her identified needs and interests, located in a community business. It may also include self-employment or a small business, or a homebased self-employment, or temporary services which may assist a participant in securing an individual position within a business. Individual supported employment may include job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching in the form or regular or periodic assistance; training and support are provided for the purpose of developing, maintaining and/or improving job skills and fostering career advancement opportunities. Job coaching at the job site is not designed to provide continuous on-going support; it is expected that as the participant develops more skill and independence the level of support will decrease and fade over time as the natural supports in the work place are established. Some on-going intermittent job related support may be provided to assist the waiver participant to successfully maintain his/her employment situation. Natural supports are developed by the provider to help increase participation and independence of the participant within the community setting. Participants are paid by

the employer. It may include transportation if not available through another source. Transportation assistance between the participants' place of residence and the employment site is included in the rate paid to providers of individual supported employment services. Ongoing transportation for an participant is excluded from the rate. Time-limited transportation for components of discovery, career exploration, job development is provided. Once the participant is hired, transportation ceases. Individual supported employment may be self-directed and paid through the Fiscal Intermediary.

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

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for training that is not directly related to a participant's supported employment program.

When supported employment services are provided at work sites where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required for participants receiving the waiver service as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) Individual supported employment excludes participants working in mobile crews or in small groups. It excludes volunteer work.

This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a.

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

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E		■	Provider managed
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Individual Qualified Supported Employment Provider		Work/Day Non Profit, For Profit and State Provider Agencies	

Provider Qualifications

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

Work/Day Non Profit, For Profit and State Provider Agencies	115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)	High School diploma, GED or relevant equivalencies or competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Massachusetts Criminal Offender Record Information (CORI) and National Criminal Background check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.
Individual Qualified Supported Employment Provider		High School Diploma, GED, or relevant equivalencies or competencies.	All individual providers must: Possess appropriate qualifications as evidence by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language

			and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Work/Day Non Profit, For Profit and State Provider Agencies	DDS Office of Quality Enhancement, Survey and Certification staff.	Every two years
Individual Qualified Supported Employment Provider	Department of Developmental Services	Every two years

Service Specification

Service Type: ☐ Statutory ☐Extended State Plan ■ Other

Service Name: Individualized Day Supports

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Services and supports provided to participants tailored to their specific personal goals and outcomes related to the acquisition, improvement, and/or retention of skills and abilities to prepare and support a participant for work and/or community participation and/or meaningful retirement activities, and could not do so without this direct support.

This service can only be participant-directed. A qualified family member or relative, independent contractor or service agency may provide services. This service originates from the home of the participant and is generally delivered in the community. This service is primarily delivered in person; telehealth may be used to supplement the scheduled in-person service based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a.

Examples

- Develop and implement an individualized plan for day services and supports;
- Assist in developing and maintaining friendships of choice and skills to use in daily interactions;
- Provide support to explore job interests or retirement options;
- Provide opportunities to participate in community activities, including support to attend and participate in post- secondary or adult education classes;
- Provide support to complete work or business activities including supports for participants who own their own business;
- Training and support to increase or maintain self-help, socialization, and adaptive skills to participate in own community;
- Develop, maintain or enhance independent functioning skills in the areas of sensory-motor, cognition, personal grooming, hygiene, toileting, etc.

This service is not provided in or from a facility-based day program. This service is not provided from a provider- operated or state-operated group residence. This service may not be provided at the same time as Group or Individual Supported Employment, Community Based Day Supports, Individualized Goods and Services Supports or when other services that include care and supervision are provided. This service is only available to waiver participants who self-direct his/her own supports and must be pre-approved by the Team, subject to DDS rules stated above, and must be an identified need and documented in the service plan. The Individualized Day Supports must be purchased through a self-directed budget through either the Fiscal Intermediary or the Agency with Choice.

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

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	☐	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	■	Individual. List types:	■	Agency. List the types of agencies:
	Individual Qualified Day Support and Services Provider		Work/Day Support Provider Agency	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Qualified Day Support and Services Provider		High School Diploma, GED, or relevant equivalencies or competencies.	All individual providers must: Possess appropriate qualifications as evidence by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.

Work/Day Support Provider Agency	115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement Regulations)	High School Diploma, GED, or relevant equivalencies or competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Qualified Day Support and Services Provider	DDS	Every two years
Work/Day Support Provider Agency	DDS Office of Quality Enhancement, Survey and Certification staff.	Every two years

Service Specification							
Service Type: ☐ Statutory ☐Extended State Plan ■ Other							
Service: Specialized Medical Equipment and Supplies							
■ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☐ Service is not included in approved waiver.							
Service Definition (Scope)**:**							
Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. Accessing the state plan benefits must occur before accessing this service. All items shall meet applicable standards of manufacture, design and installation. The medical support devices or equipment must have proven evidenced-based support and conform with acceptable medical practice; no experimental or alternative devises or equipment are permitted to be purchased. Any devices used in the provision of the service must be FDA approved. Specialized Medical Equipment and Supplies must be authorized by the Service Coordinator as part of the Individual Service Plan process. Specialized medical equipment and supplies must be purchased through a self-directed budget through the Fiscal Intermediary.							
Specify applicable (if any) limits on the amount, frequency, or duration of this service:							
This service is limited to $3,500 per waiver year.							

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E		☐	Provider managed		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Specialized Medical Equipment Providers
				Pharmacies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Specialized Medical Equipment Providers			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully

			demonstrated, at a minimum, the following - Providers shall ensure that individual workers employed by the agency have been CORI checked and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks) and are able to perform assigned duties and responsibilities. - Providers of specialized medical equipment and supplies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.
Pharmacies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Providers shall ensure that individual workers employed by the agency have been CORI checked, and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks) and are able to perform assigned duties and responsibilities. - Providers of specialized medical equipment and supplies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Specialized Medical Equipment Providers	Department of Developmental Services	Every 2 years
Pharmacies	Department of Developmental Services	Every 2 years

Service Specification

Service Type: ☐ Statutory ☐Extended State Plan ■ Other

Service: Peer Support

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Peer support is designed to provide training, instruction and mentoring to participants about self-advocacy, participant direction, civic participation, leadership, benefits, and participation in the community. Peer support is designed to promote and assist the waiver participant's ability to participate in self-advocacy through either a peer mentor or through an individual/agency peer support facilitator. Peer support may be provided in 1) small groups or 2) peer support may involve one individual who is either a peer or an individual peer support facilitator providing support to a waiver participant. The one to one peer support is instructional; it is not counseling. The service enhances the skills of the participant to function in the community and/or family home. Documentation in the participant's record demonstrates the benefit to the participant. This service may be provided in small groups or as a one-to-one support for the participant. Peer support is available to participants who reside in 24 licensed settings, in the family home, a home of their own or receive less than 24 hours of support per day. This service may be self- directed. This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Service Coordinator during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a.

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

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E		■	Provider managed		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian	

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Individual Peer Support Trainers		Peer Support Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Peer Support Trainers	Individuals who meet all relevant state and federal licensure or certification requirements for their discipline if needed.	Relevant competencies and experiences in Peer Support.	Applicants must possess appropriate qualifications to serve as staff as evidenced by interview(s), two personal and or professional references, Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks). The applicant must have the ability to communicate effectively in the language and communication style of the family to whom they are providing training. The applicant must have experience in

			providing family leadership, self-advocacy and skills training and independence. Minimum of 18 years of age; Be knowledgeable about what to do in an emergency; Be knowledgeable about how to report abuse and neglect; Must maintain confidentiality and privacy of participant information; Must be respectful and accept different values, nationalities, races, religions, cultures and standards of living; Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance

			officer. This methodology is accepted by DDS and EOHHS officials.

Peer Support Agencies	If Agency is providing activities where licensure is necessary, individuals need to meet all relevant state and federal licensure or certification requirements in their discipline.	If the agency is providing activities where certification is necessary, the applicant will have the necessary certifications. For mental health professionals such as Family Therapists, Rehabilitation Counselors, Social Workers, necessary certification requirements must be met for those disciplines .	Possess appropriate qualifications to serve as staff as evidenced by interview(s), two personal and or professional references, a Criminal Offender Record Information (CORI) and National Criminal Background Check: 115 CMR 12.00 (National Criminal Background Checks). Agency needs to employ individuals who are self-advocates and supporters must be able to communicate effectively in the language and communication style of the participant or family for whom they are providing training. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team The applicant must have experience in providing peer support, self-advocacy, skills and training in independence. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Peer Support Trainers	Department of Developmental Services	Every 2 years

Peer Support Agencies	Department of Developmental Services	Every 2 years

Service Specification

Service Type: ☐ Statutory ☐Extended State Plan ■ Other

Service: Stabilization

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

This service is designed to provide stabilization and support for waiver participants who due to either behavioral or environmental circumstances cannot remain in their current residence or family home. The service is provided in either a licensed respite facility or in the home of an individual family provider to waiver participants who are unable to care for themselves. The home of an individual family provider is overseen by a qualified stabilization agency. The participant's need for stabilization and support is assessed and is documented in the Individual Plan of Care. The service includes over-night supervision and support. Stabilization services may be available to participants who receive other waiver services on the same day, such as community based day supports, group or individual supported employment or individualized day supports or day habilitation supplement. Stabilization services cannot be provided when other services that provide care and supervision are being provided. The length of stay is based on the assessed needs of the waiver participant and is regularly reviewed by the Regional Management Team. This service cannot be self-directed.

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

Stabilization may be provided up to 90 days per year and is reflected in the Individual Service Plan based on assessed need.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Nonprofit or for-profit residential, individual support stabilization agencies, qualified stabilization agencies licensed as respite providers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Nonprofit or for-profit residential, individual support stabilization agencies, qualified stabilization agencies licensed as respite providers	115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of	High School diploma, GED or relevant equivalencies or competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and a National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about

	Developmental Services Certification, Licensing and Enforcement Regulations)		what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant will be delineated in the Support Plan by the Team.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Nonprofit or for-profit residential, individual support stabilization agencies, qualified stabilization agencies licensed as respite providers	DDS Office of Quality Enhancement, Survey & Certification Staff.	Every 2 years

Service Specification

Service Type: ☐ Statutory ☐Extended State Plan ■ Other

Service Name: Transitional Assistance

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Transitional Assistance Services are non-recurring set-up expenses for participants who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence whether or not the participant is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a participant to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the participant's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) activities to assess need, arrange for and procure needed resources; (f) assistance with housing search and housing application processes; and (g) assistive technology devices that enable the individual to participate in

planning their transition remotely/via telehealth. (g) phones, tablets, computers, and ancillary equipment necessary for the operation of devices that enable the individual to participate in telehealth services. Transitional Assistance Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the participant is unable to meet such expense or when the services cannot be obtained from other sources. Transitional Assistance Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. This service may be self-directed paid through the Fiscal Intermediary. This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process as outlined in Appendix D. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D.

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

Room and board costs are excluded. This may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing. Participants may not receive duplicative devices though both the Transitional Assistance Service and the Assistive Technology Service. The Assistive Technology evaluation includes identification of technology already available and assesses whether technology modifications or a new device is appropriate based on demonstrated need.

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E		■	Provider managed
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐ Legal Guardian

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Individual Qualified Transitional Assistance Provider		Individual, Family Support and Residential Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Qualified Transitional Assistance Provider		High School Diploma, GED, or equivalencies or relevant competencies.	Possess appropriate qualifications as evidenced by interviews, two personal or professional references and a CORI and a National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), Age 18 years or older, be knowledgeable about what to do in an emergency,

			be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, must maintain confidentiality and privacy of participant information, must be respectful and accept different values, nationalities, races, religions, cultures, and standards of living, Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.
Individual, Family Support and Residential Agencies	115 CMR 7.00, 8.00.	High School diploma, GED or relevant equivalencies or competencies.	Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and a National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant.

			Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Qualified Transitional Assistance Provider	DDS	Every wo years
Individual, Family Support and Residential Agencies	DDS Office of Quality Enhancement, Survey and Certification staff.	Every two years

Service Specification
Service Type: ☐ Statutory ☐Extended State Plan ■ Other
Service: Transportation
■ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☐ Service is not included in approved waiver.
Service Definition (Scope)**:**
Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. Transportation services under the waiver are offered in

accordance with the participants service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized. This service includes travel to and from day programs and travel for accessing community activities and resources. Transportation may also include the purchase of transit and bus passes for public transportation systems and mileage reimbursement for qualified drivers. The provision of transportation is based on a service plan that meets the need in the most cost-effective manner. Transportation that is part of a day or residential program or a contracted transportation provider cannot be self-directed. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan defined at 42 CFR 440.170(a), and does not replace them.

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

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Qualified Individual Transportation provider		Non for profit or for profit Transportation Agency	
			Transportation Pass Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Non for profit or for profit Transportation Agency	Valid Massachusetts Driver's License.		Specifications written into all contracts with transportation providers; attachment to contract which requires valid drivers license, liability insurance, reporting of abuse; timeliness, written certification of vehicle maintenance, age of vehicles; passenger capacity of vehicles; RMV inspection; seat belts; list of safety equipment; air conditioning and heating; first aid kits; snow tires in winter; and two-way communication.
Qualified Individual Transportation provider	Valid Massachusetts Driver's License.	High School Diploma, GED, or relevant equivalencies or competencies.	All individual providers must: Possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the

			participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Valid driver's license, liability insurance, RMV inspection; seat belts; Specific competencies needed to meet the support needs of the participant based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team.
Transportation Pass Provider			Transportation passes may be purchased from vendors or retail locations authorized to sell passes for public transportation systems, bus services or other transit providers. Vendors must meet industry standards in the community.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Non for profit or for profit Transportation Agency	DDS Regional Transportation Coordinator.	Annually
Qualified Individual Transportation provider	Department of Developmental Services	Annually or prior to utilization of service
Transportation Pass Provider	Department of Developmental Services	Annually or prior to utilization of service

Service Specification
Service Type: ☐ Statutory ☐Extended State Plan ■ Other
Service: Vehicle Modification
■ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☐ Service is not included in approved waiver.
Service Definition (Scope)**:**
Vehicle Adaptations Adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to engage more fully in the broader community and to ensure the health, welfare and safety of the participant. Examples of vehicle adaptations include:

•Van lift
•Tie downs
•Ramp
•Specialized seating equipment
•Seating/safety restraint

The following are specifically excluded vehicle modifications:
1.Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant.
2.Purchase or lease of a vehicle
3.Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the adaptations.
The participant must be in the family home, vehicle modification is not available to participants who reside in a provider residential setting or in 24 self-directed 24 home sharing supports or in the live-in caregiver model.

Funding for adaptations to a new van or vehicle purchased/leased by family can be made available at the time of purchase/lease to accommodate the special needs of the participant.
This service is must be an identified need and documented in the service plan. The Vehicle modifications must be purchased through a participant-directed budget and paid through the Fiscal Intermediary
1. The Service Coordinator must receive in advance for his/her review and recommendation the following information: a proposal detailing the request for funding and the completed Vehicle/Home Adaptations Funding Request Form. The participant's Individual Support Plan that clearly defines and explains the need for a vehicle adaptation must be attached to this information.
2. If the DDS Service Coordinator recommends the proposal for funding, the request is then forwarded to the Area and then the Regional Director for review and recommendation of funding.
3. All payments for Vehicle Adaptations must be made through the Fiscal Management Service and purchased through a self -directed budget

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

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Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	☐	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
		Independent Contractors		Vehicle Modification Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Vehicle Modification Agencies	Licensed as businesses doing vehicle modifications and conversions.		Vehicle Modifications must be performed by certified entities who are licensed to perform vehicle conversions and modifications.
Independent Contractors			Vehicle Modifications must be performed by certified entities who are licensed to perform vehicle conversions and modifications.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Vehicle Modification Agencies	Department of Developmental Services	Every two years
Independent Contractors	Department of Developmental Services	Every two years.

Service Specification

Service Type: ☐ Statutory ☐Extended State Plan ■ Other

Service Name: Remote Supports and Monitoring

■ Service is included in approved waiver. There is no change in service specifications.

☐ Service is included in approved waiver. The service specifications have been modified.

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Remote Supports and Monitoring (RSM) are designed to provide support using communication and non-invasive monitoring technologies to assist participants to attain and/or maintain independence in their homes and communities while minimizing the need for onsite staff presence and intervention. The use of RSM promotes skill acquisition and maintenance through instruction/guidance with the goal of promoting independence in the least restrictive environment. RSM uses two way "real time" audio/video technology delivered by qualified provider staff at a monitoring center. RSM staff monitor and provide prompts to participants in real time. RSM is delivered on a scheduled and as-needed basis as identified in the participant's Individual Support Plan (ISP). RSM must include an in-person backup plan, based on the needs of the participant, documented in the ISP. Individual interaction with Remote Supports and Monitoring staff may be scheduled, on-demand, or in response to an alert from a device in the remote support and monitoring equipment system.

The provider of RSM must have a process to assess needs, identify any areas of concern, and identify how these can be addressed with the use of RSM technologies. Additionally, the ISP will detail the supports necessary to ensure participants' health and safety needs are met if the device/system is turned off. In the event the participant no longer wants the service, or the service no longer meets the participant's needs, appropriate changes in service provision will be addressed on a timely basis through the person-centered planning process in the same manner as any other service.

The participant's ISP will outline the schedule of when RSM is to be provided. Initial and ongoing training of the individual receiving RSM on how to use the remote support system will be outlined in the ISP. Training will include how to report technology malfunctions. RSM providers do not provide in person services. However, RSM providers are required to have back-up capabilities to respond in person to address technology malfunctions, system checks, or urgent situations that do not require a 911 call. Such urgent situations are rare and are characterized by the need for a timely assessment that is not achievable via the technology and other in-person options are not available. The circumstances under which an individual may receive an in-person response from an RSM provider are agreed upon in advance and outlined in the individual's ISP. If an individual requires an in-person response by the RSM provider more than three times in a 30-day period, or fewer than three times in a 30-day period but for a recurring reason, then the individual would be reassessed and the need for in-person services would be re-evaluated.

This does not affect in-person visits by Service Coordinators or providers of other services. As part of the person-centered planning process, if the participant needs hands-on assistance, they will be offered the services necessary to meet their needs; hands-on assistance may be provided through other services in addition to RSM but will not be provided at the same time as RSM. Hands-on assistance is not provided through RSM.

RSM can be used in conjunction with Individualized Home Supports, but only when Individualized Home Supports are being provided in person. RSM and Individualized Home Supports providers will share service plans and schedules so that RSM timing and activities will not overlap with in-home supports.

All participants who are interested in RSM are evaluated and the evaluation considers whether this service could help enhance their ability to engage in meaningful activities, stay connected with others, and be integrated in their communities. RSM may be authorized to complement other in-person services in meeting these goals. RSM can be mobile, where participants may take a tablet or device into the community to help promote or increase independence.

The overall care plan will address the participant's needs including community integration through the use of RSM and other services. The ISP includes documentation of community involvement or measurable objectives regarding a participant's need for support to promote community integration.

Placement of RSM devices will be considered based on assessed need, privacy and right considerations, and informed consent of the participant and others who live in the home. Use of the system may be restricted to certain hours as indicated in the ISP. The system must have visual or other indicators that inform the participant when the RSM system is activated. Use of RSM audio devices that have a continuous feed will not be permitted in bedrooms or bathrooms. However, RSM audio devices may be triggered in the event of an emergency or otherwise activated by the participant. RSM video monitoring devices will not be permitted in bedrooms or bathrooms.

As part of the informed consent process, the participant will be informed and trained as to how to turn off or remove the device. Depending on the type of RSM device and the participant's abilities, they may be able to turn off the RSM device themselves. If they are unable to do so, then they will be informed as to who to contact for assistance with turning off the device.

This service is not available to participants who receive Residential Habilitation or 24-Hour Self Directed Home Sharing Support. Participants may not receive RSM and MassHealth State Plan PERS at the same time.

The rate for Remote Supports and Monitoring includes a standard per diem cost for two-way communication equipment rental and call center staffing. If a participant is assessed to require specialized equipment to interface with the standard RSM equipment and call center, that specialized equipment is paid for through the Assistive Technology service.

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

A participant can be enrolled in both Individualized Home Supports and Remote Supports and Monitoring but cannot receive both simultaneously. Participants who receive both services must receive their IHS in person, not via telehealth.

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative	☐	Legal Guardian

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■	Agency. List the types of agencies:
				Remote Supports and Monitoring Providers / qualified vendor

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Remote Supports and Monitoring Providers	115 CMR 7.00 (Department of Developmental Services Standards for all Services and Supports) and 115 CMR 8.00 (Department of Developmental Services Certification, Licensing and Enforcement)	High School diploma, GED or relevant equivalencies or competencies.	Possess appropriate qualifications to serve as staff as evidenced by interview(s), two personal or professional references, and a Criminal Offender Record Information (CORI) and National Criminal Background Check:115 CMR 12.00 (National Criminal Background Checks), be 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect; have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the participant, respect and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed to meet the support needs of the participant, based upon the unique and specialized needs of the participant related to their disability and other characteristics will be delineated in the Support Plan by the Team. RSM providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 123B, Section 17, to protect the privacy and security of the participant's protected health information. DDS/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by DDS and EOHHS officials.

			Additionally, the RSM provider must provide: - Safeguards and/or emergency backup systems such as batteries and/or generators, or other emergency solutions, for the electronic devices in place at the remote monitoring center and locations utilizing the system, e.g., participants' homes. - Detailed and written backup procedures to address/manage system failure (e.g., prolonged power outage), fire or weather emergency, participant medical issues, or personal emergency, etc. for each location utilizing the system will be discussed, agreed upon, and included in each participant's ISP with acceptable timing for response.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Remote Supports and Monitoring Providers	DDS	Every 2 years

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

○	**Not applicable** – Case management is not furnished as a distinct activity to waiver participants.	
■	**Applicable** – Case management is furnished as a distinct activity to waiver participants. Check each that applies:	
	☐	As a waiver service defined in Appendix C-3 *Do not complete item C-1-c.*
	☐	As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*
	■	As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
	☐	As an administrative activity. *Complete item C-1-c.*
	☐	As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

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

Department of Developmental Services

Appendix C-2: General Service Specifications

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

■	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	DDS and its providers are governed by Executive Office of Health and Human Services (EOHHS) regulations 101 CMR 15.00 et seq. For any applicant for a position that has the potential for unsupervised contact with a waiver participant, a Massachusetts CORI (Criminal Offender Record Information) check is performed. These checks are mandated by the regulations. These are checks on the criminal record history in Massachusetts of applicants. No individual may begin to provide services and supports to a waiver participant in an unsupervised setting until a CORI check is completed. Providers submit the CORI request to the Department of Criminal Justice Information Services (DCJIS), which is an agency of the Executive Office of Public Safety and Security. The DCJIS sends the results back to the requesting provider agency. The Investigations Division of DDS employs a staff person whose sole responsibility is to conduct audits of provider agencies to assure compliance with 101 CMR 15.00. Agencies not in 100% compliance with this requirement must submit a corrective action plan. DDS follows up to ensure that the correction action has been completed. Participants who are self-directing their supports must request a CORI Check through the Financial Management Service (FMS). The FMS Manual contains guidance and the forms to assist the participant in making this request. The FMS receives the CORI report and informs the Department of whether the results prohibit the applicant from being hired. DDS regulations 115 CMR 12.00: National Criminal Background Checks, implements MGL Chapter 19 B s. 19 and 20: An Act Requiring National Background Checks, which requires DDS to conduct fingerprint-based checks of the state and national criminal history databases to determine the suitability of all current and prospective employees who have the potential for unsupervised contact with persons with an intellectual or developmental disability in any department-licensed or funded program. "Employees" is defined broadly to include any apprentice, intern, transportation provider, volunteer or sub-contractor who may have direct and unmonitored contact with a person with an intellectual or developmental disability. 115 CMR 12.00 also requires that any household members, age 15 or older, or persons regularly on the premises subject to licensure, shall be subject to a fingerprint-based state and federal criminal background check. DDS began conducting national criminal background checks of individuals who provide waiver services in January 2016 and all individuals who provide waiver services will be subject to such checks by January 2019. Participants who are self-directing their supports must request a state and federal criminal Background Check through the Financial Management Service (FMS). The FMS Manual contains guidance and the forms to assist the participant in making this request. The FMS receives the criminal background check report and informs the Department of whether the results prohibit the applicant from being hired.
○	**No**. Criminal history and/or background investigations are not required.

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

○	**Yes**. The state maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
■	**No**. The state does not conduct abuse registry screening.

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

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
■	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

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

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Respite Facilities		
Provider or State-Operated Group Residence		

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

All community residential settings, regardless of size, are subject to the same requirements and expectations related to maintaining a home and community-based character. Community residences are located throughout Massachusetts in neighborhoods in cities and towns. They may be either existing houses or new construction. Houses are required to reflect the normal rhythms and activities of any household with kitchens for preparing meals, dining areas, living rooms/dens and private/semi-private bedrooms.

This homelike and community-based character is initially evaluated for new homes through the site feasibility process, which is conducted to determine if a proposed site offers a safe and suitable living support environment for the participants it is intended to serve. For existing homes, ongoing compliance with requirements for home and community-based settings is monitored through the licensure and certification process. This process was revised and enhanced in September 2016 to clarify expectations and even more closely and strongly align the tool with the critical elements of the Community Rule in terms of residential (and non-residential) settings These expectations include both homelike characteristics of the house (including physical setting, privacy and choice and control) as well as community access and meaningful involvement.

DDS's policies clearly reflect an overall commitment to ensuring participants' meaningful engagement with and incorporation into the community and a move away from settings with institutional-like qualities. In this vein, DDS amended an existing regulatory provision to limit the capacity of residential settings to no greater than five residents. The regulations provide an exception to this limitation such that homes that had a licensed capacity greater than five prior to 1995 are permitted to retain the capacity approved in the license for the life of the original building if the site can accommodate more than five participants. The regulations further provide that capacity in excess of five must be reduced if the Department determines at any time that the site can no longer accommodate more than five participants. In the event that DDS determines that a site can no longer accommodate more than five participants, the provider must develop and implement a plan to reduce the capacity. DDS will work collaboratively with the provider on plans to effectuate the reduction in capacity to five or fewer participants.

115 CMR 7.00: Standards for All Services and Supports/7.08 (Capacity)

Facility type: Respite Facility

Waiver Service	Provided in Facility
Individual Supported Employment	☐
Individual Goods and Services	☐
Residential Habilitation	☐
Chore	☐
Transitional Assistance Services	☐
Specialized Medical Equipment and Supplies	☐

Home Modification and Adaptations	☐
Adult Companion	☐
24-Hour Self Directed Home Sharing Support	☐
Family Training	☐
Behavioral Supports and Consultation	☐
Transportation	☐
Community Based Day Supports	☐
Individualized Day Supports	☐
Peer Support	☐
Individualized Home Supports	☐
Day Habilitation Supplement	☐
Vehicle Modification	☐
Stabilization	■
Assistive Technology	☐
Group Supported Employment	☐
Respite	■

Facility Capacity Limit: Four persons (see ii below)

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

Standard	Topic Addressed
Admission policies	■
Physical environment	■
Sanitation	■
Safety	■
Staff : resident ratios	■
Staff training and qualifications	■
Staff supervision	■
Resident rights	■
Medication administration	■
Use of restrictive interventions	■
Incident reporting	■

Provision of or arrangement for necessary health services	■

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

Facility type: Provider or State-Operated Group Residence

Waiver Service	Provided in Facility
Individual Supported Employment	☐
Individual Goods and Services	☐
Residential Habilitation	■
Chore	☐
Transitional Assistance Services	☐
Specialized Medical Equipment and Supplies	☐
Home Modification and Adaptations	☐
Adult Companion	☐
24-Hour Self Directed Home Sharing Support	☐
Family Training	☐
Behavioral Supports and Consultation	☐
Transportation	☐
Community Based Day Supports	☐
Individualized Day Supports	☐
Peer Support	☐
Individualized Home Supports	☐
Day Habilitation Supplement	☐
Vehicle Modification	☐
Stabilization	■
Assistive Technology	☐

Group Supported Employment	☐
Respite	■

Facility Capacity Limit: Four persons (see ii below)

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

Standard	Topic Addressed
Admission policies	■
Physical environment	■
Sanitation	■
Safety	■
Staff : resident ratios	■
Staff training and qualifications	■
Staff supervision	■
Resident rights	■
Medication administration	■
Use of restrictive interventions	■
Incident reporting	■
Provision of or arrangement for necessary health services	■

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

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

■	**No**. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	**The state does not make payment to relatives/legal guardians for furnishing waiver services.**
■	**The state makes payment to relatives/legal guardians under *specific circumstances* and only when the relative/guardian is qualified to furnish services**. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	The state makes payments to relatives but not to legal guardians, spouses or legal representatives for furnishing waiver services when the relative is qualified and either the relative is employed by a provider agency or the participant is self-directing his\her services. Relatives employed by qualified provider agencies may provide any waiver service. Provider agencies are responsible for ensuring that every employee meets service-specific qualifications. When a participant is self-directing his or her services the circumstances under which a relative may be paid are: •the lack of a qualified provider in the geographic area; •the lack of a qualified provider who can furnish services at necessary times and places; •the unique ability of the relative to meet the needs of the participant; •there is a cost-benefit to having the relative provide the service, such as transportation •The delivery of services by a relative must be discussed and reviewed during the development of the service plan. This includes why it is more beneficial for the relative to provide the service including any cost-benefit and why it is in the best interest of the participant.

	Payment rates to a relative must be consistent with the rates paid by the state for similar supports. Payment is made only when the service is not a function that a family member normally provides for the participant without charge as a matter of course in the usual relationship among members of a nuclear family. Relatives who would not qualify to be paid caregivers include parents of minor children, spouses or legal guardians. The Targeted Case Manager must review all payments to relatives and ensure that waiver services were delivered. The services included are: individual supported employment, transportation, individualized home supports, individualized day supports, chore, adult companion, respite provided in the home of an individual family provider and 24-hour self directed home sharing support. Individual providers of home modifications and adaptations and vehicle modifications are not subject to the review process noted above but must meet the individual provider qualifications noted for the relevant service type. Approval of the home or vehicle modification is subject to the service-specific approval process. Relatives may not be employed as participant-directed providers for the following services: live-in caregiver, behavioral supports and consultation, family training, individual goods and services, assistive technology, and, peer support.
○	**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.** Specify the controls that are employed to ensure that payments are made only for services rendered.
○	Other policy. *Specify*:

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

Any willing and qualified provider has the opportunity to submit a proposal to enroll with the department as a provider of waiver services. The Commonwealth's Executive Office of Health and Human Services has a prequalification process (808 CMR 1.04) to determine the fiscal health of the provider. All providers must complete this process in order to qualify as a provider of services.

DDS also has standards that ensure that waiver providers possess the requisite skills and competences to meet the needs of the waiver target population. The Department typically reviews qualifications in 30 days or less and then updates the list of qualified providers. Any participant may choose from among qualified providers who meet both the state's prequalification and DDS service standards.

The Department has posted on its website the requirements and procedures for potential providers to qualify to deliver services. The qualifying system is open and continuous to enable potential providers to qualify as they become ready to deliver services to waiver participants.

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

i. Performance Measures

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

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

Performance Measure:	QP a1. Percent of new providers that received an initial license to provide supports. (Number of new providers that received a license to operate within 6 months of initial review/Number of new providers who require licensing and were selected to provide supports.)

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☒ *Other Specify:*
	Semi-annually

Performance Measure:	QP a2. Percent of licensed clinicians that meet applicable licensure requirements (Number of licensed clinicians with appropriate credentials/Number of licensed clinicians providing services.)

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☒ *Other Specify:*	☐ *Annually*	
	Fiscal Management Service	☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☐ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☒ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☒ *Other Specify:*	☐ *Annually*
Fiscal Management Service	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	QP a4: Percent of providers that have corrected identified deficiencies in licensing/certification requirements (The number of licensed/certified

	providers that have corrected deficiencies in licensing/certification requirements / The number of licensed/certified providers with identified deficiencies.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☒ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	QP a3. Percent of providers that continue to meet applicable licensure or certification standards (Number of providers that continue to meet

	applicable licensure or certification standards/ Number of providers subject to licensure/certification).
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☒ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
Fiscal Management Service	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

b. Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

i. Performance Measures

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

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

Performance Measure:	QP b1: Percent of individual providers not subject to licensure or certification who are offering self-directed services who meet requirements to provide supports. (Number of individual providers not subject to licensure or certification who meet the qualification requirements to provide services/ Number of individual providers providing services.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☒ *Other Specify:*	☐ *Annually*	
	Fiscal Management Service	☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*

■ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	■ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
■ *Other* *Specify:*	☐ *Annually*
Fiscal Management Service	☐ *Continuously and Ongoing*
	☐ *Other* *Specify:*

Performance Measure:	QP b2: Percent of Support Services Qualified Agency (SSQUAL) Providers that meet the qualifications to provide services. (Number of SSQUAL providers that meet the qualifications to provide services/ Number of SSQUAL agency providers providing services.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	■ *State Medicaid Agency*	☐ *Weekly*	■ *100% Review*
■	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
■	☐ *Sub-State Entity*	☐ *Quarterly*	■ ☐ *Representative Sample; Confidence Interval =*
■	☐ *Other* *Specify:*	☐ *Annually*	■
		☐ *Continuously and Ongoing*	■ ☐ *Stratified: Describe Group:*
		■ *Other* *Specify:*	■
		Semi-Annually	■ ☐ *Other Specify:*
			■

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*

■ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	■ *Other Specify:*
	Semi-annually

c. Sub-Assurance: The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

i. Performance Measures

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

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

Performance Measure:	QP c2. Percent of individual providers who have received training in reporting of abuse/neglect and incidents. (The number of individual providers who have received training in reporting abuse/neglect and incidents/ Number of individual providers providing services.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	■ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
■	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
■	☐ *Sub-State Entity*	☐ *Quarterly*	■ ☐ *Representative Sample; Confidence Interval =*
■	■ *Other Specify:*	☐ *Annually*	■

	Fiscal Management Service	☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☒ *Quarterly*
☒ *Other Specify:*	☐ *Annually*
Fiscal Management Service	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	QP c1. Percent of licensed/certified providers that have staff trained and current in required trainings including medication administration, CPR, first aid, restraint utilization and abuse/neglect reporting. (Number of providers that have staff trained in medication administration, CPR, first aid, restraint utilization and abuse/neglect reporting/ Number of licensed/certified providers reviewed.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other*	☐ *Annually*	

	Specify:			
		☒ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☒ *Other Specify:*
	Semi-annually

Add another Performance measure (button to prompt another performance measure)

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

b. Methods for Remediation/Fixing Individual Problems

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

The State Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by DDS. In the event problems are discovered with the management of the waiver program processes at waiver service providers or DDS

Area Offices, DDS and MassHealth are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Further, MassHealth and DDS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
[redacted]	☒ *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☒ *Annually*
		☐ *Continuously and Ongoing*
		☐ *Other: Specify:*

c. Timelines

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

■	**No**
○	**Yes** Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

○	**Not applicable – The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.**
■	**Applicable – The state imposes additional limits on the amount of waiver services.**

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above*.
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
■	**Other Type of Limit.** The state employs another type of limit. *Describe the limit and furnish the information specified above.*
	a)The aggregate number of day and employment supports cannot exceed the total number of business days per month as expressed in 8 hours per day. Maximum number of hours varies by month but total cannot exceed 184 hours in any month. b)The limit is based on DDS historical experience providing these supports in its current Intensive, Community Living and Adult Supports Waiver. c)The limit will not be adjusted based on appropriation because there are no more available business days. d)The limit for day and employment services cannot be exceeded to meet the health and safety needs of the waiver participant. Additional supervisory services may be needed to meet the participant's health and welfare needs. If the participant has identified emergency needs the waiver has the mechanism in place to assure health and safety of the participant. Service coordinator maintains regular contact with the providers of waiver services across all settings. Both the Risk Management System and the Critical Incident Reporting System continuously alert the Service Coordinator to

	possible emergency needs. Residential provider programs are subject to licensure and certification. Waiver participants are also observed by a variety of service providers across a variety of settings. DDS also has available a RN or Nurse Practitioner in the Department's Area Offices to provide medical consultation as well as Psychologists to provide behavioral consultation. Medical and Behavioral issues are the most common types of emergencies in the system. All providers have developed Emergency back-up plans. All families have been advised and instructed to create emergency back-up plans. All providers have back up plans for weather related emergencies and actively participate in COOP planning regionally. All are connected to the Massachusetts Emergency Management Agency. Families are also advised to alert local officials of the presence of a participant with a disability in their home. If the waiver participant cannot be safely served on the waiver the participants will be offered other state plan services to address the participant's health and safety needs. e)The participants will be offered the right to appeal as described in Appendix F. f)The Quality Assurance System as described in Appendix H outlines the safeguards that are in effect to insure continuous monitoring of the participant by the DDS Service Coordinator. The description of services and the amounts of the limits are available on the DDS website. As part of the service planning process the DDS Service Coordinator notifies participants of the aggregate limits for day and employment services.

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 participants who live in their family home with a comprehensive array of supports, as well as participants who live in the community in 24-hour residential settings, including: 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. DDS developed and disseminated a policy (dated September 2, 2014) that describes the Department's position on future development of settings as well as how existing settings that do not come into compliance with the Community Rule will be addressed. This policy is now in force.

Following is a description of the means by which DDS assessed waiver settings' current compliance with HCBS settings requirements, a description of the settings that EOHHS has determined fully comply or are near-compliance with the HCBS 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 participants living in the community in their family home, these settings are considered fully compliant with the HCBS 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 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 exceptions noted below.

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 may have the effect of isolating participants from the broader community. Based on this analysis, DDS is engaged with these providers in an ongoing, collaborative process to transition their settings into compliance by March 2022, as described in the Main Module at Attachment #2.

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

The outcomes identified in the federal HCBS settings requirements apply to the following Intensive Supports non-residential waiver services: Community Based Day Supports (CBDS), Group Supported Employment, and Individual Supported Employment. Based on DDS's 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). To reach full compliance, a DDS/provider workgroup meets regularly to address systemic changes needed in order to bring all Community Based Day Supports services into compliance with the HCBS 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 other mechanisms related to outcome goals in the Community Rule.
Also, please note that the phase-out of Center Based Day Supports settings (i.e., Sheltered Workshops) was complete by June 2016 and such settings are no longer part of this waiver.

The licensure and certification process is the basis for qualifying providers to do 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. These indicators are supportive of and fully in compliance with the HCBS settings requirements. The licensure and certification tool was revised (September 2016) to clarify expectations and even more closely and strongly align the tool with the critical elements of the HCBS settings requirements for both residential and nonresidential settings. DDS survey teams use the licensure and certification tool to 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.

115 CMR 7.00: Standards for All Services and Supports 115 CMR 8.00: Licensure and Certification of Providers

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Plan of Care

a. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	**Registered nurse, licensed to practice in the state**
☐	**Licensed practical or vocational nurse, acting within the scope of practice under state law**
☐	**Licensed physician (M.D. or D.O)**
☐	**Case Manager** (qualifications specified in Appendix C-1/C-3)
■	**Case Manager** (qualifications not specified in Appendix C-1/C-3). *Specify qualifications*:

The Department employs Service Coordinators who meet the requirements of the State Plan for Targeted Case Management.
Service Coordinators:
Applicants must have at least (A) three years of full-time or equivalent part-time professional experience in human services; (B) of which at least one year must have been spent working with people with disabilities (intellectual disability; developmental disabilities; deafness; blindness; multi-handicapped) or (C) any equivalent combination of required experience and the substitution below.
Substitutions:
1.A Bachelor's degree with a major in social work, social casework, psychology, sociology, counseling, counselor education, rehabilitation counseling may be substituted for a maximum of one year of the required (A) experience*
2. A Master's degree with a concentration in social work, psychology, sociology, counseling, counselor education, rehabilitation counseling may be substituted for a maximum of two years of the required (A) experience.
3. Applicants who meet all federal requirements for Qualified Intellectual Disability Professional may substitute those requirements for three years of the required combined (A) and (B) experience.
4. *Education toward such a degree will be prorated on the basis of the proportion of the requirements actually completed.

Personnel Qualifications Required at Hire:
Knowledge of the principles and theories of human growth and development.
Knowledge of the principles and techniques of counseling, especially people with disabilities and their families. Knowledge of the types and symptoms of mental and/or emotional disorder
Knowledge of interviewing techniques and of motivation and reinforcement techniques.

	Knowledge of the types of services and supports available to people with disabilities and their families. Knowledge of group process for counseling. Knowledge of methods of general report writing. Ability to understand and explain the laws, rules, regulations, policies, procedure, specifications, standards and guidelines governing agency activities. Ability to exercise discretion in handling confidential information. Ability to make comprehensive assessments by examining records and documents and through questioning and observing consumers. Ability to plan training or instruction and to facilitate groups. Ability to effectively coordinate the activities of an interdisciplinary team. Ability to make effective oral presentations and to give oral and/or written instruction. Ability to evaluate and maintain accurate records. Ability to interact with people who are under physical or emotional stress and to deal tactfully with others. Ability to make decisions, act quickly and maintain a calm manner in a stressful and/or emergency situations. Ability to establish and maintain harmonious working relationships with others. Ability to respond to multiple demands for consumers and staff.
☐	**Social Worker** *Specify qualifications:*
☐	**Other** *Specify the individuals and their qualifications:*

b. Service Plan Development Safeguards.

Select one:

■	**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
○	**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The service planning process described in Appendix D produces the Waiver Plan of Care document. The Service Coordinator supports a participant through the entire service planning process, also known as home and community based waiver plan of care development/individual support planning process, by helping the participant prepare for the meeting and assisting them to voice their wants and needs at the meeting.

The Service Coordinator has a discussion with the participant or guardian prior to the support plan meeting. If the participant agrees, other team members such as family and staff may also participate in this discussion. The discussion includes:

- The participant's goals and vision for the future
- A review of the past year and the participant's present circumstances
- Issues to discuss or not to discuss at the support plan meeting
- Identification of additional assessments needed for planning
- Explanation of the support plan process to the participant, family and guardian
- Who to invite to the meeting
- The date, time, and place of the meeting

Other preparation includes talking to people who know the participant well such as staff, friends, advocates, and involved family members. In selecting people to talk to, the Service Coordinator respects the participant's wishes about who is part of the service planning process. When participants cannot communicate their preferences, Service Coordinators collect information through observation, inference from behavior, and discussions with people who know the participant well. All conversations should be respectful of the participant and focus on his or her strengths and preferences. The Service Coordinator also looks for creative ways to focus the team on the unique characteristics of the participant and his (or her) situation. The Service Coordinator does this by helping team members think creatively about how they can better support the person.

During the service planning consultation, the participant and Service Coordinator identify who will be invited to the meeting. These individuals constitute the team members. In situations where personal and sensitive issues are discussed, certain team members may be invited to only part of the meeting. Any issue about attendance at the service planning meeting is resolved by the participant and the Service Coordinator.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The service planning process is described at 115 CMR 6.20-6.25: Individual Support Planning.

The state uses a single service/support planning process that is designed to yield two documents: the Individual Support Plan (ISP) and the Plan of Care (POC) which set forth details of the participant's authorized waiver services, The service plan development process occurs annually with a full ISP plan developed once every two years and an ISP update in the interim year; the POC is updated annually. The process each year is similar, requiring a review of assessments

and progress notes and a meeting of the Team. The service planning process provides guidance for the planning team to follow in supporting participant to meet his or her goals.

The ISP articulates the hopes, desires and needs of the participant and describes the participant's current circumstances. The ISP describes a point in time emphasizing the present circumstances and future plans. The ISP is designed to balance competing desires and needs and reflects the participant's voice. The Vision Statement emphasizes the importance of the participant's wishes. It describes the participant's preferences, interests and how the participant wishes to live, work and use leisure time. The Visioning is focused on four standard questions: What does s/he identify as important activities and relationships to continue to be involved in? What other things would s/he like to be explore; 2) What does s/he think someone needs to know in order to provide effective supports?; 3) What does s/he think are her/his strengths and abilities?; 4) What would s/he like to see happen in his/her life over the next two years? These four questions undergird the service planning process. For some participants the answers to the questions will evolve over time and always reflect a process which is respectful, participant-centered and keeps the participant in the forefront of all decisions.

Information about waiver services is first provided to potential participants at the time of waiver eligibility. Upon initial enrollment in the waiver, the Service Coordinator will provide the participant with information about supports available under this waiver and potential providers of these supports. Provider information is also available on the DDS website. If waiver participants request additional information, or if their needs change, additional information about waiver services is made available. At the supports planning meeting, the Service Coordinator provides each participant with a brochure describing the Choice of Service Delivery Method, including self-directed options, and a Family Handbook which explains the concepts of Choice, Portability, and Service Options within the waiver structure. The participant is also provided information on how to access a website where all qualified agency providers of services are listed.

Participants are encouraged to ask questions and discuss waiver service options as part of the Individual Service Planning process.

There are seven components of the participant-centered support planning process; each area is addressed within the plan:

1) Vision statement, which forms the basis of the plan,
2) Current supports, including services, settings and the people involved,
3) Safety and Risk;
4) Legal/Financial/ Benefit Status;
5) Successes, challenges, Emerging issue and Unmet Needs,
6) Goals, and
7) Objectives and Strategies.

In order to facilitate a participant focused plan, DDS has a standard set of steps in the process which includes: pre- meeting activities, the design of the plan, implementation, updates and plan modification. The requirements for each step are prescribed by DDS.

In general, the person-centered planning process documents a specific and individualized assessed need. As part of the planning process for all waiver participants, there are four required assessments that assist the planning team to identify the participant's capabilities, support needs, and opportunities for skill development. The assessments assist the Team in establishing Goals, Objectives and Support Strategies that are likely to be effective and assist the participant to attain his/her goals. The four required assessments are: Assessment of Ability, Safety Assessment, Health and Dental Assessment, and the Funds Management Assessment. In addition to these assessments, for participants receiving medication to manage or treat behavioral symptoms a functional behavior assessment, a positive behavior support plan and a medication treatment plan are required. The Service Coordinator and team members may also identify additional assessments at any time as needed.

When an assessed need is identified that may result in a restriction to the requirement for lockable doors, privacy, choice of roommates, freedom to decorate one's room, freedom to control schedule and activities, access to food or visitors, the modification will be discussed with the participant through the person-centered planning process and their agreement is obtained and documented. The person-centered plan or the positive behavior support plan identifies the positive interventions and supports that have been utilized prior to the implementation of the restriction, the less intrusive methods which have not worked, a rationale for the restriction and how it is related to the specific assessed need, a method for review of data collection to measure effectiveness and a time frame to review pursuant to the regulations, consent and an assurance that the interventions cause no harm.

The DDS Service Coordinator is the principle organizer of the service plan. The Service Coordinator's role is to support the participant to participate as fully as possible, to ensure that support is provided to the participant to take part in the support planning process, and to be the voice of the participant when the participant is not able to fully participate. Other team members include the guardian, family, and other identified formal and informal supporters.

The Service Coordinator's responsibilities include developing the ISP/ POC with the participant and his/her guardian, as appropriate, requesting and reviewing assessments, goals, objectives and strategies, facilitating the meeting, ensuring the plan represents the participant's needs, maintaining the electronic service plans, monitoring the participant's satisfaction with the plan and progress on goals, and scheduling periodic progress or update meetings.

The Service Coordinator is responsible for any reasonable accommodation needed for the participant's or family/guardian's involvement in service planning. Accommodations may include personal assistance, interpreters, physical accessibility, assistive devices, and transportation.

ASSIGNING RESPONSIBILITIES

Following the meeting, the goals and objectives are carried out by the appropriate Team member identified at the ISP meeting. The providers track, document, and review progress for each goal. The review dates for each goal are decided at the meeting and written in the plan. All goals are reviewed at least semi-annually.

The POC details both waiver and non-waiver services the participant will receive. The Service Coordinator has day to day responsibility for POC coordination.

UPDATING AND MODIFYING THE ISP

At the mid-point between meetings, the team members send progress summaries for each goal to the Service Coordinator. These summaries include:

- Progress toward the goal
- Satisfaction with the ISP
- Effectiveness of the supports
- Quality of the interventions
- Need for modification

The Service Coordinator writes a note in the participant's record stating that the ISP was reviewed. The note specifies if there are changes in the ISP and if the changes require a modification. Requirements for Modifications are found in 115 CMR 6.00. The changes that require modification to the ISP include any change in the ISP goals, supports or services, strategies used for unmet support needs, the priority of services or supports, and the location of the participant's home.

DDS, in both its regulations and manual, spells out the procedures to be followed when a team member, including the participant or representative, believes a modification is needed. As described at 115 CMR 6.25, the process begins when the Service Coordinator is notified stating the reason for the modification.

Participants have the right to appeal their ISP and POC. The ISP and POC are implemented as written unless DDS receives written notice of appeal within 30 days from the date of their ISP/POC. Massachusetts regulations 115 CMR 6.33-6.34 sets forth the appeal process. Additional information regarding appeals can be found in Appendix F-1.

PROCEDURE FOR DEVELOPING AN INTERIM, TEMPORARY PLAN OF CARE

In order to initiate services until a more detailed service plan can be finalized, an interim POC will be developed that is based on the results of the MASSCAP and all other available assessment information. This information will be used to identify the participant's needs and the type of services to meet those needs.

The Service Coordinator will include the participant and/or guardian in the development of the Interim POC. This plan will become effective on the day services begin with a full planning meeting occurring no later than 90 days from that date. The Interim POC includes both the waiver and non-waiver services to be provided, their frequency, and who will provide the service.

The description above includes some information contained in proposed amendments to DDS regulations pertaining to behavior support plans and medication. DDS anticipates final promulgation of regulations will occur prior to the expiration of the current waiver program, projected for March 2018.

115 CMR 5.00: Standards to Promote Dignity (Proposed); 6.20-6.25: Individual Support Plans

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk assessment and mitigation are a core part of the service planning process. Health, behavioral, and safety assessments are reviewed during the development of the ISP and potential risks to the participant's health and safety are identified.
Potential risks may also be identified by any member of the team at any point. The team member notifies the Service Coordinator of a potential risk, and the service coordinator discusses the information with area office supervisory staff. If the participant has a Risk Plan developed through the DDS Risk Management System, relevant components are discussed by the Team. The Team, including the participant, develops a set of prevention strategies and responses to mitigate these risks that are sensitive to the participant's preferences. In the event the assessment process and review indicates the participant may require a Risk Plan, the Team makes a referral for the development of such a plan. The ISP will include reference to the Risk Plan and backup plans to address contingencies such as emergencies, including the occasions when a support worker does not appear when scheduled to provide necessary services when the absence of the service may present a risk to the participant's health and welfare.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

All waiver participants have the right to freely select from among any willing and qualified provider of waiver services. The Service Coordinator provides each participant with information about supports available under the waiver and potential providers of these supports. This information includes an electronic index of providers available throughout the state and informs the participant regarding the option to obtain written material about DDS services and standards and providers.

As part of the pre-planning activities for the annual ISP meeting, and as requested by the participant, the Service Coordinator also provides information about the range of services and supports offered through this waiver and other sources such as the state plan.

The Service Coordinator provides information about qualified providers relevant to the participant's expressed needs and concerns and supports the participant to identify and select from among qualified and willing providers. The Service Coordinator also informs the participant of his or her option to change providers, and the process to do so.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Department of Developmental Services maintains participant files at each area office. ISPs developed as described in this appendix, are maintained in the participant file. ISPs are reviewed for content, quality, and required components through the Service Coordinator Supervisor Tool. The sample is randomly generated by a computerized formula which generates the sample on a quarterly basis throughout the year and assures that each Service Coordinator Supervisor reviews the same number of reviews of Service Plans completed by Service Coordinators whom they supervise.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

○	**Every three months or more frequently when necessary**
○	**Every six months or more frequently when necessary**
■	**Every twelve months or more frequently when necessary**
○	**Other schedule** *Specify the other schedule*:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies)*:

■	**Medicaid agency**
☐	**Operating agency**
■	**Case manager**
☐	**Other** *Specify:*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Service Coordinator has overall day to day responsibility for monitoring the implementation of the ISP and ensuring the participant is satisfied with waiver services, services are furnished in accordance with the support plan to meet the participant's needs and achieve their intended outcomes, and for monitoring the health and welfare of the participant.
Other DDS staff and providers conduct several additional quality management processes, to ensure individual participants are receiving the services they need and their health and welfare is protected. These processes are described more fully in other appendices:

a) incident reporting and management (described in Appendix G)
b) medication occurrence reporting (described in Appendix G)
c) restraint reporting,(described in Appendix G)
d) investigations process (described in Appendix G)
e) "trigger" reports (described in Appendix G)
f) bi-monthly site visits
g) risk assessment and management system
h) human rights and peer review processes
i) licensure and certification system
j) annual standard contract review process
k) periodic progress and update meetings
l) on-going contact with the participant and service providers.

Through HCSIS, service coordinators are timely notified of any reportable events, including incidents, medication occurrences, and restraints that occur for individuals on their caseload. Service coordinators review and approve (typically with additional oversight and review by area and regional directors) action steps taken to remediate or resolve reported issues. Incidents are not "closed" until action steps have been approved. In addition, service coordinators and area offices receive monthly "trigger" reports, which identify participants who have experienced a threshold number of incidents. Area Offices are required to review all "trigger" reports to assure that appropriate action has been taken to protect the health and welfare of participants.

The Department also has an extensive risk management system. Area based risk management teams identify, assess and develop risk management plans for participants who require specific supports in order to mitigate risk to health and safety. Plans are reviewed on a regular basis by the area teams to assure their continued efficacy.

Frequency of contact with the participant is based on the participant's individual needs. The Service Coordinator meets with the participant at least every six months. In addition, the Service Coordinator maintains regular contact with the participant through a variety of means and in the ways the participant prefers between visits. Every participant has direct in-person contact at least annually. The frequency of contacts is related to a number of possible variables including whether the participant has a risk plan, the number of potential providers who have daily contact with the participant, the frequency of program monitoring activities within the provider site, the frequency and type of family or community monitoring, etc. In response to incidents reported through HCSIS, "trigger reports" are generated which provide additional information to the Service Coordinator which may result in increased direct in-person contact.

Participants with changing needs experience more frequent contact based on their individual needs. Service Coordinators review progress notes from providers and maintain regular contact with providers of waiver services which also serve to inform the frequency of direct in-person contact. Participants who have not received at least one waiver service in a month, receive contact in the following month.

The support planning process includes backup plans to address contingencies which may impact a participant. The ISP team assesses the participant's needs and includes a review of the natural and generic supports available to assist the participant. Monitoring for effectiveness of backup plans is the responsibility of the Support Planning Team led by the Service Coordinator. As part of the ISP process, the safety assessment is reviewed and a determination is made about whether there is a need for additional risk assessment. The outcome of the safety and risk assessments assist the team to determine the type of back-up plan required for each participant. Back-up plans are individualized and specific to the participant's circumstances. Secondly, all incidents are reported in HSCIS including participant health and safety. A broad-based on-call system is in place throughout the state including an emergency hotline with 24/7 response.
Individuals and families are provided with information on who to contact in an emergency and how to access the hotline number. The Supervisor Tool is also used to monitor the efficacy of back-up plans.. Licensure and certification of providers is the underpinning for addressing health and safety issues and offers an additional perspective about the effectiveness of back-up plans. The DDS and providers also develop a Continuity of Operations Plans (COOP) providing guidance to ensure essential functions are available in the event of an emergency. Providers are also connected to the Massachusetts Emergency Management Agency (MEMA).
DDS also uses the Supervisor Tool to monitor the access to non-waiver services on a quarterly basis. Service Coordinator Supervisors routinely review service coordinator notes to monitor participant access to non-waiver services identified in the service plan including the types and frequency of access to health services.

Area office staff, also conducts bi-monthly site visits of 24 hour residential supports and quarterly site visits of less than 24 hour supports. Service coordinators utilize a standardized site visit form that prompts review of such issues as the condition of the homes, interactions and knowledge of staff of the participant and his or her individualized needs, and whether the supports address the participant's health and clinical needs. In the event an issue is identified as the result of a site visit, follow up is conducted by the service coordinator, program monitor, or other designated area office staff.

Providers are required to maintain active human rights committees and designate site based human rights officers. Human rights committees assist the provider to affirm, promote and protect the human and civil rights of individual and to monitor and review the activities of the provider. Among other duties, Human rights committees review restrictions on a participant's possessions or funds, emergency restraints, use of health related protective equipment and behavior plans containing restrictive procedures.

Peer review committee (PRC) review also is required for behavior plans containing restrictive procedures. PRC comments must be addressed by the treating clinician prior to the implementation of such plans, except in an emergency. Periodic PRC review of behavior plans containing restrictive procedures is required.

Peer consultation also is available and encouraged to assist providers to improve clinician quality and skills and service plan development.

DDS License and Certification review process includes determining provider compliance with required safeguards such as the presence of behavior plans, if necessary, and incident and restraint reporting, etc.

Licensing and certification of providers also safeguard participants by ensuring providers are achieving foundational safeguards and positive outcomes in the lives of participants they support. This oversight process selects a sample of participants and reviews how the provider is supporting health, safety, choice, control, growth and accomplishments, community integration and relationships. The Area Office receives a copy of the outcomes for each participant contained in the sample. Follow up is conducted on participants and the provider agency as a whole to assure participants are receiving the services identified in their ISP/POC and that their health and safety is protected.

The Annual Standard Contract Review Process is conducted by Area Directors and compiles data from a variety of sources including the licensure and certification reviews, bi-monthly site visits and incident reports. The process allows the area offices and providers to identify how participants are supported to be healthy and safe and to achieve overall quality of life and to recommend improvements to provider activities, as necessary.

Service coordinators conduct semi-annual reviews of each participant's support plan and its continued efficacy in assisting the participant to achieve his or her goals and objectives. Providers submit progress reviews and modifications are made, if necessary.

As described more fully in the Quality Improvement Section of Appendix D, the DDS Service Coordinator Supervisor Tool, and the ISP checklist, further enhance the oversight and monitoring of the service plan.

115 CMR 3.09: Protection of Human Rights/Human Rights Committees, 5.00: Standards to Promote Dignity (Proposed); 6.20-6.25: (Individual Support Plans); 7.00: Standards for All Services and Supports; 8.00: Licensure and Certification of Providers

b. Monitoring Safeguards. *Select one:*

■	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
○	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.** The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Quality Improvement: Service Plan

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

a. **Methods for Discovery: Service Plan Assurance**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-assurances:

a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

i. Performance Measures

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

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

	SP a5: Percent of service plans that have been developed in accordance with waiver requirements as indicated by the inclusion of all required components, including all required assessments, support strategies, choice forms, LOC & POC.(Number of service plans developed in accordance with waiver requirements as indicated by the inclusion of all required components/ Number of service plans reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: Service Coordinator Supervisor Tool/ISP Checklist	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*
	☐ *Sub-State Entity*	☒ *Quarterly*	☒ *Representative Sample; Confidence Interval =*

	☐ *Other Specify:*	☐ *Annually*		95% margin of error +/-5
		☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	SP a4: Percent of service plans that have required assessments. (Number of service plans with required assessments/ Number of service plans reviewed.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*
	☐ *Sub-State Entity*	☒ *Quarterly*	☒ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95% margin of error +/-5

		☐ *Continuously and Ongoing*	■	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
■ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	■ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	SP a2: Percent of service plans that reflect personal goals identified through the assessment process (Number of service plans that address personal goals identified during the assessment process/ Number of service plans reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	■ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
■	☐ *Operating Agency*	☐ *Monthly*	■ *Less than 100% Review*
■	☐ *Sub-State Entity*	■ *Quarterly*	■ *Representative Sample; Confidence Interval =*
■	☐ *Other Specify:*	☐ *Annually*	■ 95% margin of error +/-5

		☐ *Continuously and Ongoing*	☐	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Performance Measure:	SP a1: Percent of service plans that reflect needs identified through the assessment process. (Number of service plans that address needs identified during the assessment process/ Number of service plans reviewed.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*
	☐ *Sub-State Entity*	☒ *Quarterly*	☒ *Representative Sample; Confidence Interval =*

	☐ *Other Specify:*	☐ *Annually*		95% margin of error +/-5
		☐ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

b. Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.

i. Performance Measures

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

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

Performance Measure:	No longer needed in new QM system
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
[redacted]	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
[redacted]	☐ *Sub-State Entity*	☐ *Quarterly*	[redacted] ☐ *Representative Sample; Confidence Interval =*
[redacted]	[redacted] *Other Specify:*	☐ *Annually*	[redacted]
	No longer needed	☐ *Continuously and Ongoing*	[redacted] ☐ *Stratified: Describe Group:*
		[redacted] *Other Specify:*	[redacted]
		No longer needed	[redacted] *Other Specify:*
			[redacted] No longer needed

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☐ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
[redacted] *Other Specify:*	☐ *Annually*
No longer needed	☐ *Continuously and Ongoing*
	[redacted] *Other Specify:*
	No longer needed

Add another Performance measure (button to prompt another performance measure)

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

i. Performance Measures

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

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

Performance Measure:	SP c1. Percent of service plans that are completed and/or updated annually. (Number of participants whose service plans are completed and/or updated annually/Number of participants with service plans reviewed.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*
	☐ *Sub-State Entity*	☒ *Quarterly*	☒ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95% margin of error +/-5
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Performance Measure:	
Data Source *(Select one) (Several options are listed in the on-line application):* Other	
If 'Other' is selected, specify: DMRIS Information System Database	

	Responsible Party for data collection/generation	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	(check each that applies)		
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☒ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	SP c2: Percent of service plans updated when warranted by changes in participants' needs. (Number of service plans updated when needs change/number of participants reviewed with changing needs.)
Data Source *(Select one) (Several options are listed in the on-line application):* Other	
If 'Other' is selected, specify: Service Coordinator Supervisor Review Tool/ISP Checklist	

	Responsible Party for data collection/generation	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	(check each that applies)		
	☒ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*
	☐ *Sub-State Entity*	☒ *Quarterly*	☒ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95%, +/-5% margin of error
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

i. Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section

provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	SP d1. Percent of participants who are receiving services according to the type, scope, amount, frequency and duration identified in their plan of care. (Number of participants who are receiving services according to the type, scope, amount, frequency and duration identified in their plan of care/Number of participants' plans of care reviewed.)
Data Source *(Select one) (Several options are listed in the on-line application):* Other	
If 'Other' is selected, specify: Service Coordinator Supervisor Tool/ISP Checklist	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*
	☐ *Sub-State Entity*	☒ *Quarterly*	☒ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95% margin of error +/-5
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other*

	Specify:

Add another Performance measure (button to prompt another performance measure)

e. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

i. Performance Measures

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

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

Performance Measure:	SP e2: Percent of service plans that contain a signed form indicating that participant was informed of his/her choice between service providers and method of service delivery. (Number of service plans that contain a signed form/ Number of service plans reviewed.)
Data Source *(Select one) (Several options are listed in the on-line application):* Other	
If 'Other' is selected, specify: Service Coordinator Supervisor Tool/ISP Checklist	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*
	☐ *Sub-State Entity*	☒ *Quarterly*	☒ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95% margin of error +/-5
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

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

b. Methods for Remediation/Fixing Individual Problems

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

The State Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by DDS. In the event a problem is discovered pertaining to the management of the waiver program processes at waiver service providers or DDS Area Offices, DDS is responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Further, DDS and MassHealth are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	**Responsible Party** *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	■ **State Medicaid Agency**	☐ **Weekly**
	☐ **Operating Agency**	■ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other** Specify:	■ **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

c. Timelines

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

■	**No**
○	**Yes**

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

Appendix E: Participant Direction of Services

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

■	**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
○	**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

○	**Yes. The state requests that this waiver be considered for Independence Plus designation.**
■	**No. Independence Plus designation is not requested.**

Appendix E-1: Overview

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

Subject to the limits described in this waiver application, participants in this waiver may lead the design of their service delivery through a participant directed process. The Department of Developmental Services provides consumer-directed options for participants who choose to direct the development of their ISP and to have choice and control over the selection and management of waiver services. Participants may choose to have either employer authority or budget authority or both. As part of the initial and on-going planning process of assessment and enrollment into the waiver, the participant is provided information by the Area Office about the opportunity to self-direct and the models by which they can utilize once eligibility has been established. The DDS provides two models of self-direction, the Participant Direction Program (PDP) and the Agency with Choice Program (AWC). Participants may choose to self-direct their services through PDP, AWC or both. With PDP, participants are the employer and are responsible for hiring, training, and managing the staff, and use the services of the FEA/FMS to perform the financial employer required tasks. With AWC, which is a co-employer model, participants utilize an Agency to assist with hiring, training and managing the staff but the participant serves as the managing employer.

All participants who self-direct have a Targeted Case Manager (Service Coordinator) to assist them to direct their plan of supports. The planning process includes the participant, responsible legal representative, the Service Coordinator, and may include others of the participant's choosing and other clinicians and supporters appropriate to the needs of the participant. The initial step of the planning process results in a service plan that indicates the type, frequency, and duration of the waiver services necessary to address the individual's support needs. The participant then has the opportunity to direct some or all of their services as long as the services included in the waiver are

allowable for self- direction. They have the opportunity and choice of what model to utilize in the self-direction of their service however, not all services can be self-directed.
Every year at the time of a Person Centered Planning process, participants are given the opportunity to self-direct. The team assesses the participant's ability to self-direct and what supports are needed to ensure success.

In addition to other case management activities, the Service Coordinator assists participants to access community and natural supports and advocates for the development of new community supports as needed. They assist participants to monitor and manage their Individual Budgets. Service Coordinators may provide support and training on how to hire, manage and train staff and to negotiate with service providers. They assist participants to develop an emergency backup plan and may assist participants to access self-advocacy training and support.

The budget allocation is determined as part of the Person Centered Planning process and is based on the outcome of the participant assessment of need and the costing out of the needed services based on the established rate ceilings.
Participants may choose to self-direct some or all of their services. Participants who self-direct may choose to be the direct employer of the workers who provide waiver services through the PDP model or may select a qualified Agency through the AWC model. If the AWC model is chosen, the Agency handles payroll and taxes and related functions. The participant may refer prospective employees to the Agency for employment through AWC. The AWC is the employer of record for employees hired and is responsible for conducting Massachusetts Criminal Offender Record Information (CORI) as well as Federal Criminal Background Checks; however, the participant maintains the responsibility to select, train, and supervise these workers on a daily basis. In both models (PDP and AWC) the participant, or his or her designated representative if any, have responsibility for managing the services they choose to direct.

Participants who self-direct and hire their own workers through the PDP model have the authority to recruit, hire staff, verify qualifications, determine staff duties, set staff wages and benefits within established guidelines, approve time sheets within established guidelines, provide training and supervision, evaluate staff, and terminate staff employment. Once the Person Centered Plan and budget is complete, the service budget is entered into the Fiscal Employer Agent (FEA/FMS) system for implementation of the plan and the budget. The participant indicates in what manner and from whom the approved waiver services are purchased.

In the PDP model the FEA/FMS performs the payment tasks associated with the purchase of waiver services and supports. If the participant chooses the employer authority option and functions as the common law employer, the FEA/FMS provides fiscal services related to income and social security tax withholding and state worker compensation taxes. The FEA/FMS provides monthly reports and expenditures with disbursements and remaining fund balances so that the participant can monitor his/her budget. The FEA/FMS also executes the agreements with providers of services, assists participants in verifying support worker citizenship status, collects and processes time-sheets of support workers, pays invoices for approved goods and services as approved in the support plan. The FEA/FMS also does the final collection of all qualification data and conducts Criminal Offender Record Information (CORI) as well as Federal Criminal Background Checks and maintains a list of qualified providers. The FEA/FMS executes and holds Medicaid provider agreements on behalf of the Medicaid agency.

The FEA/FMS is required to be utilized by participants and families who choose to hire their own staff and self-direct some or all of their waiver services in their Individual Support Plan via the PDP model.

The administrative costs associated with the FEA/FMS and AWC model are not included in the participant's budget.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
■	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

■	**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
■	**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
■	**The participant direction opportunities are available to persons in the following other living arrangements** *Specify* these living arrangements: In group homes

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	**Waiver is designed to support only individuals who want to direct their services.**
○	**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
■	**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.** *Specify the criteria* Within the PDP model, participants must demonstrate an ability and desire to self-direct. This is assessed during the service planning process by the Team and reviewed annually. As appropriate, the Department will work with participants who are determined to require significant assistance to self-direct their services. The Service Coordinator will provide that assistance. Should evidence arise that a participant who is self-directing all of his/her services through the PDP model is no longer able to do so, s/he will be offered the option to have a surrogate volunteer assist with their self-direction decisions. If they do not wish to use a surrogate they will be denied the opportunity to continue and will be required to receive supports through a traditional provider and/or through AWC. Appeal rights will be granted. Participant direction opportunities are available to all participants enrolled in this waiver. Services which cannot be self-directed are the following: facility based respite, Day Habilitation Supplement, Transportation that is part of a day program or a contracted route, , Community Based Day Supports, Group Supported Employment. Other services require prior approval including: Behavioral Supports and Consultation, Vehicle Modifications, Home Modifications and Adaptations. Specialized Medical Equipment and Supplies, and Assistive Technology and are authorized as part of the Service Planning Process.

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

As part of the intake and waiver eligibility process, information about the waiver and opportunities for self-direction is provided to each participant. The range of options is discussed as part of the planning process and throughout the implementation of the support plan by the Targeted Case Manager (Service Coordinator). Participants are provided written material about their responsibilities of being an employer. Within the PDP, the FEA/FMS acts to insure that all tax

filings and other payroll associated costs are handled. On behalf of participants the FEA/FMS arranges for a worker's compensation policy which provides protection for the waiver participant as well as the employee. With the AWC, the Agency acts as co-employer and as such is responsible for tax filings and other payroll associated costs and worker's compensation. Participants are informed of the components of both models when applicable at the time of the Person Centered Planning process. Once the participant has selected the participant directed option, additional information about the FEA/FMS or the selected Agency through AWC are provided.

For PDP, the FEA/FMS is responsible for processing Criminal Offender Record Information and Federal Criminal Background Checks. For AWC, the Agency is responsible for processing Criminal Offender Record Information and Federal Criminal Background Checks.

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one)*:

○	**The state does not provide for the direction of waiver services by a representative.**
■	**The state provides for the direction of waiver services by representatives.** Specify the representatives who may direct waiver services: *(check each that applies)*:
■	**Waiver services may be directed by a legal representative of the participant.**
■	**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
	The state's practice is to allow participants the opportunity to self-direct their waiver services independently, if they are able to do so, or with assistance, if needed from a legal representative of the participant, family members, or a non-legal representative chosen by an adult participant. The representative of the participant may not be paid for directing the services.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Individual Supported Employment	■	■
Individual Goods and Services	□	■
Chore	■	■
Transitional Assistance Services	■	■
Specialized Medical Equipment and Supplies	□	■
Home Modification and Adaptations	□	■
Adult Companion	■	■
24-Hour Self Directed Home Sharing Support	■	■
Family Training	■	■
Live-in Caregiver	□	■
Behavioral Supports and Consultation	■	■
Transportation	■	■

Individualized Day Supports	■	■
Peer Support	■	■
Individualized Home Supports	■	■
Vehicle Modification	☐	■
Assist Technology	☐	■
Respite	■	■

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

■	**Yes**. **Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).* Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
	☐ **Governmental entities**
	■ **Private entities**
○	**No**. **Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service specified in Appendix C-1/C-3 **The waiver service entitled:**	
■	**FMS are provided as an administrative activity.** ***Provide the following information***	
i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
	For the PDP model, Financial Management Services are provided through a Fiscal Employer Agency (FEA/FMS). The designation was the result of an open, competitive procurement.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
	For the PDP model, Financial Management Services are furnished as an administrative activity between the Department of Developmental Services and the FEA/FMS. Currently, financial management services are provided through Public Partnerships Limited (PPL) as the result of an open and competitive procurement. The contract between DDS and PPL provides for a monthly Financial Management Services fee per member per month for members with ongoing services or a transaction fee when the member is purchasing goods, but is not self-directing ongoing services. PPL reports budget status to the Department and to participants on a monthly basis. PPL executes individual provider contracts with each waiver participant for Fiscal Management Services and with the participant and the provider of direct supports and services.	

iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	
	Supports furnished when the participant is the employer of direct support workers:	
	■	**Assists participant in verifying support worker citizenship status**
	■	**Collects and processes timesheets of support workers**
	■	**Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
	■	**Other** *Specify:* Processes Criminal Offender Record Information (CORI); Federal Criminal Background Checks, provides information to participants, provides a help line, accepts applications from interested potential providers and maintains a "good to provide" list.
	Supports furnished when the participant exercises budget authority:	
	■	**Maintains a separate account for each participant's participant-directed budget**
	■	**Tracks and reports participant funds, disbursements and the balance of participant funds**
	■	**Processes and pays invoices for goods and services approved in the service plan**
	■	**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
	■	**Other services and supports** *Specify*: Assures that payment is made to only those providers that have qualified to provide supports.
	Additional functions/activities:	
	☐	**Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
	■	**Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
	■	**Provides other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
	■	**Other** *Specify:* FEA/FMS provides an enrollment packet to each participant to whom it provides fiscal intermediary services under their state contract. The enrollment packet includes the forms and information (employee application, fact sheet on employer liability and safety, Criminal Background checks, Federal Criminal Background Check, Individual Provider agreement, employee and Vendor Agreement forms, Individual Provider Training Verification Record and training materials including information on the Disabled Persons Protection Commission (DPPC).
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions	

	that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
	The Department of Developmental Services is responsible under its competitive procurement and negotiated contract to manage the performance of the FEA/FMS. The Department has established performance metrics and requires that its FEA/FMS meet them and has established a process of remediation if they do not achieve them. The FEA/FMS maintains monthly individual budgets on a management information system and provides monthly financial reports to both participants and to the Department. Monthly invoices contain specific line items identifying the disbursements made on behalf of the participants. Monthly FEA/FMS reports reconcile expenditures for a participant with that participant's approved individual budget. The FEA/FMS configures data so as to produce reports of performance measures, and to develop a unified format both for utilization and financial reporting, and reporting pursuant to the Real Lives Statute. The Real Lives Statute, Massachusetts General Law Chapter 19B, Section 19, was enacted to further enhance participant direction within the Commonwealth of Massachusetts and DDS. The FEA/FMS is responsible for providing data and reports for DDS QA measures and waiver assurances. DDS has regular monitoring meetings with its FEA/FMS, Public Partnerships, Limited (PPL) to address business process issues that may arise and ad hoc contacts whenever issues occur outside of these regularly scheduled times.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

■	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
	Discussion between the participant, service coordinator and area office occurs where service delivery options are discussed including the identification of participant directed services and a support plan is created. Participants who desire to self-direct their services are assessed to determine their capacity to do so and what types of supports will be required to assist them. Each participant will have a Service Coordinator who will monitor the implementation of the support plan and provide coordination and oversight of supports. The role of the DDS Service Coordinator in individual planning is to support the person and other team members to develop and implement a plan that addresses the participant's needs and preferences. Service Coordinators support participants to be actively involved in the planning process. Service Coordinators share information about choice of qualified providers and self-directed options at the time of the planning meeting and upon request. Service Coordinators assist the person to develop an individual budget and assist with arranging supports and services as described in the plan. They also assist the participant to monitor services and make changes as needed. Service Coordinators share information regarding the ability to change providers when participants are dissatisfied with performance. Service Coordinators support participants to hire, train and manage the support staff, negotiate provider rates, develop and manage the individual budget, develop emergency back up plans, and provide support and training to access and develop self-advocacy skills.
☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-1/C-3 (check each that applies):

	Participant-Directed Waiver Service	**Information and Assistance Provided through this Waiver Service Coverage**
	(list of services from Appendix C-1/C-3)	☐

■	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and (e) the entity or entities responsible for assessing performance:*
	The Targeted Case Manager (Service Coordinator) assists the participant or the legal representative of the participant in arranging for, directing, and managing waiver services. Assistance is provided in identifying immediate and long- term needs, developing options to meets those needs and accessing identified waiver supports and waiver services. This function includes providing information to ensure that the participant or legal representative understand the responsibilities in directing their own services; the extent of assistance furnished to the participant is discussed by the team and specified in the service plan. The Service Coordinator assists in developing a person-centered plan to ensure that the needs and preferences are clearly understood and reflected in the

	plan. In addition the Service Coordinator assists in arranging for, directing and managing waiver services. The Service Coordinator focuses on the following sets of activities in support of participant-directed services: -Support the participant to recruit, train and hire staff -Review individual budgets and spending on a quarterly basis with the participant -Facilitate the development of a person-centered plan of care -Monitor and assist the participant when revisions are needed -DDS Service Coordinators are assessed through the state's personnel performance system and through the Service Coordinator Supervisory Checklist Tool; DDS Supervisory staff assess performances of its DSS Service Coordinators.

k. Independent Advocacy *(select one)*.

■	**No. Arrangements have not been made for independent advocacy.**
○	**Yes**. Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

If after all efforts to support a participant in directing his/her services have been attempted and the waiver participant voluntarily chooses to terminate this method of receiving services, the Department of Developmental Services would seek to continue supports through a traditional provider or an Agency with Choice provider to meet the participant's health and welfare needs. When appropriate, the Department would alter the plan of care to ensure that the service plan meets the needs of the participant and to ensure health and safety during the transition from participant-directed services to a more traditional provider based service.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Each participant who self-directs by hiring his or her own workers has an Agreement for Self-Directed Supports describing the expectations of participation. As part of this agreement, the participant acknowledges that the authorization and payment for services that are not rendered could subject him/her to Medicaid fraud charges under state and federal law. Breach of any of the requirements with or without intent may disqualify the participant from self-directing-services. Termination of the participant's self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement for Self-Directed Supports.

Although the Department works to prevent situations of involuntary termination of self-direction, they may be necessary. On-going support and monitoring by the Targeted Case Manager (Service Coordinator) may not be adequate to ensure that the participant's health and welfare can be assured. In that case the participant is given notice and an opportunity for a fair hearing. Reasons for termination include but are not limited to a) refusal to participate in the development and implementation of the Person Centered Planning Process, b) the continual inability to manage the budget, c) multiple attempts to hire individuals who are inappropriate, d) on-going inability to

locate, supervise, and retain employees, d) failure to submit time-sheets in a timely manner, e) inadequate protection for health and welfare, f) changing needs of the waiver participant which require greater oversight and monitoring on a daily basis, g) authorization of payment for services or supports that are not in accordance with the individual plan, and h) commission of fraudulent or criminal activity associated with self-direction.

The commission of fraudulent or criminal activity may also result in termination from the waiver with appeal rights provided.

For an involuntary termination of participant direction the participant and the support team meet to develop a transition plan and modify the Individual Service Plan. The Targeted Case Manager (Service Coordinator) ensures that the participant's health and safety needs are met during the transition, coordinates the transition of services and assists the participant to choose a qualified provider to replace the directly hired staff.

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		205
Year 2		210
Year 3		215
Year 4 (only appears if applicable based on Item 1-C**)**		215
Year 5 (only appears if applicable based on Item 1-C**)**		215

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

■	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:
	The option of Agency with Choice is permitted and encouraged. DDS requires specific assurances to enroll and be designated as an Agency with Choice organization through the submission of policies and procedures that support the control and oversight by the participants over the employees and manages potential conflict of interest, and requires periodic participation in DDS sponsored training and events in consumer-direction. If the Agency with Choice model is chosen, the Agency handles payroll and taxes etc. DDS contracts with AWC providers via a procurement process. The AWC is responsible for determining the qualifications of individuals hired and assists participants in conducting employer related functions. DDS procured Agencies with Choice and the list of qualified Agency With Choice providers is available on the state's website of approved providers.
■	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

■	**Recruit staff**
■	**Refer staff to agency for hiring (co-employer)**
■	**Select staff from worker registry**
■	**Hire staff (common law employer)**
■	**Verify staff qualifications**
■	**Obtain criminal history and/or background investigation of staff** Specify how the costs of such investigations are compensated:
	Payment for these investigations does not come from the individual's budget but is made either by the Fiscal Management Service as part of its cost of doing business or through the Agency with Choice.
■	**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3. Specify the state's method to conduct background checks if it varies from Appendix C-2-a:**

■	**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
■	**Determine staff wages and benefits subject to applicable state limits**
■	**Schedule staff**
■	**Orient and instruct staff in duties**
■	**Supervise staff**
■	**Evaluate staff performance**
■	**Verify time worked by staff and approve time sheets**
■	**Discharge staff (common law employer)**
■	**Discharge staff from providing services (co-employer)**
☐	**Other** Specify:

b. Participant – Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more***:**

■	**Reallocate funds among services included in the budget**
■	**Determine the amount paid for services within the state's established limits**
■	**Substitute service providers**
■	**Schedule the provision of services**
■	**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
■	**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
■	**Identify service providers and refer for provider enrollment**
■	**Authorize payment for waiver goods and services**
■	**Review and approve provider invoices for services rendered**
☐	Other Specify:

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The participant-directed budget amount for waiver services and goods over which the participant has authority is established through an individual assessment process that

determines the waiver services needed to ensure the participant's health and welfare and to prevent the risk of institutionalization. The specific cost of these supports is established through a review of the type, frequency, and duration of the supports needed. Also, considered are the availability of natural and generic supports and State Plan or other services available to the participant. Costs are estimated based on an analysis of the needs of participants with similar needs in similar services. Use of the standard MASSCAP assessment process and Self-Directed Supports Allocation Methodology ensures that the budget methodology is applied consistently to each waiver participant. Waiver rates are approved by the Executive Office of Health and Human Services and are publicly available upon request.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Budget development is an integral part of the support planning process which includes needs assessment and identification of supports to meet those needs. (115 CMR 6.00) Based on this plan, a funding amount for each component of service is identified and a budget established to support the implementation of the plan subject to the waiver cost limit on services and limits on particular services. The participant is part of the budget planning development and is informed of the allocated amount. The amount is then documented. The service planning process includes communication about appeal rights and the process for appeal upon the completion of the Individual Support Plan. Massachusetts' regulations at 115 CMR 6.33-6.34 set forth the appeal process for the Service Plan. Each participant can expect at least monthly contact with their Targeted Case Manager (Service Coordinator) to determine if any adjustments are needed in their budget. This is a fundamental component of their regular communication. If at any time there is a significant change in the participant's life, an adjustment can be made to ensure health and safety.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	**Modifications to the participant directed budget must be preceded by a change in the service plan.**
■	**The participant has the authority to modify the services included in the participant-directed budget without prior approval.** Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
	A participant can make changes to the existing individual budget in the amount of waiver services s/he is receiving within the parameters of the individual's allocated budget. The participant is able to make adjustments within his/her individual budget in regards to the type of services they are receiving provided that they do not exceed the limits established in the waiver and that they are services that the participant has an assessed need to receive. In the event changes are needed related to the increase or decrease of the allocated budget the Targeted Case Manager (Service Coordinator) follows the ISP process outlined in 115 CMR 6.00 as well as in Appendix D [D-1 (d)] of the waiver.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FEA/FMS operates a web-based electronic information system to:
Track allocations and payment of invoices;

Track and monitor billings and reimbursements by participant identification, name, social security number, service type, number of service units, dates of services, service rate, provider identification and participant's support plan;

Track and monitor utilization review and issue monthly reports to the Department and the participant;

Any potential for over-utilization or under-utilization of the budget or non-compliance with the support plan will be apparent based on the Department's review of monthly participant specific expenditure reports. The FEA/FMS also has systems in place to prevent payments of invalid payment requests.

Additionally, there is ongoing communication between the Targeted Case Manager (Service Coordinator) and the FEA/FMS.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals are afforded the opportunity to request a Fair Hearing in all instances when they: (a) are not provided the choice of home and community-based services as an alternative to institutional care; (b) are denied the service(s) of their choice or the provider(s) of their choice; and/or their services are denied, suspended, reduced or terminated.

Individuals are informed in writing of the procedures for requesting a Fair Hearing as part of the waiver entrance process by letter from the Waiver Management Unit. If entrance to the waiver is denied, the individual is given formal written notice of the denial and information about how to request a Fair Hearing to appeal the denial of entrance to the waiver. In order to ensure that the individual is fully informed of his right to a Fair Hearing, the written information when necessary will be supplemented with a verbal explanation of the Rights to a Fair Hearing.

Whenever an action is taken that adversely affects a waiver participant post-enrollment (e.g. services are denied, reduced or terminated), the participant is notified in writing by letter from the Area Director or designee on a timely basis in advance of the effective date of the action. The notice includes information about how the participant may appeal the action by requesting a Fair Hearing and provides, as appropriate, for continuation of services while the participant's appeal is under consideration. Copies of the notices are maintained in the individual's record. It is up to the participant to decide whether to request a Fair Hearing.

The notices regarding the right to a Fair Hearing in each instance provides a brief description of the appeals process and instructions regarding how to appeal. The notices refer the individual and/or legal representative to the DDS regulations at 115 CMR 6.33-6.34 which describe the procedure for requesting and receiving a Fair Hearing. Informal conferences and Fair Hearings are conducted in accordance with the Massachusetts Administrative Procedures Act and the Standard Adjudicatory Rules of Practice and Procedure. See 801 CMR 1.00 et seq. Individuals are notified that they may appeal Fair Hearing decisions to the Superior Court pursuant to M.G.L. c. 30 A (the Massachusetts Administrative Procedures Act.) The right to a fair hearing within time frames in Federal regulations is not impeded by any other method of problem resolution. The time frame for any other state problem-resolution activity runs concurrent with a person's right to a fair hearing.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

■	**No. This Appendix does not apply**
○	**Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

■	**No. This Appendix does not apply**
○	**Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one*:

■	**Yes**. **The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
○	**No**. **This Appendix does not apply** (*do not complete Items b through e).* *If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.*
■	

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDS systems for reporting and follow-up of a critical event or incident are managed as "incidents" and "complaints" of abuse, neglect or exploitation to the Disabled Persons Protection Commission (DPPC); such events may be subject to management under one or both systems as described below.

DDS utilizes a web based incident reporting system, the Home and Community Services Information System (HCSIS) system. The incident reporting system provides invaluable information regarding participant incidents, immediate and long range actions taken as well as aggregate information that informs analyses of patterns and trends. Providers are required to report incidents when they occur and service coordinators are required to report incidents when they learn about them if they have not already been reported. Incidents are classified as requiring either a minor or major level of review. Deaths, physical and sexual assaults, suicide attempts, certain unplanned hospitalizations, near drowning, missing person, and injuries, are examples of incidents requiring a major level of review. Suspected verbal or emotional abuse, theft, property damage, and behavioral incident in the community are examples of incidents requiring a minor level of review. The HCSIS system is an integrated "event" system and as such medication occurrences and restraint utilization are also reported. These processes are more fully described in this appendix. Incidents classified as minor are recorded in HCSIS within 3 business days and may be reclassified as major incidents, as appropriate. Major incidents are recorded in HCSIS within 1 business day. Providers also are responsible to immediately report major incidents by telephone or e-mail to DDS Area Offices. Immediate and longer term actions steps are delineated in HCSIS and must be reviewed and approved by DDS area office staff for minor incidents and area and regional staff for major incidents. An incident is closed when all action

steps are taken and all required approvals have been completed. Standard monthly management reports are provided to area, regional and central office staff for purposes of follow up on provider and systemic levels.
Aggregate data is reported by numbers and rates for each area and region on a quarterly basis.

In addition to the incident reporting system, allegations of abuse or neglect are reported to the Disabled Persons Protection Commission (DPPC) in accordance with M.G.L. c.19C. DPPC is the independent State agency responsible for investigating allegations of abuse or neglect of individuals with disabilities between the ages of 18 and 59. By regulation, DDS Investigations Unit investigates allegations of abuse of participants served by DDS who are not within the statutory authority of DPPC, for example, adults with intellectual disability over the age of 59 (115 CMR 9.00). Mandated reporters, participants, families and the general public report suspected cases of abuse or neglect directly to the DPPC. DPPC reviews all complaints and assigns investigation responsibility internally or to DDS or other state agency investigations units. DDS and DPPC developed mandated reporter training required for all staff who work with participants in provider agencies and state operated services.

(115 CMR 5.00: Standards to Promote Dignity (proposed), 9.00: Investigations and Reporting Responsibilities, and 13.00: Incident Reporting)

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Providers are required to inform all participants and families of their right to be free from abuse and neglect and to whom they should report allegations of abuse, neglect or exploitation. Participants and their families are given the information both in written and verbal formats. Service coordinators also inform participants about how to report alleged cases of abuse or neglect and, upon request, assist a participant to make a report. Quality Enhancement surveyors who conduct licensure and certification reviews check to ensure participants and guardians received information regarding how to report suspected instances of abuse or neglect and that the information is imparted in a format appropriate to the participant's or family's learning style.

As part of its on-going commitment to preventing and reporting abuse, neglect or exploitation, DDS partnered with self- advocacy groups such as Massachusetts Advocates Standing Strong to support "Awareness and Action," a training program taught by and for self-advocates regarding how to prevent and report abuse. DDS also is a partner with a private provider as part of a Robert Wood Johnson grant to train self-advocates in self-defense and to support providers to create a culture of zero tolerance for abuse and neglect.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

As described in G-1(b), DDS employs two distinct processes for reviewing events, one for incidents (classified as minor or major) and one for reporting of suspected instances of abuse, neglect or exploitation. A minor or major incident may also be the subject of an investigation, but the processes are different and carried out by different entities. The processes are described below.

Minor and major incidents are reported by the staff person observing or learning of the incident. A major incident is immediately reported verbally to the service coordinator in the DDS area office. The incident is entered into HCSIS. A major incident must be reported in HCSIS within 1 business day; a minor incident within 3 business days. Service coordinators review Initial reports, both major and minor, to ensure immediate actions have been taken to protect the participant, if necessary. A final report containing follow-up action steps is submitted to DDS by the provider. Major incidents are automatically referred to the designated regional office staff for review. The final report must be agreed upon by both the provider and DDS. If DDS does not concur with the action steps, the provider is directed to take different or additional action and to resubmit the report. Incident reports are closed only after there is consensus among DDS and the provider as to the action steps taken and all required reviews and approvals have been completed. A similar process is in place for response to incidents involving medication occurrences and restraint utilization. In the event of a medication occurrence, the review is completed by the regional Medication Administration Program (MAP) coordinator, who is a registered nurse. Restraints are reviewed by service coordinators and regional human rights specialists.

Allegations of abuse or neglect are reported as complaints to the Disabled Persons Protection Commission (DPPC). DPPC receives and reviews all complaints and determines whether a reported event meets the definition of abuse as defined in its enabling statute, M.G.L. c.19C. DPPC investigates such complaints or refers them for investigation to the DDS Investigations Unit. As appropriate, complaints are also reviewed by law enforcement and referred for criminal investigation.. DDS also investigates or conducts administrative reviews of allegations of abuse or neglect of participants served by DDS who are not within the statutory authority of DPPC, for example, adults with intellectual disability over the age of 59 in accordance with 115 CMR 9.00. When necessary, immediate protective services are provided to ensure a participant is safe while an investigation is completed. Investigators have 45 days to complete assigned investigations and issue a report to the regional director. Upon request, investigation reports are available in accordance with applicable privacy laws. Completed investigations are referred to area office complaint resolution teams (CRT) comprised of DDS area staff and community members. CRT develop an action plan and ensure the recommended actions are completed.

In addition, the Human Rights Committee (HRC) for the provider agency is a party to all complaints regarding that agency and assists participants to ensure that his or her rights are protected.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

MassHealth and DDS are parties to an Interagency Service Agreement which provides that DDS will, among other things, perform functions related to operation of the waiver, including ensuring providers comply with contractual obligations and DDS regulations and policies concerning reporting and responding to incident reports and complaints of participant abuse, neglect or exploitation. DDS has responsibility for oversight of the incident reporting system (HCSIS) and reporting of and responding to reported incidents. DDS and DPPC have responsibility of reporting and responding to complaints of abuse, neglect or exploitation.

Oversight of the incident management system occurs on three levels- the participant, the provider and the system. Incidents are reported by provider and DDS staff according to clearly defined timelines. HCSIS generates a variety of standard management reports that allow for tracking of timelines for action and follow up and patterns and trends by participant, location,

provider, area, region and state. Service coordinators are responsible for assuring that appropriate actions have been taken and followed up on. On a provider level, program monitors in area offices track patterns and trends by location and provider. On a systems level, area directors, regional directors and central office senior managers track patterns and trends in order to make service improvements. Data from the incident management database are incorporated into the annual standard contract review with providers and performance based objectives. Licensure and certification staff review incidents and provider actions when they conduct their surveys.

A central office risk management committee reviews all incident data on a system wide basis. The committee meets as needed and reviews and analyzes systemic reports generated about specific incident types. The Office of Quality Management (OQM) through from the Center for Developmental Disabilities Evaluation and Research (CDDER) disseminates quarterly reports to each area and regional office detailing the numbers and rates of specific incidents and monthly "trigger" reports, based upon 10 threshold criteria. The reports provide an additional safeguard for participants by providing a method for assuring that area offices have taken appropriate action in response to incidents identified in the monthly and trigger reports and follow up on potential patterns and trends.

In addition the Office of Quality Management (OQM) conducts a bi-weekly review of "key incidents," i.e., incidents involving the criminal justice system, accidents resulting in death or significant community disruption, and issues a report to Regional Risk Managers and Senior DDS management staff, including the Commissioner.

DDS and DPPC have responsibility of reporting and responding to complaints of abuse, neglect or exploitation. As noted above, allegations of abuse or neglect are reported as complaints to the Disabled Persons Protection Commission (DPPC). DPPC receives and reviews all complaints and determines whether a reported event meets the definition of abuse as defined in its enabling statute, M.G.L. c.19C. DPPC investigates such complaints or refers them for investigation to the DDS Investigations Unit. As appropriate, complaints are also reviewed by law enforcement and referred for criminal investigation. DDS also investigates or conducts administrative reviews of allegations of abuse or neglect of participants served by DDS who are not within the statutory authority of DPPC, for example, adults with intellectual disability over the age of 59 in accordance with 115 CMR 9.00. When necessary, immediate protective services are provided to ensure a participant is safe while an investigation is completed. Investigators have 45 days to complete assigned investigations and issue a report to the regional director. Upon request, investigation reports are available in accordance with applicable privacy laws. Completed investigations are referred to area office complaint resolution teams (CRT) comprised of DDS area staff and community members. CRT develop an action plan and ensure the recommended actions are completed.

The DDS Director of Risk Management reviews all major incidents and reviews a sample of DPPC reports. In addition, on a quarterly basis, a random sample of "trigger" reports are selected for quality assurance review by the Central Office Director of Risk Management and the Regional Risk Managers. The sample gets reviewed to determine whether action was taken, whether the actions were consistent with the nature of the incident and whether additional actions are recommended.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints ***(select one):(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)***

○	**The state does not permit or prohibits the use of restraints** Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:
■	**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

This section describes the safeguards contained in the proposed amendments to DDS regulations pertaining to the use of restraints and current practice. DDS anticipates final promulgation of regulations will occur in March 2018, prior to the expiration of the current waiver cycle.

Use of restraint is only permitted in cases of emergency, i.e. the occurrence of serious self-injurious behavior or physical assault or the substantial risk of serious self-injurious behavior or physical assault. Restraints may only be used after the failure of less restrictive alternatives or when a participant is placing him or herself at risk of imminent danger and there is insufficient time to de-escalate the participant and maintain a safe environment. Restraint techniques are limited to those contained in a DDS approved crisis prevention, response and restraint curricula; administered by persons trained in the specific restraint utilized; and may only be used for the period of time necessary for the a participant to regain control, but in no event may the duration of a restraint exceed 60 minutes. Staff are required to observe and monitor participants in restraint including the ability to see and communicate with the participant; in the event a participant in a restraint is observed to be in distress or injured, the restraint must be terminated and medical attention obtained for the participant. The use of a restraint that is not contained in an approved curricula or is administered by an untrained staff person must be reported to DDS as an incident and, if there is reasonable cause to believe serious physical injury or serious emotional injury resulted or that there was a serious risk of harm to a participant, reported to the Disabled Persons Protection Commission. (abuse or mistreatment).

As an additional safeguard, an intervention strategy must be developed in the event a participant is subject to frequent restraints, defined as more than one time within a week or two times within a month, the development of a behavior safety plan, prepared by a qualified clinician. The behavior safety plan specifies observable criteria for severe, unsafe behavior, termination criteria and maximum duration, the type of restraint as approved by the specific curriculum used by the organization, data collection, and additional safeguards.

Restraint debriefings with staff administering or present during a restraint and, a separate debriefing with the participant, are required within 72 or 24 hours after the restraint occurred, respectively.

The completion of a restraint form is required for every restraint of a participant. Providers utilize HCSIS to report, among other things, the name of the participant subject to the restraint, a description of any less restrictive alternatives utilized before the restraint was ordered, the date and time, the name of the person applying the restraint, the nature of the restraint, a description of the emergency situation necessitating the use of restraint, the duration of the restraint, any injuries which may have occurred during the restraint.

Each instance of a restraint is reviewed by a restraint manager, who is designated by the provider. The restraint manager analyzes information concerning each restraint to ensure its use was consistent with DDS regulations, including confirming an emergency precipitated the restraint and that the restraint was the least restrictive way in which to mitigate the emergency. When necessary due to a medical or psychological problem, a Crisis Prevention Response and Restraint (CPRR) Individual Modification Plan is required in order to modify a restraint technique contained in a DDS approved CPRR curriculum, in order to ensure the safety of participants.

The Commissioner or her designee and the provider's human rights committee reviews all restraint forms. 115 CMR 5.00: Standards to Promote Dignity (Crisis Prevention Response and Restraint) (Proposed)

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DDS is responsible for overseeing the use of restraints and ensuring safeguards concerning their use are followed. Information contained in this section includes summary of proposed amendments to DDS regulations pertaining to the use of restraints. DDS anticipates final promulgation of regulations will occur in March 2018, prior to the expiration of the current waiver cycle. Oversight occurs on the participant, provider and systems levels.

Providers, including DDS, are mandated to complete a restraint report in every instance that a restraint is utilized. Providers utilize HCSIS to report, among other things, the name of the participant subject to the restraint, a description of any less restrictive alternatives utilized before the restraint occurred, the date and time, the name of the person applying the restraint, the nature of the restraint, a description of the emergency situation necessitating the use of restraint, the duration of the restraint, any injuries which may have occurred during the restraint. Within 3 calendar days of the restraint, the completed restraint report is available for review by the restraint manager, who is designated by the provider. The restraint manager completes a written review of the restraint and the restraint report and submits this to the DDS area office within 5 calendar days of the restraint.

Restraint debriefings with staff administering or present during a restraint and, a separate debriefing with the participant, are required within 72 or 24 hours after the restraint occurred, respectively.

As noted above, the restraint report and the restraint manager's review is forwarded to the DDS area office for review and written comments by the participant's Service Coordinator.

The DDS Regional Human Rights Specialist, also reviews the reports and comments on a sample of the reports to ensure restraints are properly reported.

On at least a quarterly basis, the restraint reports are reviewed by the provider's Human Rights Committee. The committee reviews all applicable data, considers all less restrictive alternatives to restraint and monitors the use of restraint by the provider or specific location. The results of the review are documented and included in the restraint report in the Human Rights Committee Review section.

An intervention strategy must be developed in the event a participant is subject to frequent restraints, defined as more than one time within a week or two times within a month. The development of a behavior safety plan, prepared by a qualified clinician, describing the plan for a rapid response to the severe behavior of a participant. The behavior safety plan is a separate document specifying observable criteria for severe, unsafe behavior (circumstances under which restraints may be used to ensure safety), termination criteria and maximum duration, the type of restraint as approved by the specific curriculum used by the organization, data collection, and additional safeguards.

Restraint debriefings with staff administering or present during a restraint and, a separate debriefing with the participant, are required within 72 or 24 hours after the restraint occurred, respectively.

Quarterly and Annual restraint management reports are generated by the DDS Office for Human Rights (OHR). The reports detail patterns and trends with respect to numbers of restraints utilized, type of restraint, duration of restraint, and numbers of restraints per person. OHR produces a quarterly report of participants experiencing 10 or more restraints in a 3 month period. The report contains a brief narrative pertaining to each participant describing the circumstances leading to the use of restraints, the measures which are being tried to address the issues and recommendations pertaining to follow-up. DDS Human Rights staff consult with provider Restraint Managers and DDS Service Coordinators regarding each participant identified in the report to ensure it contains current and accurate information, to facilitate regular communication between DDS and providers regarding participants who require restraints and to follow-up regarding recommendations. Information in the reports is utilized by DDS Area and Regional Directors and Regional Risk Managers to work with providers on programmatic and clinical interventions to mitigate the use of restraints.

The Director of the DDS Office of Human Rights produces annual restraint reviews of all data, including longitudinal studies of participants experiencing a high number of restraints, statewide and regional data, and restraint data from DDS service providers to analyze patterns and trends for the purpose of reducing the necessity and/or use of restraints.

Practices of provider agencies with respect to staff training, human rights committee review, and internal safeguards with respect to restraint utilization are reviewed as part of the licensure and certification process. Licensure activities including review and analysis of reports generated by HCSIS to ensure only an approved restraint training curriculum, describe in Appendix G-2, a.(i), is being utilized and restraint report submissions are timely.

115 CMR 5.00: Standards to Promote Dignity (Crisis Prevention Response and Restraint) (Proposed)

b. Use of Restrictive Interventions

○	**The state does not permit or prohibits the use of restrictive interventions** Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
■	**The use of restrictive interventions is permitted during the course of the delivery of waiver services.** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Information contained in this section includes summary information contained in proposed amendments to DDS regulations pertaining to the use of restrictive interventions, access to other individuals, etc. DDS anticipates final promulgation of regulations will occur in March 2018, prior to the expiration of the current waiver cycle.

Restrictive procedures may be permitted only after positive approaches have been utilized and only in conjunction with an intensive positive behavior support plan and with consent of the participant or guardian, if applicable. Restrictive procedures contained in a positive behavior support plan are subject to peer review committee (PRC). PRC comments must be addressed of the prior to implementation, except in an emergency. Behavior support plans containing restrictive procedures also are subject to human rights committee (HRC) review prior to implementation. Human rights committee comments must be addressed prior to implementation of the plan and HRC review and monitoring will occur upon the introduction of a new restrictive procedure or upon a schedule developed based upon data review.

Plans containing restrictive procedures must focus on alternative strategies, may be permitted only after positive approaches have been utilized. Restrictive procedures may include: involuntary time out (considered a restraint and is subject to applicable reporting requirements), overcorrection, response cost, response blocking to prevent a maladaptive behavior from occurring that typically requires a visible motor response; and protective devices used to prevent risk of harm during self-injurious behavior.

DDS proposed regulations expressly prohibit the use of corporal punishment; noxious, unpleasant, uncomfortable or distasteful stimuli; chemical restraint; forced exercise; seclusion, or locking a participant alone in a room; the locking of exits from buildings, except in accordance with 115 CMR 5.04 and 42 CFR 441.301(c)(4); prone restraint: any physical restraint causing pressure or weight on the lungs, diaphragm or sternum causing chest compression or restricts the airway, or basket hold in a seated position on the floor; removing, withholding, or taking away money; denial of a nutritionally sound diet including withholding of a meal; denial of adequate bedding or clothing.

Behavior support plans must be designed and written by a qualified clinician; describe procedures for preventing a problem from occurring and ongoing monitoring of participants to ensure treatment integrity; behavior support plans focus on alternative strategies that address participant's needs and provide meaningful choices; document such strategies, including, that consideration was given to eliminating, reducing or minimizing antecedents or environmental conditions causing or exacerbating challenging behavior by making environmental modifications; emphasizing teaching or strengthening effective replacement behaviors and reinforcing incompatible behaviors serving the same function as and replace the identified challenging behavior(s); implementing a formal skill acquisition plan and data collection procedure in order to assess the effectiveness of skill acquisition activities; increasing monitoring of all aspects of the plan; and, initiating more frequent or external reviews of data to ensure treatment integrity.

Plans containing restrictive procedures may not be implemented until other behavior support strategies have been implanted with integrity and data have shown them to be insufficient to effect meaningful change. A functional behavior assessment is required prior to the development of a plan containing restrictive procedures.

To further the goal of promoting the welfare and dignity of participants, the Department established the principles, including, DDS supports are provided in a manner that promotes human dignity, self- determination and freedom of choice to the participant's fullest capacity, the opportunity to live and receive supports in the least restrictive and most typical setting possible and the opportunity to engage in activities and styles of living that encourage and maintain community integration. DDS has stringent regulations, standards and policies pertaining to the use of restrictive interventions. Any restriction of telephone or internet use must be based upon a demonstrable risk, documented in the participant's record, reviewed by the provider's human rights committee and is required subject to a training plan to eliminate the need for the restriction, documented in the participant's ISP, and should be included in a PBSP if clinically required.
Restrictions on visitation require a modification of the participant's ISP, subject to regulatory criteria and appeal, and review at by the provider's human rights committee.

Health-related supports may be used only to achieve proper bodily position and balance, to permit the participant to actively participate in ongoing activities without the risk of physical harm from those activities, to prevent re-injury during the time an injury is healing, or to prevent infection of a condition for which the participant is being treated, or to enable provider staff to evacuate a participant who is not capable of evacuation. Devices providing such support include, but are not limited to, orthopedically prescribed appliances, surgical dressings and bandages, protective helmets, and supportive body bands. Health-related protective equipment may be used during a specific medical or dental procedure for a participant's protection during the time he or she is undergoing treatment or to prevent injury for an ongoing medical condition; for example, the use of a helmet for drop seizures, and may only be used when ordered by physician, dentist, physician assistant, or a nurse practitioner.

Health-related protective equipment used to prevent risk of harm during challenging self-injurious behavior; for example, a helmet or arm splints, may only be used when authorized by a qualified clinician. Protective equipment used to prevent risk of harm during self-injurious behavior may only be used as part of a behavior support plan and is subject to human rights committee review. Health-related supports and protective equipment cannot not be used for the convenience of staff.

(115 CMR 5.00: Standards to Promote Dignity) (proposed)

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DDS is responsible for monitoring and oversight of restrictive interventions. In addition to the reviews by the ISP team, human rights committees, and peer review committees, the use of restrictive interventions is monitored in the following ways:

- Service coordinators conduct bi- monthly site visits of homes providing 24 hour supports and quarterly visits of homes providing less than 24 hour supports. As part of the visit, service coordinators monitor participants, including incident reports.
- Licensure and certification staff conduct extensive review of ISPs and behavior plans and review interventions identified therein in order to ensure that all the necessary reviews have been completed confirming they have been implemented in accordance with DDS regulations, staff is trained, and documentation is properly maintained and periodically reviewed. Licensure staff will cite areas of concern in reports to providers in the event they identify that any of the above requirements have not been met. Follow up will be conducted by licensure and certification staff.
- Aggregate data regarding the review, approval and monitoring of interventions collected during the licensure and certification process is included in quality reports and subject to review by the statewide quality council for the identification of patterns and trends.
- Any instance of serious physical injury or death of a person is immediately reported in HCSIS and to the Commissioner or designee for review and follow up.
- Restrictive interventions are reviewed by a participant's ISP Team, which includes DDS service coordinators. The ISP team reviews the proposed restrictions and ensures they are appropriate.
- Restrictive interventions reviewed by the Provider's Human Rights committee. Minutes from the Human Rights Committee meetings are reviewed by DDS Human Rights Specialists. In addition, the Specialists attend at least one meeting per year of each Human Rights Committee to insure that they are run correctly, and to offer feedback regarding any improvements that could be made.
- Any individual, family member, provider or DDS employee may seek guidance from the DDS Office for Human Rights in the event he or she has any concerns regarding the plan or its implementation.
- The DDS Office for Human Rights provides training and educational materials to participants and their families regarding restrictive interventions, their rights to participate in the development of any plan and to withhold consent if they do not agree with the plan.

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:

Information contained in this section includes content contained in proposed amendments to DDS regulations pertaining to the use of seclusion. DDS anticipates final promulgation of regulations will occur in March 2018, prior to the expiration of the current waiver cycle.

Department regulations prohibit the use of seclusion with participants; therefore, any use of seclusion is unauthorized and is subject to reporting as an incident or to the Disabled Persons Protection Commission.

Service coordinators conduct bi-monthly site visits of homes providing 24 hour supports, quarterly visits of homes providing less than 24 hour supports, and regular visits to day programs. Service Coordinators and DDS Program Monitors make observations, and speak with participants and staff and review incident data (HCSIS) in order to determine if unauthorized use of seclusion has occurred at a program site.

	(115 CMR 5.00: Standards to Promote Dignity, (proposed) 9.00: Investigation and Reporting Responsibilities; 13.00: Incident Reporting)
○	**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 G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○	**No**. **This Appendix is not applicable** *(do not complete the remaining items)*
■	**Yes**. **This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The responsibility for monitoring medication regimens is a joint one between providers and DDS staff (specifically, service coordinators, area office nurses, Regional Medication Administration (MAP) coordinators and the ISP team). An electronic Health Care Record for participants is maintained by providers and DDS service coordinators and updated for purposes of the annual ISP. The health care record includes a list of all medications and dosages the participant is taking. The list of medications is reviewed by the ISP team, and available to primary health care providers. Provider agency and DDS staff monitor the use of medication and side effects on an on-going basis. DDS area office nurses are available for consultation and to answer questions about medications from providers and DDS staff . Direct support professionals are educated about the side effects of the specific medications participants they are supporting are taking, and report any issues to the appropriate supervisory or consultant personnel.

Medication used to manage or treat behavioral symptoms may be administered subject to regulatory requirements, including, consent by the participant or guardian. A participant receiving medication to manage or treat behavioral symptoms must have a behavior support plan and a medication treatment plan specifying the goals and safeguards related to such treatment information including, but not limited to: a description of the behavioral symptoms to be managed or treated; tracking of all relevant effects of the treatment, including secondary effects such as weight gain or changes in sleep patterns; progress monitoring data concerning the target behavior subsequent to the intervention with the medication used to treat or manage behavioral symptoms; and regular review by the provider.

The administration of medication incidental to treatment requires consent by the participant or guardian and ISP objectives to assist participants to learn to cope with medical treatment in order to reduce or eliminate the need for medication incidental to treatment.

115 CMR 5.00: Standards to Promote Dignity/5.15 (Medication) (proposed)

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Service coordinators maintain regular contact with participants on their caseload and monitor the health status of participants they are supporting. In addition, through its Health Promotion and Coordination Initiative, DDS has created several processes that facilitate the exchange of information regarding health status and medication regimens between the DDS provider and the participant's health care provider. DDS licensure and certification staff conduct an extensive review of the systems and processes that providers have in place to assure coordination, communication and follow up with health care providers on key issues. They also review the level of training and knowledge that direct support professionals have about the health status and medications that the participant is taking (also see information on MAP training and certification below). Aggregate data about health and medication use is reported in the DDS Annual Quality Assurance Report and reviewed by the regional and state quality councils.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

○	Not applicable (*do not complete the remaining items*)
■	**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The state medication administration program (MAP) is implemented by DDS and overseen by the Department of Public Health in accordance with DDS, DPH regulations and MAP Policy Manual. The MAP program provides for the registration of locations where medication is administered by non-licensed, certified staff, identifies the requirements about storage and security of medications, defines the specific training and certification requirements for non-licensed staff, and specifies documentation and record keeping requirements.

Community residential programs, day programs and short term site based respite services are required to obtain a site registration from DPH for the purpose of permitting medication administration by MAP certified staff and the storage of medications on site.

Direct support professionals, including licensed nurses working in positions that do not require a nursing license, must be MAP certified in order to administer medications. MAP certification is valid for two years. Staff must be re-certified every two years. In order to be certified, staff must be trained by an approved MAP Training program using the approved training curriculum of a duration not less than 16 hours, including classroom instruction, testing and a practicum. Trainers must be a registered nurse, nurse practitioner, physician assistant, registered pharmacist or licensed physician who meets applicable requirements as a trainer. MAP trained staff must pass a test in order to be certified to administer medications. The initial certification is done by an independent contractor, currently D & S Diversified Technologies.

Training for re-certification may be administered by D & S or by an approved MAP trainer. MAP certified staff and providers must maintain proof of current MAP certification at the program site. An individual's certification may be revoked for cause, after an informal hearing process. A record of revoked certifications is maintained by D & S.

Providers are required to adhere to a strict set of standards with respect to storage of medications, documentation of medication counts at the start and end of each shift, labeling of medications and documentation of medication administration for each participant.

Oversight of the medication administration program is conducted by nurses within provider programs as well as DDS Regional MAP Nurses known as MAP coordinators and the Department of Public Health Clinical Review process.

A participant's ISP team, using an assessment process, may determine that he or she can self-administer medications Self-administering means using medication in the manner directed by a health care provider, without assistance or direction by program or facility staff, in accordance with Department standards. A verbal reminder that the time for taking a dose of medication has arrived or providing mechanical assistance under the direction of the participant is considered self-medication.
If a participant is determined to be capable of learning to self- administer medication, a teaching plan is developed and documented in the ISP. An oversight system is developed with built-in review periods of at least every 3 months for participants who are self-administering. A participant's ability to self- administer is also reviewed in conjunction with the annual ISP process.

115 CMR 5.00: Standards to Promote Dignity/5.15 (Medication) (proposed)
Information contained in this section includes summary of proposed amendments to DDS regulations pertaining to medication administration. DDS anticipates final promulgation of regulations will occur in March 2018, prior to the expiration of the current waiver cycle.

iii. Medication Error Reporting. *Select one of the following:*

■	**Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).** *Complete the following three items:*
	(a) Specify state agency (or agencies) to which errors are reported:
	Providers are required to file medication occurrence reports (MOR) to the Department of Developmental Services through the HCSIS web-based event reporting system. MOR's that involve any intervention by a health care provider are also reported to the State Department of Public Health. Pharmacy errors get reported to the Board of Registration in Pharmacy.
	(b) Specify the types of medication errors that providers are required to *record:*
	Providers are required to record a MOR in all of the following circumstances: anytime a medication is given to the wrong person, the wrong medication is given, a medication is given at the wrong time, a wrong dose is given, a medication is administered through the wrong route, or when the medication is omitted.
	(c) Specify the types of medication errors that providers must *report* to the state:
	All types of medication errors specified in (b) above must be reported to the State.
○	**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.** Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department of Developmental Services has primary responsibility of oversight of the Medication Administration Program for programs funded, licensed or supported by DDS. The Department of Public Health (DPH) also participates in the oversight responsibility. Providers are required to report all medication occurrences in HCSIS within 24 hours of discovery. The HCSIS Medication Occurrence Report (MOR) identifies the person involved, the type of error, the medications involved, the consultant contacted, any medical interventions that were involved, what followed from the intervention and supervisory follow up action taken. Any MOR that involves medical intervention is also reported to the DPH and is defined as an MOR "hot-line" call. All MORs are reviewed and checked for completeness, clarity, and accuracy and finalized by DDS Regional MAP coordinators who are registered nurses. Follow-up by DDS Regional MAP coordinators occurs with providers regarding all MOR hotline calls. The DPH MAP Clinical Reviewer also does their own review of the hotline MORs. Follow- up may be accomplished by telephone or a direct site visit, utilizing a MAP Technical Assistance Tool for the site review.

On an individual level, MOR hotline calls are reviewed by service coordinators and are part of an integrated review of all incidents that pertain to the participant. Program monitors and Area Directors review MOR information as part of the standard contract review process. Licensure and certification staff do a thorough review of both the medication storage and administration records as well as the certification of staff and their knowledge of the medications and their side effects.

Finally, on a systems level, DDS generates quarterly management reports containing aggregated information regarding all medication occurrences. . These reports, detailing the number of medication occurrences including the type and follow up action, are reviewed and analyzed to identify trends and patterns. In addition, the HCSIS medication occurrence data base includes detailed information as to the factors contributing to a medication occurrence. Review of the management reports enable DDS senior staff and Quality Councils to identify service improvement areas and strategies leading to a reduction in the number of medication occurrences. Information pertaining to medication occurrences is shared through training, publication of newsletters and advisories designed to identify steps and strategies providers can use to reduce the number of medication occurrences. Data is also aggregated on an annual basis and incorporated into the DDS Annual Quality Assurance Report, which is reviewed by the regional and statewide quality councils for purposes of identifying and developing service improvement targets.

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-assurances:

a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.
(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

i. **Performance Measures**

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

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

Performance Measure:	HW a7. Percent of providers who conduct CORI's of prospective employees and take appropriate action when necessary. (Number of providers that conduct CORI's of prospective employees and take required action/Total number of providers reviewed.)

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	HW a1. Number and rate of substantiated investigations by type (Number of substantiated investigations by type/ Number of total adults served and rate per 1000 adults)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95%, margin of error +/-5%
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	HW a4. Percent of providers, subject to licensure and certification, that report abuse/neglect as mandated. (Number of providers that report abuse/neglect as mandated by statute/number of providers reviewed.)

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☒ *Other Specify:*
	Semi-annually

Performance Measure:	HW a2. Number of intakes screened in for investigation of abuse where the need for protective services was reviewed by the Area Office/Total

	number of intakes where a review for protective services was recommended by the senior investigator.
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☒ *Other Specify:*
	Semi-annually

	HW a3. Percent of participants receiving services subject to licensure and certification who know how to report abuse and/or neglect (Number of participants receiving services subject to licensure and certification who know how to report abuse and neglect/Number of participants reviewed.)

Data Source *(Select one) (Several options are listed in the on-line application):*
If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☒ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95%, margin of error -/+ 5%
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☒ *Other Specify:*
	Semi-annually

	HW a6. Percent of deaths that are required to have a clinical review that received a clinical review. (Number of deaths that have a clinical review/ Total number of deaths required to have a clinical review.)
Data Source *(Select one) (Several options are listed in the on-line application):*	

If 'Other' is selected, specify:			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

	HW a5. Percent of medication occurrences (Number of medication occurrences (errors) reported/ Number of medication doses administered.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☒ *Other Specify:*
	Semi-annually

Add another Performance measure (button to prompt another performance measure)

b. Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

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

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

Performance Measure:	HW b1. Percent of incident "trigger" reports that have had follow up action taken (Number of incidents that reach the "trigger" threshold for which action has been taken/Total number of incidents that reach the "trigger" threshold that were reviewed.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*
	☐ *Sub-State Entity*	☒ *Quarterly*	☒ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	95%, +/-5% margin of error
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*

	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	HW b2. Percent of substantiated investigations where actions have been implemented. (Number of action plans implemented for substantiated investigations/ Total number of action plans written for substantiated investigations.)

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☒ *Other*

	Specify:
	Semi-annually

Add another Performance measure (button to prompt another performance measure)

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

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

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

Performance Measure:	HW c1. Percent of providers that are in compliance with requirements concerning restrictive interventions (Number of providers that are in compliance with requirements concerning restrictive interventions/ Number of providers reviewed by survey and certification with restrictive interventions.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☒ *Other Specify:*
	Semi-annually

Performance Measure:	HW c2. Percent of participants with high utilization of restraints (10 or more per quarter) whose incidents of restraints have been reviewed by the Director of DDS Office for Human Rights. (Number of participants with high utilization of restraints that have been reviewed/Total number of participants with high utilization of restraints.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☒ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	HW c3. Percent of providers that are in compliance with the requirement to have restraint reports reviewed by that Providers Human Rights Committee within the required timeline. (# of providers that are in compliance with the requirement to have restraint reports reviewed by their Human Rights Committee within the required timeline /Total number of Providers reviewed by License and Certification)

Data Source *(Select one) (Several options are listed in the on-line application):*

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

			■

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
■ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	■ *Quarterly*
☐ *Other Specify:*	☐ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

d. Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

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

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

Performance Measure:	HW d1. Percent of participants who have had an annual physician visit in the last 15 months (Number of participants with a documented physician visit in the past 15 months/ Number of participants reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	☒ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☒ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	Confidence Interval = 95%
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	HW d3. Percent of physicians' orders and treatment protocols followed (Number of participants for whom a treatment protocol/physicians' orders are followed/Number of participants reviewed with treatment protocols/physicians' orders)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*

	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☒ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	Confidence Interval = 95%
		☒ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☒ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	HW d2. Percent of participants who have had an annual dental visit in the past 15 months (Number of participants with a documented dental visit in the past 15 months/Number of participants reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☒ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☒ *Less than 100% Review*

	☐ *Sub-State Entity*	☐ *Quarterly*		■ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*		Confidence Interval = 95%
		■ *Continuously and Ongoing*		☐ *Stratified: Describe Group:*
		☐ *Other Specify:*		
				☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
■ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	■ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

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

b. Methods for Remediation/Fixing Individual Problems

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

The State Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by DDS. In the event problems are discovered with the management of the waiver program processes at waiver service providers or DDS

Area Offices, DDS is responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Further DDS and MassHealth are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii. Remediation Data Aggregation

	Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies)*
■	■ **State Medicaid Agency**	☐ **Weekly**
	☐ **Operating Agency**	■ **Monthly**
	☐ **Sub-State Entity**	■ **Quarterly**
	☐ **Other** Specify:	■ **Annually**
		☐ **Continuously and Ongoing**
		■ **Other** Specify:
		Semi-annually

c. Timelines

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

■	**No**
○	**Yes**

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

Appendix H: Quality Improvement Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- 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.

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 other 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.0827 (Intensive Supports Waiver) and MA.0828 (Adult Supports Waiver). The reporting for all three Adult Waivers is consolidated. 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.

DDS also participates in National Core Indicators which gathers a standard set of performance and outcome measures which is used to track performance over time, compare results across states, and establishes national benchmarks. The data obtained is derived from the entire DDS adult population and helps target and inform system improvement and performance enhancement which then benefits and improves waiver quality and services.

DDS QA Reports 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 primary 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.

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.

Area, region and Provider-specific aggregate data on incidents are 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, aging resources, pressure ulcers, 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 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. By June 2016, all remaining workshops were 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 and available 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:
1)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.
2)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.
3)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 MassHealth and DDS engaged in during the amendment process, we analyzed reporting across several waivers. As determined by that evaluation process and as noted above, we consolidated the reporting for this waiver together with MA.0827 (Intensive Supports Waiver) and MA.0828 (Adult Supports Waiver). Our ongoing evaluation supports the determination 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 continue to 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.

H.2 Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one):*

- o No
- • Yes *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- o HCBS CAHPS Survey;
- • NCI Survey;
- o NCI AD Survey;
- o Other *(Please provide a description of the survey tool used)*:

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) 808 CMR 1.00 requires organizations entering into a contract with the Commonwealth to perform an independent audit and annually submit a Uniform Financial Statement and Independent Auditor's Report to the Executive Office of Administration and Finance's Operational Services Division. These are reviewed by the DDS contracts office annually (for existing/current providers) New providers must submit financial statements for review by the Department before a contract can be executed.

(b) The integrity of the provider billing data for Medicaid payment of waiver services is managed by the Department of Developmental Services' (Department) Meditech operating and claims production system, Home and Community Services Information System (HCSIS) and the Massachusetts Medicaid Management Information System (MMIS). Meditech contains waiver service enrollments, demographic information, the level of care (LOC), the Plan of Care approval, the Medicaid category of assistance (CAT), and assigned service coordinator information for each waiver participant. HCSIS contains service delivery information including service name, frequency and duration of service, and provider, which is included in the Plan of Care (POC/ISP). DDS has access to all data within Meditech and HCSIS, and various checks and balances, including system edits, -are in place to ensure appropriate waiver service claims are submitted to MMIS. MMIS validates waiver service rates and MassHealth eligibility for dates of services claimed as a condition of payment.

Providers submit attendance data through a web-based electronic service delivery report system. On a quarterly basis, the Area Offices sample attendance data and confirm that service data is accurate. The service delivery information provides the documentation necessary for payment to the provider and for development of a claim for the Medicaid Agency.
Providers also maintain original paper source documentation of service delivery. Once DDS Regional staff has approved all monthly or supplemental invoices, the data are matched with rates and with participant waiver eligibility criteria and are submitted by electronic submissions in accordance with procedures mandated by the Commonwealth's Medicaid Management Information System (MMIS). Claim checks are part of the Department's electronic claims processing system to assure that all waiver assurances are met prior to processing. If an individual's Medicaid status has changed, when a submission is processed through MMIS, any claim for dates of services where the individual was not Medicaid eligible is automatically denied.

(c) The Executive Office of Health and Human Services is responsible for conducting the financial audit program.

The MassHealth Program Integrity Unit oversees rigorous post payment review processes that identify claims that are paid improperly due to fraud, waste and abuse. MassHealth maintains an

interdepartmental service agreement with the University of Massachusetts Medical School's Center for Health Care Financing to carry out post-payment review and recovery activities through its Provider Compliance Unit (PCU). MassHealth maintains consistent post-payment review methods, scope, and frequency for self-direction and agency providers.

On a regular basis, PCU runs Surveillance Utilization Review System (SURS) reports to identify aberrant billing practices. MassHealth runs SURS reports and algorithms that examine all provider types such that every provider type is generally being reviewed with a SURS report each year. For example, MassHealth and the PCU run a recurring algorithm that identifies any claims paid for members after their date of death as well as a report that identifies outliers in billing growth by provider type and reports that identify excessive activity, e.g., unusually high diagnosis and procedure code frequencies, by provider as well as "spike" reports that identify providers receiving higher than average payments. On average, MassHealth runs between 30 and 40 algorithms per year and 100 to 120 SURS reports of varying scope (e.g. all provider types, specific provider types, or a single provider) per year. These SURS reports and algorithms are run manually and not on a set schedule. There are no set criteria that must be met prior to MassHealth running particular SURS reports and algorithms.

When MassHealth identifies outliers in SURS reports or algorithms, additional SURS reports or algorithms may be run that are focused on that provider type identifying specific providers with unusual patterns or aberrant practices to enable targeting for additional review, including desk review or on-site audit. Desk reviews and audits are not solely initiated following findings in SURS reports and algorithms and may also be initiated due to a member complaint or a concern raised by the MassHealth program staff.

In addition, MassHealth and PCU regularly develop algorithms that identify duplicative or noncompliant claims for recovery. MassHealth regularly reviews algorithm and SURS report results to identify providers with a large number of noncompliant claims, aberrant billing patterns or excessive billings. Upon discovering such providers, MassHealth and PCU will open desk reviews or on-site audits targeting the provider. The scope and sampling methodology of post-payment reviews will vary from case to case. Algorithms and SURS reports typically review 100% of claims received for a given provider type over a specified timeframe. The sampling process for post-payment review (desk review and on-site audits) entails generating a random sample of all members receiving services over the audit review period. For audits and desk reviews, MassHealth and PCU will perform a random sample of members at a 90% confidence level and review all claims and associated medical records for each member over a specified timeframe (typically 4 to 6 months). A margin of error is calculated and determined only for reviews and audits in which MassHealth intends to extrapolate overpayments based on the findings from the review or audit to the provider's full census. Where extrapolation may be performed, MassHealth and PCU typically pull a sample of 25 members and use the lower 90% confidence interval amount as the extrapolated overpayment amount to be recouped. The margin of error for the extrapolated amount can vary depending upon the total number of members the provider has served during the audit period. Where the provider has served fewer than 25 members over the audit period, MassHealth and PCU will review all of the members and associated claims resulting in a margin of error of +/- 0%.

On average, MassHealth and PCU run between 30 and 40 algorithms and SURS reports to identify recoveries as well as target providers for desk reviews and on-site audits. Because SURS reports and algorithms do not always identify providers exhibiting aberrant billing behavior, and because member complaints or program staff concerns are raised on an ad hoc basis, there is no scheduled number of desk reviews or on-site audits to be conducted on a year-to-year basis. When MassHealth identifies findings through SURS reports and algorithms, it is MassHealth practice to conduct a desk review or on-site audit within one month.

As part of its post-payment review activities, MassHealth and PCU regularly carry out desk reviews and on-site audits of providers. When initiating a provider desk review, auditors will request medical records, including individualized plans of care, for a sample of MassHealth members receiving services from the provider and compare them against claims data to ensure all paid claims are supported by accurate and complete documentation. As part of on-site audits, MassHealth and PCU develop an audit scope document that identifies specific regulatory requirements to be reviewed. Based on this scope, PCU will develop an audit tool to record the auditors' findings related to compliance or noncompliance of each regulatory requirement being reviewed. During their on-site visit, auditors will collect medical records for a sample of members to review for completeness and accuracy. Finally, to verify that services were rendered, auditors will visit a random sample of member homes, interview the members, and observe living conditions to ensure services are rendered consistently with each member's plan of care. The sampling process for home visits is to select a random sample of three to five members.
MassHealth and PCU select a smaller sample size for home visits than for desk reviews due to the logistics of conducting on-site audits within a two to three day timeframe.

Upon completion of an on-site audit or desk review, MassHealth will review the findings of noncompliance, if any, with regulatory requirements and determine whether to issue a notice of overpayment or sanction to the provider, depending on whether the provider was found in violation of applicable regulatory requirements. The notice of overpayment or sanction identifies and explains each instance of noncompliance, and notifies the provider of the associated sanctions and identifies the related overpayments. Within the notice, the provider receives the detailed results of the audit review, including lists of each regulatory requirement, the description of the provider's noncompliance, and the associated sanction or overpayment amount. On a case-by-case basis, MassHealth may meet with the provider to review the audit findings and discuss the appropriate corrective actions.

Providers have the opportunity to appeal MassHealth's determination of sanction or overpayment and dispute the related findings. While the appeal is processed, MassHealth will withhold the identified amount of identified overpayments or impose sanctions of administrative fines from future payments to the provider. If the sanctions or overpayment determinations are not appealed, MassHealth will work with the provider to establish a payment plan where a percentage of the overpayment amount is withheld from future payments of the provider's claims until the entire balance of the overpayment or sanction of administrative fines have been recouped.

As a result of a desk review or on-site audit, MassHealth may also require the provider to submit a plan of correction and may identify the provider to be re-audited after a specified period of time (e.g., 6 months) to ensure corrections are made.

Unlike desk reviews and on-site audits where reviewers are manually reviewing claims for a sample of members over a four to six month time period, algorithms and SURS reports generally look back over a longer timeframe up to five years for all claims associated with one or more provider types.

In addition to the activities described above, MassHealth maintains close contact with the Massachusetts Attorney General's Medicaid Fraud Division (MFD) to refer potentially fraudulent providers for MFD review and to ensure MassHealth is not pursuing providers under MFD's review.

The Commonwealth also conducts an annual Single State Audit that includes sampling from the Department's waiver(s) service claims. The Audit reviews contract and Quality Enhancement certification documents; Plans of Care, Choice and Level of Care documents; service delivery data, claims and payment records. As necessary the Department can establish an audit trail including the

point of service, date of service, rate development, provider payment status, claim status, and any other waiver related financial information. KPMG is the contractor that performs the Single State Audit for the Commonwealth of Massachusetts.

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability Assurance**
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-assurances:

a Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:	FA a1. Percent of submitted service claims that were coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Numerator: The number of service claims that were coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Denominator: Total service claims submitted.
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☑ *Other Specify:*	☑ *Annually*
UMASS Revenue Unit	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	FA a2. Percent of submitted FMS service claims that were approved and paid at the appropriate rate and in accordance with the plan of care. Numerator: The number of FMS service claims that were approved and paid at the appropriate rate and in accordance with the plan of care. Denominator: Total number of claims filed with the FMS.
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☒ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☒ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☒ *Other Specify:*	☐ *Annually*	
	Financial Management Service	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☒ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☒ *Other Specify:*	☒ *Annually*
Financial Management Service	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

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

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

Performance Measure:	FA b1. Services are coded and paid for in accordance with the reimbursement methodology specified in the waiver application. (Numerator: number of services with rates derived from and consistent with rate regulations. Denominator: Number of services for which claims were submitted.)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☐ *Annually*	
		☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☑ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other Specify:*	☑ *Annually*

	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

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

b. Methods for Remediation/Fixing Individual Problems

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

The State Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by DDS. In the event problems are discovered with the management of the waiver program processes at waiver service providers or DDS Area Offices, DDS and MassHealth are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Further, MassHealth and DDS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	■ **State Medicaid Agency**	☐ **Weekly**
	☐ **Operating Agency**	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other** Specify:	■ **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

c. **Timelines**

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

■	**No**
○	**Yes**

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

APPENDIX I-2: Rates, Billing and Claims

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

EOHHS is required by state law to develop rates for health services purchased by state governmental units, and which includes rates for waiver services purchased under this waiver. State law further requires that rates established by EOHHS for health services must be "adequate to meet the costs incurred by efficiently and economically operated facilities providing care and services in conformity with applicable state and federal laws and regulations and quality and safety standards and which are within the financial capacity of the commonwealth." See MGL Chapter 118E Section 13C. This statutory rate adequacy mandate guides the development of all rates described herein.

In establishing rates for health services, EOHHS is required by statute to complete a public process that includes issuance of a notice of the proposed rates with an opportunity for the public to provide written comment, and EOHHS is required to hold public hearing to provide an opportunity for the public to provide oral comment. See MGL Chapter 118E Section 13D; see also MGL Chapter 30A Section 2. The purpose of this public process is to ensure that the public (and in particular, providers) are given advance notice of proposed rates and the opportunity to provide feedback, both orally and in writing, to ensure that proposed rates meet the statutory rate adequacy requirements noted above.

All rates established in regulation by EOHHS are required by statute to be reviewed biennially and updated as applicable, to ensure that they continue to meet the statutory rate adequacy requirements. See MGL Chapter 118E Section 13D. In updating rates to ensure continued compliance with statutory rate adequacy requirements, a cost adjustment factor (CAF) or other updates to the rate models may be applied.

Additional information on the rate development for waiver service follows.

1. For waiver services where there is a comparable EOHHS Purchase of Service (POS) rate, the waiver service rate was established in POS regulation after public hearing pursuant to MGL Chapter 118E, Section 13D. All POS rates were established in regulation pursuant to this statutory requirement. POS rates are developed using Uniform Financial Reporting (UFR) data submitted to the Massachusetts Operational Services Division, in accordance with UFR reporting requirements under 808 CMR 1.00: Compliance, Reporting and Auditing for Human and Social Services. EOHHS uses UFR data to calculate rates that meet statutory adequacy requirements described above. No productivity expectations and administrative ceiling calculations were used in establishing these rates. UFR data demonstrates expenses of providers of a particular service for particular line items. Specifically, UFRs include line items such as staff salaries; tax and fringe benefits; expenses such as training, occupancy, supplies and materials, or other expenses specific to each service; and administrative allocation. EOHHS uses these line items from UFRs submitted by providers as components in the buildup for the rates by determining the average for each line item across all providers. EOHHS uses the most recent complete state fiscal year UFR available to determine the average across providers of that

service for each line item, which are then used to build each rate. The waiver service rate is set at the comparable POS rate for the following waiver services:
-Assistive Technology, evaluation and training component (set in accordance with 101 CMR 423.00: Rates for Certain In-Home Basic Living Supports)
- Behavioral Supports and Consultation, Family Training, Peer Support, and Respite (set in accordance with 101 CMR 414.00: Rates for Family Stabilization Services)
-Community Based Day Supports (set in accordance with 101 CMR 415.00: Rates for Community-Based Day Support Services)
-Day Habilitation Supplement (set in accordance with 101 CMR 424.00: Rates for Certain Developmental and Support Services)
-Group Supported Employment and Individual Supported Employment (set in accordance with 101 CMR 419: Rates for Supported Employment Services)
-Individualized Home Supports (set in accordance with 101 CMR 423.00: Rates for Certain In-Home Basic Living Supports)
-Residential Habilitation (set in accordance with 101 CMR 420.00:Rates for Adult Long-Term Residential Services)
-Stabilization (set in accordance with 101 CMR 412.00: Rates for Family Transitional Support Services)
-Remote Supports and Monitoring (RSM) (set in accordance with 101 CMR 426.00: Rates for Certain Adult Community Mental Health Services) RSM is reimbursed on a two-tiered rate, based on the level of intensity of service that is required by the participant and to prevent duplication of payments. Determination of intensity is based on an individual evaluation and also takes into account factors that include other services the participant receives, natural supports, and level of technology needed. An assessment is conducted to determine whether a participant needs additional equipment to interface with the standard RSM equipment and call center. The state reimburses the higher tier rate for participants who require this additional Assistive Technology equipment, because that extra equipment and its interface with the standard RSM equipment and call center is associated with higher clinical needs and accompanied by additional RSM staff time. The state reimburses the lower tier rate for participants who do not require this additional Assistive Technology equipment. The two rate tiers are informed by model staffing ratios for the remote monitoring center and the costs of monitoring center equipment and infrastructure. The monitoring center costs are fixed between the two tiers, but the staffing ratio and infrastructure assumptions increase in the higher tier to reflect the individual's higher needs

2. Agency-based, per-trip transportation services: MA has a coordinated statewide Human Service Transportation (HST) brokerage system with six Regional Transit Authorities brokering and managing consumer trips throughout the state. Brokers arrange transportation by subcontracting with local qualified transportation providers. Work volume for transportation providers can be as limited as occasional trips for mid-day medical appointments to long-term, multiple days a week, route-structured program services. For Demand-response trips, contracted providers will be awarded trips on a daily basis based on lowest price, availability and prior performance. Program-Based trips for a specific destination, frequency and time, usually operating on a daily or regularly scheduled basis were procured for a five-year period beginning July 1, 2015. Additional routes are added as needed. Contracts are awarded based on lowest price, availability and prior performance.

3. Self-directed services with employer authority are paid through the Fiscal Employer Agent at rates within an established range of payment. Participants may determine staff wages within the established range, with the minimum rate at the state's minimum wage and the maximum set as the agency provider rate for the service. These limits apply to wages for the following self-directed waiver services:

- Adult Companion and Chore(maximum rates set in accordance with 101 CMR 359.00)
- Behavioral Supports and Consultation, Family Training, Peer Support, and Respite (maximum rates set in accordance with 101 CMR 414.00)
- Individualized Home Supports (maximum rate set in accordance with 101 CMR 423.00)
- Individual Supported Employment (maximum rate set in accordance with 101 CMR 419.00)

4. For waiver services in which there is no comparable Medicaid state plan or EOHHS Purchase of Service (POS) rate, the waiver service rate was established in regulation after public hearing pursuant to Massachusetts General Laws Chapter 118E, Section 13D, and as described below. This approach applies to the following waiver services as described below.

- Rates for Adult Companion and Chore are set in accordance with 101 CMR 359.00: Rates for Home and Community Based Services Waivers and were established based on data for comparable services provided through the Executive Office of Elder Affairs Home Care Program, the largest purchaser of these services. The most current data for SFY 2016 was used, and rates were adjusted to the median rate paid for each of these services under the Home Care Program. The Home Care Program provides MA elders with long term services and supports that enable them to live in the community. The Home Care Program includes participants in the Frail Elder Waiver and those served at state cost. The median of contracted service prices excluding the outliers was found for each service. Outliers were removed for any pricing that was 2 standard deviations away from the mean. This median is used as the rate for Chore. For Adult Companion, however, the methodology yielded a median slightly lower than the previously established rate for this service, and therefore the previous Adult Companion rate was maintained. The methodology and data sources used in this analysis were consistent with the method used in past analysis, using SAS statistical software.

5. Purchase of goods as waiver services are paid according to the cost of the good. For services that are self-directed, payments for purchase of goods are made through the FEA/FMS and purchased through a self- directed budget. This approach applies to the following waiver services:
- Assistive Technology devices
- Home Modifications
- Individual Goods and Services
- Specialized Medical Equipment and Supplies
- Transitional Assistance
- Transportation – transit passes only
- Vehicle Modification

For the purchase of goods as waiver services made through a qualified waiver provider, payments for purchase of goods are made directly by the qualified provider and authorized through the waiver plan of care. This approach applies to the following waiver service:
- Assistive Technology devices

6. Other self-directed services in which there is no comparable Medicaid state plan or EOHHS Purchase of Service (POS) rate are established as described below, specific to the following waiver services:

- Rates for Live-In Caregiver are developed and updated annually by DDS based on regional and population-based HUD Fair Market Rent (FMR) and USDA average moderate food cost data, respectively, with a multiplier adjusted to assure individuals are able to obtain fair

market value apartments in their chosen town. Additional details can be found Main Module, B. Optional.

- Self-directed, per-mile Transportation is paid in accordance with the IRS standard mileage rate.

- Individualized Day Supports are paid through the Fiscal Employer Agent (FEA/FMS) at rates determined by the participant. The minimum that may be paid is the state's minimum wage, while the maximum is determined by the participant within their individual self-directed budget limit.

All costs that are not eligible for federal financial participation, such as room and board, are excluded from the rate computation. EOHHS establishes the rates for all waiver services that are the basis for the draw of federal funds and claiming of these expenditures on the CMS-64. The rates are presented at a public meeting scheduled by EOHHS and upon approval are entered into the Meditech system and MMIS.

DDS negotiates contracts with service providers and pays providers at the regulated rates of payment. For services with multiple payment rates, claims for FFP are submitted at a provisional rate equal to the average of the contract rates for each service. At the end of each waiver year a final rate is established for each service based on the total costs for and utilization of each waiver service. Claims are then adjusted to account for any differences between the provisional and final rate.

Information about payment rates is available on the DDS website and is shared by service coordinators with waiver participants at the time of the service planning meeting.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

There are two types of billings for waiver services: Service Provider billings and billings for Self-Directed services through the Fiscal Employer Agent (FEA/FMS).

Provider billings:
Attendance data is submitted by service providers through the Enterprise Invoice Management System (EIM), a web based electronic service delivery documenting and invoicing system. DDS's Regional staff review dates of service information for all individuals. On a quarterly basis, the Area Office samples attendance records to confirm that data is accurate.

The data is matched with rates and participant waiver eligibility criteria and submitted by electronic submission in accordance with procedures mandated by the Commonwealth's Medicaid Management Information System (MMIS).

When a submission is processed through MMIS, any claim for dates of service where the individual was not Medicaid eligible is automatically denied.

Self-Directed Services:
The state's contract with Public Partnerships, Limited (PPL), the FEA/FMS effectuates direct billing for self-directed providers; i.e., when a provider bills through the FEA/FMS, the billing is considered direct to the Medicaid Agency as follows: self-directed providers bill through and are

paid by the FEA/FMS, which acts as the agent of the Medicaid agency in making payments directly to the providers. The FEA/FMS is contracted with the state and is the business associate of the state, required to perform certain employer functions that aid the Waiver participant in self-direction such as tax withholding and payroll. As the business associate of the state, the FEA/FMS is also required to adhere to other requirements that relate to data privacy, reporting functions, and others.

Public Partnerships, Limited (PPL), the FEA/FMS, submits service data to DDS. Provider billings flow from a provider to the FEA/FMS. The FEA/FMS makes payment of invoices for waiver goods and services that have been requested by the participant and are included in the participant's budget and authorized in the service plan. DDS is able to access service delivery information through the FEA/FMS portal. Individuals are coded as waiver participants in the DDS Meditech database and claims checks assure that the level of Care, Plan of Care, Medicaid eligibility, and Service Coordinator are in place prior to a claim being processed; claims are processed only for waiver eligible individuals for waiver eligible services provided by waiver eligible providers.

Components:
Original source documentation is maintained in hard copy format by service providers, and the FEA/FMS and in electronic form by DDS. Consumer specific information is on file at DDS Area Offices and in the DDS Meditech database. DDS uses the Meditech system to support various operational and policy/planning functions. As outlined in Appendix I-1, the Meditech database contains waiver service delivery information, demographic information, the level of care, plan of care approval, the Medicaid category of assistance and assigned service coordinator information for each waiver participant. Meditech is the case management data system and also includes case management progress notes.
Assessment data is in both Meditech and HCSIS.

Claim checks are part of the DDS electronic claims processing system to assure that all waiver assurances are met prior to processing a claim for FFP.

c. Certifying Public Expenditures *(select one)*:

○	**No. State or local government agencies do not certify expenditures for waiver services.**
■	**Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.** *Select at least one:*
■	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	DDS certifies public expenditures for waiver services. Expenditures are certified annually utilizing cost report data. Staff from the Public Provider Reimbursement Unit at the University of Massachusetts Medical School Center for Health Care Financing review cost reports and identify allowable and unallowable costs (such as room and board). Payments are made to waiver providers contracted through DDS. These providers retain 100% of the payment.

		Expenditures for waiver services are funded from annual legislative appropriations to the Department of Developmental Services. Claims for waiver services are adjudicated at approved rates through the state's approved MMIS system. The approved rates are set by the Executive Office of Health and Human Services and are based on the total costs for and utilization of waiver services. Once the claims have adjudicated through the CMS approved MMIS system, which validates that the claims are eligible for Federal Financial participation, the expenditures for waiver services are reported on the CMS 64 report.
	☐	**Certified Public Expenditures (CPE) of Local Government Agencies**. Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

As described above, DDS's Electronic Service Delivery system, HCSIS and Meditech systems and MMIS provide ample checks and balances to assure that FFP is claimed on the CMS-64 only when an individual is eligible for Medicaid waiver payment on the date of service rendered, the waiver service is included in the participant's approved service plan and the specific services were provided. The service delivery reporting system reconciles provider payment to dates of service reporting, and Meditech edits claims to ensure only service claims that meet all waiver criteria are submitted for payment processing to MMIS. MMIS validates all waiver service claims for dates of services and Medicaid eligibility prior to payment which is then reported as FFP in the CMS-64.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

■	**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
○	**Payments for some, but not all, waiver services are made through an approved MMIS.** Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	**Payments for waiver services are not made through an approved MMIS.** Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.** Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

■	**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
☐	**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
■	**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.** Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
	Providers may receive payment directly from the Medicaid agency. Information on how Providers may bill Medicaid directly will be posted on the DDS website and with the procurement materials on the Commonwealth Procurement Access and Solicitation Site (CommBuys). For Self-Directed Services, billings will flow from a provider to Public Partnerships, Limited (PPL), the FEA/FMS providing financial management services. The FEA/FMS will be

	responsible for submitting service data through DDS's electronic service delivery reporting system. Individuals are coded as waiver participants in the Department's Meditech database and claims checks assure that the Level of Care, Choice, Plan of Care, Medicaid eligibility and Service Coordinator are in place prior to a claim being processed and that claims are processed only for waiver eligible individuals for appropriate waiver services provided by eligible waiver providers; and that claims are processed only for services that are included in a participant's budget and authorized in the service plan. The above data is matched with rates and individual waiver eligibility criteria and submitted by electronic submission in accordance with procedures mandated by the Commonwealth's Medicaid Management Information System (MMIS). When a submission is processed through MMIS, any claim for dates of service where the individual was not Medicaid eligible is automatically denied. Components: Original source documentation is maintained in hard copy format by service providers, the FEA/FMS and in electronic form by the Department. Consumer specific information is on file at the Department's Area Offices and in the Department's database. Service providers submit information through the Enterprise Invoice Management System (EIM), a web based electronic service delivery documenting and invoicing system. Claim checks are part of DDS's electronic claims production system to assure that all waiver assurances are met prior to processing a claim for FFP.
☐	**Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.** Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

■	**No. The state does not make supplemental or enhanced payments for waiver services.**
○	**Yes. The state makes supplemental or enhanced payments for waiver services.** Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○	**No**. **State or local government providers do not receive payment for waiver services.** *Do not complete Item I-3-e.*
■	**Yes**. **State or local government providers receive payment for waiver services.** *Complete item I-3-e.* Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish. *Complete item I-3-e.*
	Department of Developmental Services provides residential habilitation, individual supported employment, group supported employment, community based day supports, behavioral supports and consultation, individualized home supports, and respite.

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

■	**The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**
○	**The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
○	**The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.** Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

■	**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
○	**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.** Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

■	**No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
○	**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).** Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

○	**No**. **The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
■	**Yes**. **The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.** Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
	(a) The Department of Developmental Services is designated as the Organized Health Care Delivery System for this home and community based waiver. It provides at least one Medicaid service and arranges for others. (b) The FEA/FMS and the Department maintain a list of qualified direct providers available throughout the state. A qualified direct provider may enroll with the FEA/FMS or the Department at any time. Waiver providers may also enroll directly with MassHealth. Providers who do not wish to contract with the OHCDS may enroll directly with MassHealth, and will be subject to all provider qualifications as outlined in Appendix C. MassHealth's Administrative Service Organization (ASO) for the MA.40701, MA40702, MA.1027 and MA.1028 waivers facilitates the waiver provider enrollment process for providers who do not wish to contract with the OHCDS. (c) Participants have free choice of qualified providers. Any willing and qualified provider has the opportunity to submit a proposal to contract with the Department as a provider of waiver services. DDS posts on its website the requirements and procedures for potential providers to qualify to deliver services. The qualifying system is open and continuous to allow potential providers to apply as they become ready to deliver services to participants. Newly qualified direct providers can be added to the list maintained by the FEA/FMS or the Department from time to time. A list of qualified providers for DDS contracted services is also maintained on the DDS website to allow participants ready access to this information. Participants are also assisted in accessing this information through their Service Coordinator. (d) The FEA/FMS or the Department oversees and monitors the contracts for providers that furnish services under the waiver. The Department or the FEA/FMS will review

	direct provider qualifications based on the qualifications in Appendix C and Appendix H. (e) OHCDS contracts with direct care providers will be governed by the provisions of an interagency service agreement between the Department and EOHHS. (f) Financial accountability is assured as described in Appendix I-1. The Commonwealth conducts an annual Single State Audit that includes sampling from the Department's waiver(s) service claims. The Audit reviews contract and Quality Enhancement certification documents; Plans of Care, Choice and Level of Care documents; service delivery data, claims and payment records. As necessary the Department can establish an audit trail including the point of service, date of service, rate development, provider payment status, claim status, and any other waiver related financial information. KPMG is the contractor that performs the Single State Audit for the Commonwealth of Massachusetts.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

■	**The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
○	**The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.** Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.
○	**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
○	**This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. *Select at least one:*

○	**Appropriation of State Tax Revenues to the State Medicaid Agency**
■	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:
	Annual legislative appropriation to the Department of Developmental Services provides the non-federal share which is expended directly by DDS as CPEs. The Department of Developmental Services directly makes expenditures from its appropriation and Federal Financial Participation (FFP) is returned to the State General Fund. Neither the Medicaid agency nor DDS retain any FFP. All FFP is returned to the State General Fund.
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select one:*

■	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
○	**Applicable** *Check each that applies:*
☐	**Appropriation of Local Government Revenues.** Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:
☐	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching

■		arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds . *Select one:*

■	**None of the specified sources of funds contribute to the non-federal share of computable waiver costs.**	
○	**The following source(s) are used.** *Check each that applies.*	
	☐	**Health care-related taxes or fees**
	☐	**Provider-related donations**
	☐	**Federal funds**
	For each source of funds indicated above, describe the source of the funds in detail:	

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○	**No services under this waiver are furnished in residential settings other than the private residence of the individual.**
■	**As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

As Specified in Appendix C the State furnishes Waiver Services in residential settings other than in the personal home of the individual. The Department of Developmental Services provides residential habilitation in both state-operated and vendor-operated residences. DDS issues separate contracts to vendor operated residences in order to pay for the costs associated with maintaining the residence and does not co-mingle costs associated with occupancy such as utilities, maintenance, room and board, with operational costs. Costs associated with occupancy are excluded from costs used to calculate waiver rate for these services.

A similar methodology is used for state-operated services. The costs of the state-operated residential habilitation and respite services are calculated and the non-reimbursable costs are excluded in order to derive waiver rate state-operated services. Room and board is always excluded except when waiver services are provided in those settings licensed as respite providers.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
■	**Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.** The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

DDS reimburses for both room and board of the unrelated live-in personal caregiver. DDS, as the provider, reimburses the waiver participant for the cost of additional living space and the increased utility costs to afford the live-in caregiver a private bedroom. The reimbursement for the increased rental costs will be based on the DDS Housing Guidelines established by the Department at 150% of the median rental costs per HUD region. Payment will not be made when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid Services. The reimbursement for food costs will be based on the USDA Moderate Food Plan cost averages.

Rates for Live-In Caregiver are developed and updated annually by DDS based on regional and population-based HUD Fair Market Rent (FMR) and USDA average moderate food cost data, respectively, with a multiplier adjusted to assure individuals are able to obtain fair market value apartments in their chosen town. The rate calculation is updated every January based upon the previous year's HUD and USDA data. The formulas for computing the maximum per diem and monthly rates for Live-In Caregiver are as follows:

Maximum Live-In Caregiver Monthly Rate = [(HUD FMR for the municipality in which the individual resides x 1.5) ÷ 2] + USDA Cost of Food

Maximum Live-In Caregiver Per Diem Rate = (Maximum Live-In Caregiver Monthly Rate x 12) ÷ 365

The HUD Fair Market Rates for a 2 bedroom home in Massachusetts for Fiscal Year 2018:
https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2018_code/2018state_summary.odn
Please note: when using this link, select New State: Massachusetts, select Statewide FMRs, the town to town rates are found on the FY2018 Massachusetts FMR Local Area Summary table.
The Official USDA Food Plans: Cost of Food at Home at Four Levels, U.S. Average, November 2017 moderate food plan costs for an individual (male and female) between the ages of 19 and 71+

	for the month of November 2017. https://www.cnpp.usda.gov/sites/default/files/CostofFoodNov2017.pdf

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

■	**No. The state does not impose a co-payment or similar charge upon participants for waiver services.** (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.** (*Complete the remaining items*)

i. Co-Pay Arrangement

Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

	Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*
☐	**Nominal deductible**
☐	**Coinsurance**
☐	**Co-Payment**
☐	**Other charge** *Specify*:

ii Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	**Basis**

iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	**There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**
○	**There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.** Specify the cumulative maximum and the time period to which the maximum applies:

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

■	**No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
○	**Yes**. **The state imposes a premium, enrollment fee or similar cost-sharing arrangement.** Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded; and (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care *(specify)*:	ICF/IID						
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$125,438.17	$ 28,223.49	$153,661.66	$ 288,383.45	$2,283.36	$ 290,666.81	$137,005.15
2	$126,998.31	$ 28,759.74	$155,758.05	$ 293,862.73	$2,326.74	$ 296,189.47	$140,431.42
3	$128,563.68	$ 29,306.17	$157,869.85	$ 299,446.13	$2,370.95	$ 301,817.08	$143,947.23
4	$130,159.18	$ 29,862.99	$160,022.17	$ 305,135.60	$2,416.00	$ 307,551.60	$ 147,529.43
5	$~~132,050.19~~ 130,646.18	$~~30,430.38~~ 31,834.41	$162,480.57	$310,933.18	$2,461.90	$ 313,395.08	$150,914.51

Appendix J-2: Derivation of Estimates

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

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care: ICF/IID
Year 1	10118	10118
Year 2	10468	10468
Year 3	10818	10818
Year 4	11168	11168
Year 5	11518	11518

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-a.

The Average Length of Stay (ALOS) of 343.9 for Waiver Years (WY) 1-5 is the ALOS in the Intensive Supports Waiver in WY 2016.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Number of Users:
The projected number of unduplicated participants each year was based on Department of Developmental Services (DDS) experience with this waiver to date and expected growth. While utilization estimates are based on data reflected in the WY 2016 CMS 372 report, the estimated unduplicated participant count of 10,118 for WY1 represents the planned waiver growth for the Intensive Supports Waiver. The WY 2018 slot capacity for this waiver is 9,568. The state plans to grow the waiver by 550 slots to WY1, and by 350 slots per year thereafter, as outlined in Appendix B-3.

Estimates for the number of users were based on data reported on the WY 2016 CMS-372 for each service in the Intensive Supports Waiver except as noted below.
- For the following services with no utilization in WY 2016, DDS estimated the number of users at 0.01% of the total estimated unduplicated participants: Live-In Caregiver, Chore, Transportation (transit pass), Transitional Assistance Services, and Vehicle Modification.
- As 24-Hour Self Directed Home Sharing Support had no utilization in WY 2016, the estimated number of users reflects expectations for initial nominal utilization with steady growth over the course of the 5-year waiver period based on the state's on-going policy goal of promoting self-direction of services in the Intensive Supports Waiver.
- Growth in the number of users of Individual Goods and Services was projected based on DDS's experience with the waiver population to date, accounting for utilization of similar state-funded

services and the increased limit (from $1,500 to $3,000) for this waiver service effectuated with this renewal.

- Estimates for the number of users of Assistive Technology devices were based on historic utilization of the Assistive Technology service, scaled up to reflect expansion of the availability of this service as a non-self-directed service. The estimate is for 4% and 6% utilization of the enrolled waiver population in WY4 and WY5, respectively.
- Estimates for the number of users of Assistive Technology evaluation and training were based on consultation with state agency program staff, programmatic goals, and anticipated need of all waiver participants. The estimate is for 4%, and 6% of the enrolled waiver population in WY4 and WY5, respectively.
- Estimates for the number of users for the new service, Remote Supports and Monitoring were based on enrollment in a pilot operated during the current waiver year, feedback from advocates, and experience in other states offering similar services. The estimate is for 2%, and 3% utilization of the enrolled population not in Residential Habilitation 24/7 placements for WY4, and WY5 respectively.

Average Units per User:
The average units per user were based on data reported on the WY 2016 CMS 372 for each service in the Intensive Supports Waiver, except as noted below.

- Estimates for units per user were based on claims data for the Community Living Waiver (MA.0826) for WY 2016 for the following services: Live-In Caregiver, Transportation (transit pass), and Vehicle Modification.
- For Chore and Transitional Assistance Services, estimates for units per user were based on state experience with comparable services in other Massachusetts HCBS waivers.
- DDS projected growth in the average units per user for Individual Goods and Services to account for the increased limit (from $1,500 to $3,000) for this waiver service effectuated with this renewal.
- For Live-In Caregiver and 24-Hour Self Directed Home Sharing Support, estimates for units per user are set equal to the ALOS.
- For Assistive Technology, devices component – units per user is that estimated for the Assistive Technology service in the existing approved waiver application.
- For Assistive Technology, evaluation and training component– based on consultation with state agency program staff, programmatic goals, and anticipated need, the estimate is for 25 hours (100 units) per year.
- For Remote Supports and Monitoring – units per user were based on average length of stay.
- For Day Habilitation Supplement, in WY5: estimates for the units per user are set at ¼ of the units per user for WY 1 – 4 to reflect removal of this service part-way through the waiver year

Average Cost per Unit:
Average costs per unit were based on data reported on the WY 2016 CMS 372 for each service in the Intensive Supports Waiver, except as noted below.

- Estimates for average costs per unit were based on claims data for the Community Living Waiver (MA.0826) for WY 2016 for the following services: Live-In Caregiver, Home Modifications and Adaptations, Transportation (transit pass), and Vehicle Modification.
- For Chore and Transitional Assistance Services, estimates for cost per unit are based on state experience with comparable services in other Massachusetts HCBS waivers.
- For 24-Hour Self Directed Home Sharing Support, cost per unit is based on rates as described in Appendix I-2- a.
- For Assistive Technology devices, the cost per unit for the devices component is that estimated for the Assistive Technology service in the existing approved waiver application.
- For Assistive Technology evaluation and training, the cost per unit is based on the current rate established for this service as described in Appendix I-2-a.

Trend:
The rates described above were used for Waiver Year 1 and trended annually using an annual inflation factor for subsequent years as follows:

- For Residential Habilitation, a 1.19 percent growth rate was derived from the most recent cost adjustment factor (CAF) applied by the Commonwealth to Adult Long- Term Residential (ALTR) services (see 101 CMR
420.00 Rates for Adult Long Term Residential Services). The ALTR CAF was 2.39%. As the state updates rates (and applies a cost adjustment factor as appropriate) every two years, the annual growth rate of 1.19 percent is derived by taking the square root of the biennial 2017 ALTR CAF.
- For other services to which an inflation factor was applied, rates described above were used for Waiver Year 1 and trended annually using an annual inflation factor of 1.35% for subsequent years. This projected growth rate is based on the 2017 cost adjustment factor (CAF) for services in which there is a comparable EOHHS Purchase of Service (POS) rate (these services are identified in Appendix I-2-a). For such services, the 2017 CAF was 1.87%, 2.62% or 2.72%. The state- based growth estimates on the highest of the three CAFs for a more conservative estimate of cost inflation at future rate adjustments. The calculations to develop the projected growth rate based on the 2017 CAF is as follows:

√1.0239 – 1 = 1.1879%, 1.1879% was rounded to 1.19%
√1.0272 – 1 = 1.3509%, 1.3509% was rounded to 1.35%

Services such as Assistive Technology devices, Home Modifications and Adaptations, Individual Goods and Services, Specialized Medical Equipment and Supplies, and Vehicle Modification were not trended annually as these services are not rate based and prices are not expected to increase annually, based on DDS's experience.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' costs are based on WY 2016 claims data for all other Medicaid services (D') by participants in the Community Living Waiver, as reported on the WY 2016 CMS-372. The annualized value of Factor D' is adjusted by the average length of stay used for Factor D to make the period of comparison comparable as follows: the annualized value of Factor D' was multiplied by the average length of stay and divided by 365. In addition, WY 2016 costs were trended forward annually by the Consumer Price Index – Medical (1.9%) to estimate Factor D' for WY 2019 (WY 1), as well as for subsequent waiver years. The State's source of the 1.9% CPI is: BLS CPI-All Urban Consumers, US City Average, Medical care services, Un-adjusted 12 mos. ended October 2017.

The calculation for Factor D' in WY1, therefore, is as follows:
WY1 D' = [WY 2016 Average Annualized D' x (ALOS ÷ 365)] x 1.019^3

As Factor D' costs are based on WY 2016 data, the cost and utilization of prescription drugs in the base data reflects the full implementation of Medicare Part D. Therefore, no Medicare Part D drug costs or utilization are included in the Factor D' estimate.

For WY5: estimates for D' were increased to reflect the addition of Individualized Staffing Supports as a state plan service part-way through the waiver year.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G costs are derived from the cost per member for MassHealth members who resided in an ICF-ID in WY 2016 as reported on the CMS-372 report for the Community Living Waiver. The annualized value of Factor G is adjusted by the average length of stay used for Factor D to make the period of comparison comparable as follows: the annualized value of Factor G was multiplied by the average length of stay and divided by 365. In addition, WY 2016 costs were trended forward annually by the Consumer Price Index – Medical (1.9%) to estimate Factor G for WY 2019 (WY 1), as well as for subsequent waiver years. The State's source of the 1.9% CPI is: BLS CPI-All Urban Consumers, US City Average, Medical care services, Un-adjusted 12 mos. ended October 2017.

The calculation for Factor G in WY1, therefore, is as follows:
WY1 G = [WY 2016 Average Annualized G x (ALOS ÷ 365)] x 1.019^3

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' costs are based on the utilization of all Medicaid services (G') other than ICF-ID services in WY 2016 for MassHealth members residing in an ICF-ID for a long stay as reported on the CMS-372 report for the Community Living Waiver.

The annualized value of Factor G' is adjusted by the average length of stay used for Factor D to make the period of comparison comparable as follows: the annualized value of Factor G' was multiplied by the average length of stay and divided by 365. In addition, WY 2016 costs were trended forward annually by Consumer Price Index – Medical (1.9%) to estimate Factor G' for WY 2019 (WY 1), as well as for subsequent waiver years. The State's source of the 1.9% CPI is: BLS CPI-All Urban Consumers, US City Average, Medical care services, Un-adjusted 12 mos. ended October 2017.

The calculation for Factor G' in WY1, therefore, is as follows:
WY1 G' = [WY 2016 Average Annualized G' x (ALOS ÷ 365)] x 1.019^3

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Group Supported Employment	manage components
Individualized Home Supports	manage components
Live-in Caregiver (42 CFR §441.303(f)(8))	manage components
Residential Habilitation	manage components
Respite	manage components
Day Habilitation Supplement	manage components
24-Hour Self Directed Home Sharing Support	manage components
Adult Companion	manage components
Assistive Technology - devices	manage components
Assistive Technology – evaluation and training	manage components
Behavioral Supports and Consultation	manage components
Chore	manage components
Community Based Day Supports	manage components
Family Training	manage components

Home Modifications and Adaptations	manage components
Individual Goods and Services	manage components
Individual Supported Employment	manage components
Individualized Day Supports	manage components
Peer Supports	manage components
Remote Supports and Monitoring	manage components
Specialized Medical Equipment and Supplies	manage components
Stabilization	manage components
Transitional Assistance	manage components
Transportation	manage components
Vehicle Modification	manage components

d. Estimate of Factor D.

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Group Supported Employment Total:					10297677
Group Supported Employment	15 min.	1235	2138	3.90	
Individualized Home Supports Total:					10086544.40
Individualized home Supports	15 min.	208	5685	8.53	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:					22693.68
Live--In Caregiver - Per Diem	Per Diem	1	344	65.97	
Residential Habilitation Total					1168962248.88
Residential Habilitation	Per Diem	9906	326	361.98	
Respite Total:					
Respite	Per diem	7	55	130.17	50115.45
Respite	15 min	5	347	4.30	7460.50
Day Habilitation Supplement Total:					17941422.33
Day Habilitation	15 min.	1833	2271	4.31	
24-Hour Self Directed Home Sharing Support Total:					
24-Hour Self Directed Home Sharing Support – Level A	Per Diem	3	344	115.27	118958.64
24-Hour Self Directed Home Sharing Support – Level B	Per Diem	3	344	151.91	156771.12
24-Hour Self Directed Home Sharing Support – Level C	Per Diem	5	344	217.03	223974.96
Adult Companion Total:					51865.00
Adult Companion	15 min.	5	2300	4.51	
Assistive Technology Total:					
Assistive Technology	Item	5	10	272.18	13609.00

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Behavioral Supports and Consultation Total:					48145.44
Behavioral Supports and Consultation	15 min	14	178	19.32	
Chore Total:					1303.80
Chore	15 min	1	164	7.95	
Community Based Day Supports Total:					40976031.98
Community Based Day Supports	15 min.	2858	3803	3.77	
Family Training Total:					848.88
Family Training	15 min	2	324	1.31	
Home Modifications and Adaptations Total:					7593.46
Home Modification and Adaptions	Item	1	2	3796.73	
Individual Goods and Services Total:					21063.60
Individual Goods and Services	Item	15	4	351.06	
Individual Supported Employment Total:					4227573.60
Individual Supported Employment	15 min	680	522	11.91	
Individualized Day Supports Total:					1678809.60
Individualized Day Supports	15 min	76	4160	5.31	
Peer Support Total:					68916.96
Peer Support	15 min	53	216	6.02	
Specialized Medical Equipment and Supplies Total:					392.19
Specialized Medical Equipment and Supplies	Item	1	1.00	392.19	
Stabilization Total:					1447395.30
Stabilization	Per diem	34	117	363.85	
Transitional Assistance Total:					500
Transitional Assistance	Item	1	1	500	
Transportation Total:					
Transportation	One-way trip	2038	327	19.15	12762057.90
Transportation	Mile	4	3457	0.51	6440.28

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Transportation	Transit pass	1	3	302.88	908.64
Vehicle Modification Total:					2000
Vehicle Modification	Item	1	1	2000	
GRAND TOTAL:					1269183368.59
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					10118
FACTOR D (Divide grand total by number of participants)					125438.17
AVERAGE LENGTH OF STAY ON THE WAIVER					343

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Group Supported Employment Total:					10792837.80
Group Supported Employment	15 min.	1278	2138	3.95	
Individualized Home Supports Total:					10572678.75
Individualized home Supports	15 min.	215	5685	8.65	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:					22999.84
Live--In Caregiver - Per Diem	Per Diem	1	344	66.86	
Residential Habilitation Total					1223838624.46
Residential Habilitation	Per Diem	10249	326	366.29	
Respite Total:					
Respite	Per diem	7	55	131.93	50793.05
Respite	15 min	6	347	4.37	9077.52
Day Habilitation Supplement Total:					18,826,340.19
Day Habilitation	15 min.	1,897	2,271	4.37	
24-Hour Self Directed Home Sharing Support Total:					

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
24-Hour Self Directed Home Sharing Support – Level A	Per Diem	6	344	116.83	241,137.12
24-Hour Self Directed Home Sharing Support – Level B	Per Diem	6	344	153.96	317,773.44
24-Hour Self Directed Home Sharing Support – Level C	Per Diem	6	344	219.96	453,997.44
Adult Companion Total:					63,066.00
Adult Companion	15 min.	6	2,300	4.57	
Assistive Technology Total:					16,330.80
Assistive Technology	Item	6	10	272.18	
Behavioral Supports and Consultation Total:					52,278.60
Behavioral Supports and Consultation	15 min	15	178	19.58	
Chore Total:					1,321.84
Chore	15 min	1	164	8.06	
Community Based Day Supports Total:					42,943,171.76
Community Based Day Supports	15 min.	2,956	3,803	3.82	
Family Training Total:					861.46
Family Training	15 min	2	324	1.33	
Home Modifications and Adaptations Total:					7593.46
Home Modification and Adaptions	Item	1	2	3,796.73	
Individual Goods and Services Total:					51,956.88
Individual Goods and Services	Item	37	4	351.06	
Individual Supported Employment Total:					4,435,580.16
Individual Supported Employment	15 min	704	522	12.07	4,435,580.16
Individualized Day Supports Total:					1,745,702.40

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Individualized Day Supports	15 min	78	4,160	5.38	
Peer Support Total:					72,468.00
Peer Support	15 min	55	216	6.10	
Specialized Medical Equipment and Supplies Total:					392.19
Specialized Medical Equipment and Supplies	Item	1	1	392.19	
Stabilization Total:					1,510,072.20
Stabilization	Per diem	35	117	368.76	
Transitional Assistance Total:					506.75
Transitional Assistance	Item	1	1	506.75	
Transportation Total:					
Transportation	One-way trip	2,108	327	19.41	13,379,623.56
Transportation	Mile	5	3,157	0.52	8,208.20
Transportation	Transit pass	1	3	306.97	920.91
Vehicle Modification Total:					2000
Vehicle Modification	Item	1	1	2000	
GRAND TOTAL:					1329418315.16
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					10468
FACTOR D (Divide grand total by number of participants)					126998.31
AVERAGE LENGTH OF STAY ON THE WAIVER					343

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Group Supported Employment Total:					11297192
Group Supported Employment	15 min.	1321	2138	4.00	

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Individualized Home Supports Total:					11068353.90
Individualized home Supports	15 min.	222	5685	8.77	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:					23309.44
Live--In Caregiver - Per Diem	Per Diem	1	344	67.76	
Residential Habilitation Total					1279730652.90
Residential Habilitation	Per Diem	10591	326	370.65	
Respite Total:					
Respite	Per diem	7	55	131.71	51478.35
Respite	15 min	6	347	4.42	9202.44
Day Habilitation Supplement Total:					19718638.80
Day Habilitation	15 min.	1960	2271	4.43	
24-Hour Self Directed Home Sharing Support Total:					
24-Hour Self Directed Home Sharing Support – Level A	Per Diem	9	344	118.41	366597.36
24-Hour Self Directed Home Sharing Support – Level B	Per Diem	9	344	156.04	483099.84
24-Hour Self Directed Home Sharing Support – Level C	Per Diem	9	344	222.93	690191.28
Adult Companion Total:					63894.00
Adult Companion	15 min.	6	10	272.18	
Assistive Technology Total:					16330.80
Assistive Technology	Item	6	10	272.18	
Behavioral Supports and Consultation Total:					52972.80
Behavioral Supports and Consultation	15 min	15	178	19.84	
Chore Total:					1339.88
Chore	15 min	1	164	8.17	
Community Based Day Supports Total:					44962298.55
Community Based Day Supports	15 min.	3055	3803	3.87	
Family Training Total:					874.80

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Family Training	15 min	2	324	1.35	
Home Modifications and Adaptations Total:					7593.46
Home Modification and Adaptions	Item	1	2	3,796.73	
Individual Goods and Services Total:					103562.70
Individual Goods and Services	Item	59	5	351.06	
Individual Supported Employment Total:					4641211.62
Individual Supported Employment	15 min	727	522	12.23	4641211.62
Individualized Day Supports Total:					1836432.00
Individualized Day Supports	15 min	81	4160	5.45	
Peer Support Total:					74753.28
Peer Support	15 min	56	216	6.18	
Specialized Medical Equipment and Supplies Total:					392.19
Specialized Medical Equipment and Supplies	Item	1	1	392.19	
Stabilization Total:					1574192.88
Stabilization	Per diem	36	117	373.74	
Transitional Assistance Total:					513.59
Transitional Assistance	Item	1	1	513.59	
Transportation Total:					
Transportation	One-way trip	2179	327	19.67	14015524.11
Transportation	Mile	5	3157	0.53	8366.05
Transportation	Transit pass	1	3	311.11	933.33
Vehicle Modification Total:					2000
Vehicle Modification	Item	1	1	2000	
GRAND TOTAL:					1390801902.35
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					10818
FACTOR D (Divide grand total by number of participants)					128563.68
AVERAGE LENGTH OF STAY ON THE WAIVER					343

Waiver Year: Year 4					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Group Supported Employment Total:					11810739.60
Group Supported Employment	15 min.	1364	2138	4.05	
Individualized Home Supports Total:					11573579.85
Individualized home Supports	15 min.	229	5685	8.89	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:					23622.48
Live--In Caregiver - Per Diem	Per Diem	1	344	68.87	
Residential Habilitation Total					1336895369.04
Residential Habilitation	Per Diem	10934	326	375.06	
Respite Total:					
Respite	Per diem	7	55	135.52	52175.20
Respite	15 min	6	347	4.48	9327.36
Day Habilitation Supplement Total:					20628106.17
Day Habilitation	15 min.	2023	2271	4.49	
24-Hour Self Directed Home Sharing Support Total:					
24-Hour Self Directed Home Sharing Support – Level A	Per Diem	12	344	120.01	495401.28
24-Hour Self Directed Home Sharing Support – Level B	Per Diem	12	344	158.15	652843.20
24-Hour Self Directed Home Sharing Support – Level C	Per Diem	12	344	255.94	932680.32
Adult Companion Total:					34722.00
Adult Companion	15 min.	6	2300	4.69	
Assistive Technology Total:					16330.80
Assistive Technology	Item	6	10	272.18	
Behavioral Supports and Consultation Total:					57273.28
Behavioral Supports and Consultation	15 min	16	178	20.11	
Chore Total:					1357.92
Chore	15 min	1	164	8.28	

Waiver Year: Year 4					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Community Based Day Supports Total:					47019075.04
Community Based Day Supports	15 min.	3154	3803	3.92	
Family Training Total:					877.76
Family Training	15 min	2	324	1.37	
Home Modifications and Adaptations Total:					7593.46
Home Modification and Adaptions	Item	1	2	3796.73	
Individual Goods and Services Total:					147445.20
Individual Goods and Services	Item	84	5	351.06	
Individual Supported Employment Total:					4861072.80
Individual Supported Employment	15 min	751	522	12.40	4641211.62
Individualized Day Supports Total:					1928908.80
Individualized Day Supports	15 min	84	4160	5.52	
Peer Support Total:					78425.28
Peer Support	15 min	58	216	6.26	
Specialized Medical Equipment and Supplies Total:					392.19
Specialized Medical Equipment and Supplies	Item	1	1	392.19	
Stabilization Total:					1684100.34
Stabilization	Per diem	38	117	378.79	
Transitional Assistance Total:					520.52
Transitional Assistance	Item	1	1	520.52	
Transportation Total:					
Transportation	One-way trip	2249	327	19.94	14664334.62
Transportation	Mile	5	3157	0.54	8523.90
Transportation	Transit pass	1	3	315.31	945.93
Vehicle Modification Total:					2000
Vehicle Modification	Item	1	1	2000	
GRAND TOTAL:					1453617754.34

Waiver Year: Year 4					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					11168
FACTOR D (Divide grand total by number of participants)					130159.18
AVERAGE LENGTH OF STAY ON THE WAIVER					343

Waiver Year: Year 5					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Group Supported Employment Total:					12324714.80
Group Supported Employment	15 min.	1406	2138	4.10	
Individualized Home Supports Total:					12088356.60
Individualized home Supports	15 min.	236	5685	9.01	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:					23942.40
Live--In Caregiver - Per Diem	Per Diem	1	344	69.60	
Residential Habilitation Total					1395230135.04
Residential Habilitation	Per Diem	112877	326	379.52	
Respite Total:					
Respite	Per diem	8	55	137.35	60434.00
Respite	15 min	6	347	4.54	9452.28
Day Habilitation Supplement Total:					5393642.80 ~~21565075.35~~
Day Habilitation	15 min.	2087	~~2271~~ 568	4.55	
24-Hour Self Directed Home Sharing Support Total:					
24-Hour Self Directed Home Sharing Support – Level A	Per Diem	15	344	121.63	627610.80
24-Hour Self Directed Home Sharing Support – Level B	Per Diem	15	344	160.29	827096.40
24-Hour Self Directed Home Sharing Support – Level C	Per Diem	15	344	228.99	1181588.40
Adult Companion Total:					65550.00

Waiver Year: Year 5					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Adult Companion	15 min.	6	2300	4.75	
Assistive Technology Total:					
Assistive Technology	Item	691	10	272.18	1880763.80
Assistive Technology – Evaluation and Training	15 min	691	100	19.45	1343995.00
Behavioral Supports and Consultation Total:					58042.24
Behavioral Supports and Consultation	15 min	16	178	20.38	
Chore Total:					1375.96
Chore	15 min	1	164	8.39	
Community Based Day Supports Total:					49113501.23
Community Based Day Supports	15 min.	3253	3803	3.97	
Family Training Total:					900.72
Family Training	15 min	2	324	1.39	
Home Modifications and Adaptations Total:					7593.46
Home Modification and Adaptions	Item	1	2	3796.73	
Individual Goods and Services Total:					191327.70
Individual Goods and Services	Item	109	5	351.06	
Individual Supported Employment Total:					5078631.96
Individual Supported Employment	15 min	774	522	12.57	
Individualized Day Supports Total:					1999878.40
Individualized Day Supports	15 min	86	4160	5.59	
Peer Support Total:					82166.40
Peer Support	15 min	60	216	6.34	
Remote Supports and Monitoring Total:					95549.44
Remote Supports and Monitoring	Per diem	7	344	39.68	
Specialized Medical Equipment and Supplies Total:					392.19

Waiver Year: Year 5					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Specialized Medical Equipment and Supplies	Item	1	1	392.19	
Stabilization Total:					1751735.70
Stabilization	Per diem	39	117	383.90	
Transitional Assistance Total:					527.55
Transitional Assistance	Item	1	1	527.55	
Transportation Total:					
Transportation	One-way trip	2320	327	20.21	15332114.40
Transportation	Mile	5	3157	0.55	8681.75
Transportation	Transit pass	1	3	319.57	958.71
Vehicle Modification Total:					2000
Vehicle Modification	Item	1	1	2000	
GRAND TOTAL:					1504782660.13 ~~1520954092.68~~
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					11518
FACTOR D (Divide grand total by number of participants)					130646.18 ~~132050.19~~
AVERAGE LENGTH OF STAY ON THE WAIVER					343.9