Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.6

Includes Changes Implemented through January 2019

Submitted by:

Submission Date:	

CMS Receipt Date *(CMS Use)*	

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Significant changes to the approved waiver that are being made in this renewal application include the following:

- Adding slot capacity.
- Adding a telehealth delivery option for a set of waiver services.
- Increasing flexibility for assessments, service planning, and case management to occur remotely/via telehealth by removing some references to specific modalities (i.e., "in person", "telephone") while maintaining operational integrity.
- Adding reassurances that providers that offer services via telehealth are following HIPAA requirements.
- Adding a unit rate for Partial Day – Day Services, in order to continue offering Day Services at less than a per diem rate, as authorized through Appendix K authority.
- Adding a new service – Home Delivered Meals – in order to continue offering this service as authorized through Appendix K authority.
- Adding Laundry and Assistive Technology as new services.
- Changing staffing requirements for Independent Living Supports.
- For many service providers, moving from annual to every two year verification of provider qualifications.
- Modifying language to reflect the fact that MFP Demonstration eligibility has been changed from 90 day to 60 day facility stay, which impacts ability of Demonstration participants to transfer to waivers if their initial facility stays were shorter than 90 days.
- Updating data sources and sampling approaches for several performance measures.
- Changing pronouns throughout to be gender neutral.

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

PURPOSE OF THE

HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors.

State:	
Effective Date	

1. Request Information

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

B. **Program Title** (*optional – this title will be used to locate this waiver in the finder*): MFP Community Living (MFP-CL)

C. **Type of Request:** *(the system will automatically populate new, amendment, or renewal)*

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

○	**3 years**
☑	**5 years**

☐	**New to replace waiver** Replacing Waiver Number:		
	Base Waiver Number:	MA.1027.R01.01	
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)		

D. **Type of Waiver** *(select only one)*:

○	**Model Waiver**
☑	**Regular Waiver**

E. **Proposed Effective Date:** 04/01/2023

Approved Effective Date *(CMS Use):*

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

☑	**Hospital** *(select applicable level of care)*	
	☑	**Hospital as defined in 42 CFR §440.10** If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:
		Chronic and Rehabilitation Hospital, Psychiatric Hospital

	○	**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.

Goals and Objectives: The goal of the Massachusetts MFP Community Living Waiver (MFP-CL) is to transition eligible adults from nursing facilities, chronic or rehabilitation hospitals or psychiatric hospitals to community settings and to furnish home or community-based services to the waiver participants following their transition from the medical facility setting.

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

Case Management and Service Delivery: Case Management for the waiver will be provided by staff of MRC. MRC will be responsible for participant needs assessment, service plan development and service authorization activities. Clinical determination of eligibility and level of care redetermination is conducted by nurses at the contracted Level of Care Entity. MRC has oversight of waiver clinical eligibility determinations.

Waiver services will be provided pursuant to a Plan of Care (POC) that is developed with the Waiver participant through a person-centered planning process. The POC is developed by an interdisciplinary team that is coordinated by the MRC Case Manager and includes the participant, their guardian if any, relevant waiver service providers, other persons as chosen by the participant and other appropriate professionals. The POC planning process will determine what waiver services and supports are needed to support the waiver participant to live safely in the community.

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. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of 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:

This section will be completed after the public comment period has ended.

The state held a public comment period for the four MFP and ABI waiver renewal applications from late September – late October, 2022 (exact dates will be inserted once they are finalized) . Massachusetts outreached broadly to the public and to interested stakeholders to solicit input on the renewal applications for these waivers. The four waiver renewal applications were posted to MassHealth's website, and public notices were issued in multiple newspapers, including: the Boston Globe, Worcester Telegram and Gazette, and the Springfield Republican. In addition, emails were sent to several hundred recipients, which included key advocacy organizations as well as the Native American tribal contacts. The newspaper notices and email provided the link to the MassHealth website that includes the draft renewal applications, the public comment period, and, for anyone wishing to send comments, both email and mailing addresses.

MassHealth outreached to and communicated with the Tribal governments about the ABI and MFP waiver renewal applications during regularly scheduled tribal consultation quarterly meetings on August 9, 2022. The tribal consultation quarterly meetings afford direct discussions with Tribal government contacts about these waivers.

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:	857-287-1200	**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:	Rodriguez				
First Name:	Rosa				
Title:	ABI/MFP Waiver Director				
Agency:	Massachusetts Rehabilitation Commission				
Address:	600 Washington Street, 2nd floor				
Address 2:					
City:	Boston				
State:	MA				
Zip :	02111				
Phone:	617-204-3680	**Ext:**		☐	**TTY**
Fax:	617-204-3889				
E-mail:	Rosa.Rodriguez2@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

Specify the transition plan for the waiver:

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

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

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

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

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

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

The Massachusetts Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency convened an interagency workgroup to address how best to comply with the requirements of the federal Home and Community Based Services (HCBS) settings rule at 42 CFR 441.301 (c)(4)-(5) (the Community Rule). The Massachusetts Rehabilitation Commission (MRC), an agency within EOHHS who has primary responsibility for day-to-day operation of the MFP-CL waiver, was a member of the workgroup. All relevant regulations, policies, standards, certifications and procedures have been reviewed against the Community Rule HCBS Regulations and necessary changes identified. These include:
- Revisions to MRC Community Living Division Policies and Procedures manual regarding day and employment settings (complete)
- Revisions to MRC monitoring tools for day and employment providers (complete)
- Revisions to provider credentialing tool for employment providers (complete)
- Develop and distribute the waiver participant handbook (complete)

Participants in the MFP-CL Waiver live in their own homes or apartments, in homes and apartments with family members and other informal supports, or in a home or apartment of a caregiver with up to one additional waiver participant. These settings fully comply with the HCBS Regulations.

Waiver services delivered to the participant in their home (for example personal care, homemaker, and chore services) are also considered to be fully compliant with the HCBS Regulations.

Adult Companion services and Individual Support and Community Habilitation services may be delivered either in the participant's home or in the community. Transportation services by definition assist the participant in engaging in waiver or other services in the community and in other community activities. As such, these services are all considered to be fully compliant with the HCBS Regulations. Most providers of Day and Employment services that serve MFP-CL waiver participants are licensed or certified by DDS. These providers are the subject of an open bid process and are required to be qualified to provide services and supports. This process demonstrates DDS's commitment to the HCBS settings requirements.
Following qualification, providers of Day and Employment services are subject to licensure and certification on an on-going basis. Certification outcomes also focus on rights, choice, control, employment and meaningful day activities, and community integration. As part of ongoing monitoring to ensure that providers are moving to enhance their outcomes, DDS revised its licensure and certification tool to clarify expectations and even more closely and strongly align the tool with the critical elements of the Community Rule.

In addition, for ABI and MFP day and employment providers not qualified through the above process by DDS, the Massachusetts Rehabilitation Commission Provider Standards for Acquired Brain Injury (ABI) and Moving Forward Plan (MFP) Waiver Service Providers identify the requirements to become credentialed to provide waiver day and employment services.
Through these processes, all day and employment providers have been determined to be in full compliance with the Community Rule.
Compliance will be monitored on a site-specific, on-going basis through the licensing and certification process.

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

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

All settings in which waiver services are delivered will be fully compliant with the HCBS Community Rule no later than March, 2023.

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 setting requirements by or before March 2023. If, in the course of ongoing monitoring process, MRC along with MassHealth determines that additional substantive changes are necessary for certain providers or settings, MassHealth and MRC 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 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):

Below is the state's 2/26/18 response to the Appendix I-2-a questions from the Informal RAI received on 2/21/18. The response incorporates the following:

Informal RAI 1/17/18
MA Response #1 2/5/18
Formal RAI 2/8/18
MA Response #2 2/16/18
CMS Response 2/21/18
MA Response #3 2/26/18

APPENDIX I

2. For each waiver service, please specify the following information:
a. What data sources are used to determine rates (e.g., provider cost survey, wage data, etc.)? What is the time period of these sources? How frequently are these data sources updated?
b. How does the State use the referenced data sources to develop waiver service rates? Describe this process.
c. Provide the rate model for each wavier service. If applicable, what cost factors (i.e., base wage, employee expenses, administrative expenses, program expenses, productivity adjustments, and inflation) and cost assumptions does the State use to determine rates?
d. When were rates last updated and/or reviewed? How frequently are rates reviewed?
e. How does the State ensure that rates are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers?
f. The State's online fee schedule shows a difference in rates between agency-directed and self-directed services. What is the difference in rate setting between agency-directed and self-directed services?
g. Describe how the cost adjustment factor for projected inflation is determined.

MA Response #1: The rates for all waiver services have been developed and promulgated in regulations established by the Executive Office of Health and Human Services (EOHHS) with the assistance of rate analysis from the Commonwealth's Center for Health Information and Analysis (CHIA). The rate development process starts with an analysis of available data including provider cost, labor and other economic market information, utilization and public agency spending data. Rates for individual providers and self-directed services exclude costs associated with agency overhead. A cost adjustment factor (CAF) is added to account for projected inflation anticipated during the prospective rate period. The CAF included in these rates was based on the Massachusetts Consumer Price Index for Spring 2016 optimistic forecast provided by Global Insights. If appropriate, the data is adjusted to reflect desired economic efficiencies, such as productivity expectations and administrative ceilings. The process includes at least one consultative session to receive input from service providers. In addition, EOHHS is required by state law to hold a public hearing for all rate regulations it proposes. Before the public hearing date, there is a public notice that includes the hearing date, time, location and the proposed rates. The public is welcomed to comment in person and/or in writing. Rates are reviewed every two years, and the HCBS rate regulation was last updated effective January 1, 2017.

CMS Response #1: We need more information from the State for their rate setting methodology. a) Provide or describe the labor, economic market information, utilization and public agency spending data sources used for rate setting. b) How does the State collect provider cost information and when was the last time the State reviewed provider costs? c) How does the State use the above data to calculate the provider rate? Provide the calculation used to develop waiver service rates based on the above data

mentioned. d) What CAF percentage did the State use in the current waiver service payment rates? e) When does the State adjust productivity expectations and administrative ceilings? Had the state applied them? If so, how? Also, specify which services have these adjustments applied.

MA Response #2: 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 Massachusetts General Laws 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 further 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 further 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, with the goal of ensuring that proposed rates meet the statutory rate adequacy requirements noted above.

The rates for all waiver services in this waiver were established in accordance with the above statutory requirements. The below provides additional information on the rate development for each of the waiver services.

1. Rates for services in which there is a comparable Medicaid state plan rate.

For waiver services in which there is a comparable Medicaid state plan rate, the waiver service rate was established in regulation at the comparable Medicaid state plan rate and after public hearing pursuant to Massachusetts General Laws Chapter 118E, Section 13D. All Medicaid state plan rates were established in regulation pursuant to this same statutory requirement. Medicaid State Plan rates are developed using provider cost data submitted to the Center for Health Information and Analysis (CHIA) in accordance with provider cost reporting requirements under 957 CMR 6.00: Cost Reporting Requirements. The provider cost data is used to calculate rates that 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 Massachusetts General Laws 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.

Below is a list of the waiver service rates that have been established in regulation at a comparable state plan rate:

Home Health Aide
Occupational Therapy
Non-agency Personal Care
Physical Therapy
Skilled Nursing

Specialized Medical Equipment
Speech Therapy
Supportive Home Care Aide
Transportation

For these rates, no productivity expectations and administrative ceiling calculations have been used in establishing the rates.

CMS Response #2:
a) Confirm CAF was not used in the services using the comparable state plan rate.
b) Update the waiver application to include MA response 1 and 2.

MA Response #3:
No CAF was used for the services using the comparable state plan rate.

2. Rates for services in which there is a comparable EOHHS Purchase of Service (POS) rate.

For waiver services in which there is a comparable EOHHS Purchase of Service (POS) rate, the waiver service rate was established in regulation at the comparable POS rate and after public hearing pursuant to Massachusetts General Laws Chapter 118E, Section 13D. All POS rates were established in regulation pursuant to this same statutory requirement. POS rates are developed using Uniform Financial Reporting (UFR) data submitted to the Massachusetts Operational Services Division, and in accordance with UFR reporting requirements under 808 CMR 1.00: Compliance, Reporting and Auditing for Human and Social Services. EOHHS uses the UFR data to calculate rates that meet the statutory 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 Massachusetts General Laws Chapter 118E Section 13D. In updating rates to ensure continued compliance with the statutory rate adequacy requirements, a cost adjustment factor (CAF) or other updates to the rate models may be applied.

Below is a list of the waiver service rates that were established in regulation at comparable POS rates:

Community Family Training
Individual Support and Community Habilitation
Peer Support

No productivity expectations and administrative ceiling calculations have been used in establishing these rates.

CMS Response #2:
a) Explain how the UFR data was used in the calculation of the Community Family Training, Individual Support and Community Habilitation, and Peer Support. While the 808 CMR 1.00 and MA General Laws indicate promulgation of the payment rates and regulatory requirements for reporting, they do not demonstrate how the rates are calculated.
b) Update the waiver application to include MA response 1 and 2.

MA Response #3:
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 for particular services by determining the average for each line item across all providers. In determining the rates for each of these services, Community Family Training, Individual Support and Community Habilitation, and Peer Support, EOHHS used the most recent complete state fiscal year UFR available and determined the average across providers of that service for each line item, which are then used to build each rate.

3. Rates for services in which there is no comparable Medicaid State Plan service or EOHHS Purchase of Service (POS) rate

For waiver services in which there is no comparable Medicaid state plan or EOHHS Purchase of Service (POS) rate, a rate for the waiver service was developed and established under 101 CMR 359 after public hearing pursuant to Massachusetts General Laws Chapter 118E, Section 13D, and as described below.

Adult Companion, Agency Personal Care, Chore Services, Homemaker Services:
Rates for Adult Companion, Agency Personal Care, Chore Services, and Homemaker Services were developed using applicable agency cost expenditure data for comparable services provided through the Executive Office of Elder Affairs 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.

CMS Response #2:
Explain in detail how the applicable agency cost expenditure data from EOHHS was used to calculate the rate. Is there a report or a rate model that the State can provide? How did the State ensure that the cost expenditure data only included the relevant waiver population? Provide any working papers or rate models used to develop the rates, if available.

MA Response #3:

The Executive Office of Elder Affairs Home Care Program provides elders in the Commonwealth 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 as well as other participants served at state cost. Home Care program services include Adult Companion, Agency Personal Care, Chore Services, Homemaker Services. For each of the four specific services, (i.e. Adult Companion, Agency Personal Care, Chore Services, Homemaker Services), the median of contracted service prices excluding the outliers was found. For the applicable services, outliers were removed for any pricing in the database that was 2 standard deviations away from the mean for that service. For Agency Personal Care, Chore Services, and Homemaker Services, this median is used as the rate. For Adult Companion, however, the methodology 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.

Day Services: Rates for Day Services were developed using FY 2010 contract data for Community Based Day Support Services purchased by the Department of Developmental Services, and in the most recent update to 101 CMR 359, have remained unchanged from the prior effective rate period. The rates remained unchanged based on provider input gathered during the public hearing process for the proposed rate updates to the rates established under 101 CMR 359.00.

CMS Response #2:

Explain in detail how the State developed the rate using the FY 2010 contract data. What is included in the contract data? How did the State calculate the rate using this information? Provide any working papers or rate models used to develop the rates, if available.

MA Response #3:

The FY2010 contract data for Community Based Day Support Services was based on model budgets for providers of this service. The budgets included line items for staff salaries (including management and direct care staff), tax and fringe benefits, occupancy, other expenses and administrative allocation. The salaries used to impute direct care resources reflect the weighted average for the applicable job titles. The unit cost elements for the other direct program costs are based on the median for the applicable input. The model budget was based on a provider capacity of 15 clients, operating at 90% of this capacity, with a ratio of 1 staff member for every 3 clients.

Independent Living Supports and Shared Home Supports:

Rates for Independent Living Supports and Shared Home Supports were developed from the previously effective MFP Waiver rate regulation at 101 CMR 357.00. The historic rates were based on existing rates for comparable service components (including personal care, skilled nursing visits, and homemaker, supportive home care aide, and individual support/community habilitation, where applicable), and weighted by projected units per week. The rates remained unchanged based on provider input gathered during the public hearing process for the proposed rate updates to the rates established under 101 CMR 359.00.

CMS Response #2:

Explain in detail how the State used the similar services to develop the rate. What specific components from the services listed were used in calculating the Independent Living Supports and Shared Home Support rates? How did the State calculate the projected units per week? How did State weight the projected units per week to calculate the service rate? Provide any working papers or rate models used to develop the rates, if available.

MA Response #3:

The state used the following services that are components of Independent Living Supports waiver services to calculate this rate: Skilled Nursing (weight = 15%), Supportive Home Care Aide (weight = 74%), and Homemaker services (weight = 11%). The state identified, with expert input from experienced staff closely associated with waiver programming and integrally involved with serving similar users of this service, the relative contribution of these components within the Independent Living Supports waiver service. The relative amounts of each of the components effectively weight their contribution to the overall service. The rate is calculated utilizing these weighted components including, on a weekly basis, skilled nursing 1 visit/week; Supportive Home Care Aide 2.5 hours/day (70 15-minute units/week); and Homemaker 3 hours/week (12 15-minute units/week), and the price per unit for each service. The rate is additive of the three components of weekly service divided by 7 to determine a per diem rate.

The state used the following services that are components of Shared Home Supports waiver services to calculate this rate: Skilled Nursing (weight = 16%), Individual Support/ Community Habilitation (weight = 20%), Personal Care (weight = 53%), and Homemaker services (weight = 11%). The state identified, with expert input from experienced staff closely associated with waiver programming and integrally involved with serving the participants who would utilize this service, the relative contribution of these components within the Shared Home Supports waiver service. The relative amounts of each of the

components effectively weight their contribution to the overall service. The rate is calculated utilizing these weighted components including, on a weekly basis, skilled nursing 1 visit/week; Individual Support/Community Habilitation 2.5 hours/week (10 15-minute units/week); Personal Care services 2 hours/day (56 15-minute units/week); and homemaker supports 3 hours/week (12 15-minute units/week), and the price per unit for each service. The rate is additive of the four components of weekly service divided by 7 to determine a per diem rate.

Orientation and Mobility services:

Rates for Orientation and Mobility services were based on the historic rate for such services from the rate regulation 101 CMR 356.00: Rates for Money Follows the Person Demonstration Services. These rates were built off the 2012 Medicare rate for CPT code 97535, adjusted for the average of the two Massachusetts Geographical Price Cost Indices and multiplied by 85% to reflect that providers are mid-level (non-physician) practitioners. The rates remained unchanged based on provider input gathered during the public hearing process for the proposed rate updates to the rates established under 101 CMR 359.00.

CMS Response #2: Provide the Medicare CPT 97535 rate source used to calculate the Orientation and Mobility services. We cannot determine the base data that the State used by using the CPT code and Year alone. We used the below web address to locate the Medicare physician services rate. https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx.

However, this website requires more detail than what the State provided. The search criteria included year, type of information, MAC option, and modifier. For example, year 2012 has two options to choose from – 2012A and 2012B. Provide the specific search criteria the State selected to derive the CPT 97535 rate.

MA Response #3:

The criteria for the website are as follows:

Type of Info=All

MAC option= Specific Locality, for both 1420201 Metropolitan Boston and 1420299 Rest of Massachusetts

Modifier=All modifiers

There is no difference in the 2012A and 2012B rates for this CPT code.

In reviewing the documentation for this rate, however, the state identified a clerical error in the original calculations from 2013.

The base utilized to calculate this rate was set at $36.49 rather than the average rate of $35.36 shown below:

Medicare 2012 A

-Metro Boston: $36.14

-Rest of MA: $34.58

-Average: $35.36 Medicare 2012 B

-Metro Boston: $36.14

-Rest of MA: $34.58

-Average: $35.36 Listed rate in the analysis documents as the base rate: $36.49

Prevocational and Supported Employment Services:

Rates for Prevocational and Supported Employment Services are based on historic rates for such services from the rate regulation 114.4 CMR 10.00: Rates for Competitive Integrated Employment Services. The rates were then updated with a retrospective CAF of 6.86%.

CMS Response #2: Provide additional information about the retroactive CAF adjustment. How is 6.86% calculated?

MA Response #3:

Data for the calculation of the CAF came from Global Insights. The CAF is the percent increase between the base period index number and the effective period index number. The percent increase is found by subtracting the effective period number minus the base period number. That difference is then divided by the base period number to find the percent increase. The base period number is the listed index value for 2012Q3 (2.533). The effective period number is the average of the index numbers over the effective period of the rate regulation (2017Q1 through 2018Q4), as follows:

2017Q1: 2.659

2017Q2: 2.671

2017Q3: 2.687

2017Q4: 2.696

2018Q1: 2.712

2018Q2: 2.727

2018Q3: 2.743

2018Q4: 2.759

Average: 2.707

Retroactive CAF = (2.707 – 2.533) ÷ 2.533 = 6.86%

As noted previously, 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 statutory rate adequacy requirements. 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. No productivity expectations and administrative ceiling calculations have been used in establishing these rates.

CMS Response #2: See above, additional information is requested regarding the State's CAF adjustment.

MA Response #3:

Data for the calculation of the CAF came from Global Insights. The CAF is the percent increase between the base period index number and the effective period index number. The percent increase is found by subtracting the effective period number minus the base period number. That difference is then divided by the base period number to find the percent increase. The base period number is the listed index value for 2012Q3 (2.533). The effective period number is the average of the index numbers over the effective period of the rate regulation (2017Q1 through 2018Q4), as follows:

2017Q1: 2.659

2017Q2: 2.671

2017Q3: 2.687

2017Q4: 2.696
2018Q1: 2.712
2018Q2: 2.727
2018Q3: 2.743
2018Q4: 2.759
Average: 2.707

Retroactive CAF = (2.707 – 2.533) ÷ 2.533 = 6.86%

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

The Massachusetts Rehabilitation Commission (MRC) and the Department of Developmental Services (DDS), in collaboration with MassHealth, oversee and assess the Level of Care entity on a continuous and ongoing basis through activities including but not limited to monitoring weekly, monthly, and quarterly reporting by the LOC entity; participation in the LOC entity's weekly clinical eligibility process; reviewing all clinical denials; and monitoring appeals of clinical denials.

EOHHS also contracts with an Administrative Service Organization (ASO) which is responsible for managing the expansion and oversight of the waiver service provider network of MassHealth providers. MRC, with the collaboration of DDS, will ensure that contracting providers adhere to the contractual obligations imposed on them for performing these functions, will work with the contractors to provide any necessary training, regarding their performance of waiver functions and will collect and report information on waiver enrollees' utilization and experience with waiver enrollment.

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

In addition, the LOC and ASO submit reports for specific performance management indicators to both DDS and MassHealth on an annual basis.

b) MRC and DDS have entered into Interagency Services Agreements with MassHealth to document the responsibility for performing and reporting on these functions.

c) MassHealth, within the Executive Office of Health and Human Services (EOHHS) the single state agency, will administer and oversee performance of the waiver. MassHealth meets with MRC and DDS staff on a monthly basis regarding the performance of these activities and other operational aspects and reporting for these waivers. MassHealth also oversees MRC and DDS in their oversight of the contracted Level of Care and Administrative Service Organization contractors in the performance of their duties for this waiver. The frequency of oversight meetings will be re-evaluated periodically. The Medicaid Director reviews and signs all waiver applications, amendments and waiver reports to CMS.

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

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

	MassHealth contracts with an Administrative Service Organization (ASO). The ASO solicits direct service providers, assists these providers in executing MassHealth provider agreements, verifies vendor qualifications and conducts vendor and quality monitoring activities. The ASO assumes or subcontracts billing agent responsibilities, and conducts customer service activities for both direct service providers and waiver participants. The ASO engages in multiple third party administrator activities including the following: - Recruiting and facilitating enrollment of waiver service providers in MassHealth so that waiver services and service locations are available and accessible to waiver participants. - Establishing and using MassHealth-approved enrollment criteria for ensuring that waiver service providers are qualified to provide the appropriate waiver services. - Assisting waiver service providers, as needed, with various aspects of waiver service claims processing and other related transactions. - Identifying quality issues and concerns for MassHealth, MRC and DDS. - Undertaking training activities as appropriate for providers and their staff. MassHealth contracts with a Fiscal Management Service (FMS) entity that will be responsible for supporting the participant as the employer of self-directed services as outlined in Appendix E. The State will manage the performance of the FMS via contract, including review of performance metrics and required monthly reports. The agreements that outline the requirements for these contractors will be available to CMS upon request.
○	**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:

The Massachusetts Rehabilitation Commission (MRC), with the collaboration of the Department of Developmental Services (DDS) will oversee and assess the performance of the administrative services organization that is responsible for provider recruitment, credentialing and enrollment as well as for overseeing the performance of waiver service providers. MRC will report to MassHealth on an annual basis regarding these activities and any issues or concerns regarding same.

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:

MRC and DDS, in collaboration with MassHealth, oversee and assess the Level of Care entity on a continuous and ongoing basis through activities including but not limited to monitoring weekly, monthly, and quarterly reporting by the LOC entity; participation in the LOC entity's weekly clinical eligibility process; reviewing all clinical denials; and monitoring appeals of clinical denials.

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

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

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:	The ASO reviews waiver service providers in accordance with the requirements and schedule outlined in the contract with the Medicaid Agency. (Number of service provider reviews conducted by ASO/ Number of service provider reviews due for review)		
Data Source *(Select one) (Several options are listed in the on-line application):* **Reports to State Medicaid Agency on delegated Administrative functions**			
If 'Other' is selected, specify:			
	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*	
	Administrative Services Organization	☐ *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:	MassHealth, MRC and the Fiscal Management Service agencies (FMS) work collaboratively to ensure systematic and continuous data collection and analysis of the FMS entity functions and systems as evidenced by the timely and appropriate submission of required data reports. (Number of FMS reports submitted on time and in the correct format/ Number of FMS reports due)
Data Source *(Select one) (Several options are listed in the on-line application):* **Reports to State Medicaid Agency on delegated Administrative functions**	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *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 Agencies	☐ *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:	% of annual redeterminations with a completed Waiver LOC determination instrument before the end of 365 days. (Number of annual redeterminations with a completed Waiver LOC determination instrument before the end of 365 days/ Total number of individuals needing annual redeterminations)
Data Source *(Select one) (Several options are listed in the on-line application):*	
*If 'Other' is selected, specify:***Level of Care Entity Reports**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Level of Care Entity	☐ *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:	Participants are supported by competent and qualified case managers. (Number of Case Managers with a rating of "meets expectations" or "exceeds expectations" on their performance evaluations/ Number of Case Managers due for performance evaluation
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **Performance Evaluations**	

	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)

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 Massachusetts Rehabilitation Commission, the Department of Developmental Services and MassHealth are responsible for ensuring effective oversight of the waiver program. As problems are discovered with the management of the waiver program at individual entities, MassHealth, MRC, and DDS are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, MassHealth is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☑ *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)	65		☑
	☑	Disabled (Physical)	18	64	
	☐	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			☐
	☐	Mental Retardation			☐
☑	**Mental Illness** *(check each that applies)*				
	☑	Mental Illness	18		☑
	☐	Serious Emotional Disturbance			

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

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

Applicants to the MFP Community Living (MFP-CL) Waiver must also meet the following program criteria to participate in the waiver:

1. Reside (and have resided for a period of not less than 90 consecutive days) in an inpatient facility (specifically, a nursing facility, chronic disease or rehabilitation hospital, or psychiatric hospital);

2. Meet the level of care criteria as specified in Appendix B.6.d.; and

3. Be able to be safely served in the community within the terms of the MFP-CL Waiver and with the services provided therein.

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*:

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	1,343
Year 2	1,418
Year 3	1,483
Year 4 (only appears if applicable based on Item 1-C)	1,548
Year 5 (only appears if applicable based on Item 1-C)	1,613

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: Waiver Transfer		
	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):
		Waiver Transfer	
		Purpose (describe):	**Purpose** (describe):
		The state reserves capacity for individuals who have been receiving service from another 1915(c) waiver or receiving State Plan services who now require the services of the MFP-CL waiver to meet their needs. MFP-RS, ABI-RH, and ABI-N Waiver Participants, and MFP Demonstration Participants within their MFP Demonstration period or up to 180 days thereafter, who request a transfer to the MFP-CL Waiver will be considered to have met the additional targeting criteria outlined in Appendix B-1-b item #1. All such individuals must meet the remaining eligibility criteria as outlined in Appendix B-1-b.	
		Describe how the amount of reserved capacity was determined:	**Describe how the amount of reserved capacity was determined:**
		The reserved capacity is an estimate of anticipated need for waiver transfers and will be adjusted if necessary based on actual experience.	
	Waiver Year	**Capacity Reserved**	**Capacity Reserved**

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

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:

I. Residents of Inpatient Facilities

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

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

3. Any applicants who are denied entry to the waiver will be offered the opportunity to request a fair hearing as noted in Appendix F. Applicants who are denied entry into the waiver will receive a list of other resources.

II. Moving Forward Plan Residential Supports (MFP-RS) and Acquired Brain Injury with Residential Habilitation (ABI-RH), and Acquired Brain Injury Nonresidential Habilitation (ABI-N) Waiver participants and MFP Demonstration participants

1. The following individuals may request a transfer to the MFP-CL waiver: MFP-RS, ABI-N, and ABI-RH Waiver Participants. These applicants will be considered to have met the requirement of having resided for a period of not less than 90 consecutive days in an inpatient facility. MFP Demonstration participants within their MFP Demonstration period and MFP Demonstration participants within 180 days of the conclusion of the MFP Demonstration period may request a transfer to the MFP-CL waiver only if they resided for a period of not less than 90 consecutive days in an inpatient facility (specifically, a nursing facility, chronic disease or rehabilitation hospital, or psychiatric hospital) prior to their enrollment in the MFP Demonstration. Such Participants who request enrollment in the MFP-CL Waiver will be subject to all other requirements for enrollment in the MFP-CL waiver. These applicants will be accepted based on availability of open capacity in the waiver on the date of their determination of eligibility.

2. Any applicants who are denied entry to the waiver will be offered the opportunity to request a fair hearing as noted in Appendix F. Applicants who are denied entry into the waiver will receive a list of other resources.

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
☐	☐	☐	☐	☐

State:	
Effective Date	

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 December 31, 2018.*

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

☑		Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state elects to (*select one*):
	☑	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○		Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

Note: 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. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
☑	The following standard included under the state plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional state supplement standard**		
	○	**Medically needy income standard**		
	☑	**The special income level for institutionalized persons** *(select one):*		
		☑	**300% of the SSI Federal Benefit Rate (FBR)**	
		○	%	**A percentage of the FBR, which is less than 300%** Specify the percentage:
		○	$	**A dollar amount which is less than 300%.** 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**			
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.	

State:	
Effective Date	

○	**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**

State:	
Effective Date	

○	**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. <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.**

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

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

○	**Directly by the Medicaid agency**
○	**By the operating agency specified in Appendix A**
☑	**By 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:

The registered nurse performing waiver evaluations must:

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

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

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

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

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

A person will be considered to meet a nursing facility level of care if the individual meets the criteria as defined in 130 CMR 456.409 (MassHealth Nursing Facility Regulation that describe the requirements for medical eligibility for nursing facility services). The MassHealth nursing facility provider regulations define in 130 CMR 456.409 the nursing facility level of care criteria. To be considered medically eligible for nursing facility services, you must require one skilled service daily or require a combination of at least three services that support activities of daily living and nursing services, one such service of which must be a nursing service.

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

I. Assistance with Activities of Daily Living (ADL) and Nursing Needs
A. ADL assistance includes continual supervision required throughout the task or activity, or daily limited, extensive, maximal physical assistance, or total dependence per MDS-HC, for needs with the following activities
1. Bathing - complete body bath via tub, shower or bathing system
2. Dressing - dressed in street clothes including underwear
3. Toileting - assistance to & from toilet, includes catheter, urostomy or colostomy care
4. Transfers - assistance to & from bed, chair or wheelchair
5. Locomotion Inside and Outside Home - movement inside and outside the home, excluding stairs. Note if the participant uses a wheelchair, self-sufficiency once in wheelchair

6. Eating - does not include meal or tray preparation
7. Bed Mobility-requires physical assistance of at least one person to change positions while in bed.

B. Nursing Services. Nursing services, including any of the following procedures performed at least three times a week, may be counted in the determination of eligibility:
1. Any physician-ordered skilled service specified in 130 CMR 456.409(A) (MassHealth Nursing Facility Regulation that describes the skilled service requirement for nursing facility eligibility);
2. Positioning while in bed or a chair as part of the written care plan;
3. Administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions;
4. Physician-ordered occupational, physical, speech/language therapy or some combination of the three;
5. Physician-ordered licensed registered nursing observation and/or vital-signs monitoring, specifically related to the need for medical or nursing intervention; and
6. Treatments involving prescription medications for uninfected postoperative or chronic conditions according to physician orders, or routine changing of dressings that require nursing care and monitoring.

II. Behavior Intervention: Staff intervention required for selected types of behaviors that are generally considered to present excessive risk of harm to self or others, or considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers. Risk indicators and behaviors include:
1. Wandering or getting lost
2. Verbally abusive
3. Physically abusive (physically assaultive/exhibition of violence toward others)
4. Socially inappropriate/disruptive behavior that requires ongoing and consistent staff intervention, including problematic sexual behaviors (impulsivity, public masturbation, inappropriate sexual advances)
5. Inability to avoid simple dangers, to react appropriately to unsafe situations (ability to exit building in response to fire/natural disaster) and/or to curtail activities that create dangers to self or others such as fire safety issues, including unsafe smoking practices, unsafe cooking, fire setting behaviors
6. Substance abuse
7. History of non-adherence to treatment and/or medication regimens
8. Suicidal ideation or attempts

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

IV. Functional and Independent Living Skill Development
1. Meal preparation,
2. Ordinary Housework (includes laundry)
3. Budgeting and Personal Finances
4. Managing Medications

5. Outdoor Mobility 6. Transportation 7. Grocery Shopping 8. Personal Hygiene

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

○	**The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
☑	**A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.** Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.
	The MDS-HC, plus several additional assessment questions, are used for re-evaluation of level of care for the waiver. The additional questions are used to document the skilled nursing needs and their frequency, staff monitoring, oversight or intervention required for behavior intervention and staff intervention needed for memory and learning and reality orientation. The MDS-HC is the same tool used by MassHealth's agents to evaluate level of care of nursing facility residents to determine eligibility for payment. MassHealth Office of Clinical Affairs nurse reviewers assess chronic and rehabilitation hospital for level of care. Psychiatric hospitals assessment of level of care is documented by the attending physician utilizing an admission certification form and the continued need for psychiatric hospital level of care is documented by the attending physician and the social worker in progress notes.

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

Evaluation- A Registered Nurse from the Level of Care entity will be responsible for reviewing the most recent assessment performed in the medical facility. The nurse will use this information to screen each waiver applicant to determine whether they meet the criteria outlined in Appendix B-1-a and B-1-b. For participants transferring from the ABI-N, MFP-RS, or ABI-RH the Registered Nurse may either review the most recent level of care assessment performed for that waiver, or conduct an updated assessment to confirm that the participant meets a nursing facility or hospital level of care. The evaluation may be conducted in-person, telephone, video-conferencing and/or other electronic modalities with the participant. Re-evaluation- A registered nurse from the contracted Level of Care entity makes an evaluation of each waiver participant. Information gathered for the re-evaluation of level of care is derived from interviews done in-person, telephone, video-conferencing and/or other electronic modalities with the participant. Re-evaluations also include a thorough evaluation of the client's individual circumstances and medical records.

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

○	**Every three months**
○	**Every six months**
☑	**Every twelve months**

○	**Other schedule** *Specify* the other schedule:

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

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

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

The Level of Care entity will maintain a database of waiver participants, the dates of level of care evaluations and dates for re-evaluation. They will be responsible for ensuring that the re-evaluation is triggered 60 days prior to the date it is due. Through the use of management reports registered nurses are provided with the data needed to ensure timely completion of reevaluation.

The nurse documents the results of the re-evaluation using the MDS-HC, additional assessment questions and case notes. Level of Care entity reports to MRC include the date each Level of Care (LOC) re-evaluation is completed and the results of the level of care determination.

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 by the Level of Care entity. Records are maintained for each waiver participant in accordance with 808 CMR 1.00 (the State's Division of Purchased Services regulations that describe the contract compliance, financial reporting, and auditing requirements applicable to state procurements of human and social services).

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:	% of applicants who received an initial clinical eligibility assessment within 90 days of waiver application. (Number of individuals who received an initial clinical eligibility assessment within 90 days of waiver application/ Number of individuals who received an initial clinical eligibility assessment)		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify: **Level of Care Entity reports**			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Level of Care Entity	☐ *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:	
Effective Date	

☑ *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 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*	

State:	
Effective Date	

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

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

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

If 'Other' is selected, specify: **Level of Care Entity reports**

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Level of Care Entity	☐ *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:	% of clinical determinations of "denial" that have been reviewed for appropriateness of denial. (Number of denials reviewed/ Number of denials))
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **Level of Care Entity reports**	

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

State:	
Effective Date	

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 Massachusetts Rehabilitation Commission, the Department of Developmental Services and MassHealth are responsible for ensuring effective oversight of the waiver program As problems are discovered with the management of the waiver program at individual entities, MassHealth, MRC, and DDS are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, MassHealth is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii Remediation Data Aggregation

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

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).

Once initial waiver eligibility has been determined, the Case Manager delivers a Recipient Choice Form to the participant (or legal representative) either in person ,by mail or electronically. This form includes written notification that the participant has been determined eligible for the waiver and offers the applicant the opportunity to choose between community-based or facility-based services. The participant indicates their preference on the Recipient Choice Form. The signed and dated form is maintained, for all waiver participants, by the case manager in the client record.

If the participant chooses to receive community-based services, the Case Manager informs the participant of the services available under the waiver as part of the person-centered service plan development process.

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

The Recipient Choice Form is maintained in the participant electronic record.

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):

MassHealth and the Massachusetts Rehabilitation Commission (MRC) have developed multiple approaches to promote and ensure access to the waiver by Limited English Proficient persons. MassHealth eligibility notices and information regarding appeal rights are available in English and Spanish. In addition, these notices include a card instructing individuals in multiple languages that the information affects their health benefit, and to contact MassHealth Customer Service for assistance with translation.

Information about waiver eligibility and services is available in a number of languages and is posted on the MassHealth ABI/MFP Waivers webpage. Waiver denial notices include a card instructing individuals how to get assistance with translation. MRC also creates documents for participants in cognitively accessible formats. Case Managers are required to ensure the provision of services that are accessible to current and potential consumers. Accessible services are defined as those that address geographic, physical, and communication barriers so that consumers can be served according to their needs. Case Managers conduct outreach with materials in languages appropriate to the populations residing in the geographic service area. Case Managers also work collaboratively with minority community organizations that provide social services to identify individuals and families who may be eligible for waiver program services. MRC also has qualified Cultural Facilitators that may be accessed to assist in this process.

MRC attempts to ensure that employees are capable of speaking directly with consumers in their primary language and in cognitively accessible formats. When this is not possible, they arrange for interpreting services by either a paid interpreting service, a cultural facilitator or through an individual, such as a family member, designated by the consumer. MRC also provides access to TTY services for persons calling the agency.

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:*

Service Type	Service
Statutory Service	**Home Health Aide**
Statutory Service	**Homemaker**
Statutory Service	**Personal Care**
Statutory Service	**Prevocational Services**
Statutory Service	**Respite**
Statutory Service	**Supported Employment**
Other Service	**Adult Companion**
Other Service	**Assistive Technology**
Other Service	**Chore**
Other Service	**Community Based Day Supports (CBDS)**
Other Service	**Community Behavioral Health Support and Navigation**
Other Service	**Community Family Training**
Other Service	**Day Services**
Other Service	**Home Accessibility Adaptations**
Other Service	**Home Delivered Meals**
Other Service	**Independent Living Supports**
Other Service	**Individual Support and Community Habilitation**
Other Service	**Laundry**
Other Service	**Occupational Therapy**
Other Service	**Orientation and Mobility Services**
Other Service	**Peer Support**
Other Service	**Physical Therapy**
Other Service	**Shared Home Supports**
Other Service	**Skilled Nursing**
Other Service	**Specialized Medical Equipment**
Other Service	**Speech Therapy**
Other Service	**Supportive Home Care Aide**
Other Service	**Transitional Assistance**
Other Service	**Transportation**
Other Service	**Vehicle Modification**

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 Service						
Service:						
Home Health Aide						
☑ 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 defined in 42 CFR §440.70 that are provided in addition to home health aide services furnished under the approved State plan. Home health aide services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from home health aide services in the State plan. The difference from the State plan is as follows: Agencies that provide Home Health Aide services under the waiver do not need to meet the requirements for participation in Medicare, as provided in 42 CFR §489.28.						
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:
				Home Health Agencies
				Homemaker/Personal Care Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agencies	Supervision of Home Health Aides must be provided by a Registered Nurse with a valid Massachusetts license.	Individuals employed by the agency providing home health aide services must have either of the following: - Certificate of Home Health Aide Training	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency

		- Certificate of Certified Nurse's Aide Training	situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of participant information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and policies that comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies

			that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). In addition, providers shall ensure that individual home health aides employed by the agency have been CORI checked and are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.
Homemaker/Personal Care Agencies	Supervision of Home Health Aides must be provided by a Registered Nurse with a valid Massachusetts license.	Individuals employed by the agency providing home health aide services must have either of the following: - Certificate of Home Health Aide Training - Certificate of Certified Nurse's Aide Training	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established

			strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of participant information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and policies that comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a homemaker agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting

			and Protective Services Program regulations). In addition, providers shall ensure that individual home health aides employed by the agency have been CORI checked and are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect 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
Home Health Agencies	Administrative Service Organization	Every 2 years
Homemaker/Personal Care Agencies	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Statutory Service
Service:
Homemaker
☐ 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 that consist of the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Individual Homemakers		Homemaker Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Homemaker Agencies		Individuals employed by the agency providing homemaker services must have one of the following: - Certificate of Nurse's Aide Training - Certificate of Home Health Aide Training - Certificate of 40-Hour Homemaker Training - Certificate of 60-Hour Personal Care Training	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of participant information in accordance with applicable laws and policies.

			- Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and policies that comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a homemaker agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Homemaker Service Providers must have experience providing services to persons with disabilities. In addition, providers shall ensure that individual homemakers employed by the agency have been CORI checked, and are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept people of differing abilities, different values, nationalities, races, religions, cultures and standards of living.
Individual Homemaker		Individuals providing homemaker services must have	Individuals who provide Homemaker services must have responded satisfactorily to the Waiver provider

		certification in one of the following: - Certification in Home Health Aide Training - Certification in Nurse's Aide Training - Certification of 40-Hour Homemaker Training - Certification of 60-Hour Personal Care Training	enrollment process and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; and have ability to meet legal requirements in protecting confidential information. Individuals must be provided with information regarding the applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Homemaker Agencies	Administrative Service Organization	Every 2 years
Individual Homemaker	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Statutory Service
Service:
Personal Care
☐ 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)**:**

A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing and supervision to prompt the participant to perform a task. Such assistance may include assistance in bathing, dressing, personal hygiene and other activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the care plan, this service may also include such housekeeping chores as bed-making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health or welfare of the individual, rather than the individual's family. Personal care services may be provided on an episodic or on a continuing basis.

Personal care under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from personal care services in the State plan. Personal care under the waiver may include supervision and cuing of participants.

All waiver participants are entitled to receive medically necessary State plan services. MassHealth All Provider regulations at 130 CMR 450.140 through 149 detail the ESPDT requirements for MassHealth providers and Appendix W of the MassHealth provider manual for personal care services lists EPSDT screening schedules.

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 Personal Care Worker		Personal Care Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Care Agencies		Individuals employed by the agency providing personal care services must have one of the following: - Certificate of Home Health Aide Training - Certificate of Nurse's Aide Training - Certificate of 60-Hour Personal Care Training	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for

			appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a personal care agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose,

			rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Personal Care Service Providers must have experience providing services to persons with disabilities. In addition, providers shall ensure that individual personal care workers employed by the provider agency have been CORI checkedand are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept people of differing abilities, different values, nationalities, races, religions, cultures and standards of living.
Individual Personal Care Worker		Individuals providing personal care services must have one of the following: - Certificate of Home Health Aide Training - Certificate of Nurses Aide Training - Certificate of 60-Hour Personal Care Training	Individuals who provide Personal Care services must have responded satisfactorily to the Waiver provider enrollment process and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required. Individuals must be provided with information regarding the applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse

			allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Care Agencies	Administrative Service Organization	Every 2 years
Individual Personal Care Worker	Administrative Service Organization	Every 2 years

Service Specification

Service Type:

Statutory Service

Service:

Prevocational 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)**:**

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

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

Services are reflected in the participants individualized service plan and are directed to address habilitative or rehabilitative rather than explicit employment objectives. Prevocational services may be provided one-to-one or in a group format. This service may be provided as a site-based service, in community settings or in a combination of these settings and must include integrated community activities that support the development of vocational skills. 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 Case Manager 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. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Prevocational Service Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Prevocational Service Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Education, Training, Supervision: Providers are responsible for ensuring staff are trained on: - Applicable regulations and policies governing waiver service delivery and the principles of participant-centered, community-based care. - Potential cognitive and/or mental health issues as well as physical needs of participants with disabilities - All aspects of their job duties, including handling a range of potential emergency situations. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services

			provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include

			provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. - Agencies must ensure that staff who provide Prevocational services: have been Criminal Offender Record Information (CORI) checked, have a College degree plus experience in providing community-based services to individuals with disabilities, or at least two years comparable community-based, life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information. Physical Plant: - Understanding and compliance with all required policies, procedures, and physical plant standards relevant to the community setting as established by MRC. - Demonstrated compliance with health and safety, accessibility standards and the ADA, as applicable. Providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Prevocational Service Agencies	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Statutory Service
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)**:**
Waiver services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite Care may be provided to relieve informal caregivers from the daily stresses and demands of caring for a Participant in efforts to strengthen or support the informal support system. Respite Care services may be provided in the following locations: - Respite Care in an Adult Foster Care Program provides personal care services in a family-like setting. A provider must meet the requirements set forth by MassHealth and must contract with MassHealth as an AFC provider. - Respite Care in a Hospital is provided in licensed acute care medical/surgical hospital beds that have been approved by the Department of Public Health. - Respite Care in a Skilled Nursing Facility provides skilled nursing care; rehabilitative services such as physical, occupational, and speech therapy; and assistance with activities of daily living such as eating, dressing, toileting and bathing. A nursing facility must be licensed by the Department of Public Health. - Respite Care in a Rest Home provides a supervised, supportive and protective living environment and support services. Rest Homes must be licensed by the Department of Public Health. - Respite Care in an Assisted Living Residence provides personal care services by an entity certified by the Executive Office of Elder Affairs. - Respite care in the home of a Community Respite Provider home which provides personal care services in a home like setting. Provider must meet the site based requirements for respite of the Department of Developmental Services (DDS) - Respite care in DDS Licensed Respite Facilities provides care and supervision in a setting licensed by the Department of Developmental Services. 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 approved by the State that is not a private residence.
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

State:	
Effective Date	

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Adult Foster Care
				Skilled Nursing Facility
				DDS Licensed Respite Facilities
				Rest Home
				Assisted Living Residence
				Hospital
				Community Respite Providers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Foster Care			An organization which meets the requirements of 130 CMR 408.000 (MassHealth Adult Foster Care regulations that define provider eligibility requirements and program rules) and that contracts with MassHealth as the provider of Adult Foster Care.
Skilled Nursing Facility			Licensed by the Department of Public Health in accordance with 105 CMR 153.000 (Department of Public Health Licensure Procedure and Suitability Requirements for Long-Term Care Facilities Regulations that describes the licensure procedures and suitability requirements for long-term care facilities in Massachusetts).
DDS Licensed Respite Facilities			An organization which meets the Department of Developmental Services (DDS) site-based respite requirements found at 115 CMR 7.00 and 8.00 and that contracts with DDS to provide these services. Department of Developmental Services (DDS) regulations at 115 CMR 7.00 describes the requirements for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training and 115 CMR 8.00 describes the licensure, certification and enforcement requirements for all DDS residential supports, work/day supports, placement

			services, or residential site-based respite supports provided by public and private providers.
Rest Home	Licensed by the Department of Public Health in accordance with 105 CMR 153.000 (Department of Public Health Licensure Procedure and Suitability Requirements for Long-Term Care Facilities Regulations that describes the licensure procedures and suitability requirements for long-term care facilities in Massachusetts).		
Assisted Living Residence		Certified by the Executive Office of Elder Affairs in accordance with 651 CMR 12.00 (Department of Elder Affairs regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts).	
Hospital	Licensed by the Department of Public Health in accordance with 105 CMR 130.000 (Department of Public Health Hospital Licensure Regulations that describes the standards for the maintenance and operations of		

	hospitals in Massachusetts).		
Community Respite Providers			An organization which meets the Department of Developmental Services (DDS) site-based respite requirements found at 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) and that contracts with DDS to provide these services.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Foster Care	Administrative Service Organization	Every 2 years
Skilled Nursing Facility	Administrative Service Organization	Every 2 years
DDS Licensed Respite Facilities	Administrative Service Organization	Every 2 years
Rest Home	Administrative Service Organization	Every 2 years
Assisted Living Residence	Administrative Service Organization	Every 2 years
Hospital	Administrative Service Organization	Every 2 years
Community Respite Providers	Administrative Service Organization	Every 2 years

Service Specification

Service Type:

Statutory Service

Service:

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)**:**

Supported employment services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are

employed. 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 Case Manager 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. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

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

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

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

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

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

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

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

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

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

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Community-Based Employment Services Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community-Based Employments Services Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has demonstrated the experience and ability to successfully provide four components of supported employment programs, including Assessment, Placement, Initial Employment Supports and Extended

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

			Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Staff and Training: - Experience recruiting and maintaining qualified staff; assurance that all staff

			will be CORI checked; policies/practices which ensure that: - There is a team approach to service delivery - Program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principals of participant choice, as it relates to those with disabilities. Quality: - Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. Providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community-Based Employments Services Agencies	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
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 a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan.

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 Case Manager 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 Aide		Home Care Agencies
				Human Service Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Care Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for

			effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a adult companion agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse

			allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. - Individuals employed as Adult Companions must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required.
Individual Aide			Individuals who provide Adult Companion services must have responded satisfactorily to the Waiver provider enrollment process and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have life or work experience providing services to

			individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required. Individuals must be provided with information regarding the applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information.
Human Service Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services

			provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by an adult companion agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

			- Individuals employed as Adult Companions must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required. 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Care Agencies	Administrative Service Organization	Every 2 years
Individual Aide	Administrative Service Organization	Every 2 years
Human Service Agencies	Administrative Service Organization	Every 2 years

Service Specification

Service Type

Other Service

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 goals identified in their Plan of Care. 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 set up 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 Plan of Care; 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 Case Manager as part of the Plan of Care. The Case Manager 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 Case Manager 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 this service and either the Transitional Assistance Service or the Specialized Medical Equipment 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 Specifications

Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Individual Assistive Technology Provider		Assistive Technology Agencies	
			Assistive Technology Device Provider	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Assistive Technology Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Providers shall ensure that individual workers employed by the agency have been CORI checked and are able to perform assigned duties and responsibilities. - Providers of assistive technology must ensure that all devices and accessories have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate. Staff providing services must have: - Bachelor's degree in a related technological field and at least one year of demonstrated experience providing adaptive technological assessment or training; or - A bachelor's degree in a related health or human service field with at least two years of demonstrated experience providing adaptive technological assessment or training; or - Three years of demonstrated experience providing adaptive technological assessment or training.

			Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with a disability, including functional evaluation of the individual in the individual's customary environment. - Knowledge and experience in the purchasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities. - Knowledge and/or experience in selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices. - Knowledge and/or experience in coordinating and using other therapies, interventions, or services with assistive technology devices. - Knowledge and/or experience in training or providing technical assistance for an individual with disabilities, or, when appropriate, the family of an individual with disabilities or others providing support to the individual. - Knowledge and/or experience in training and/or providing technical assistance for professionals or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities. In addition, providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.
Individual Assistive Technology Provider			Individuals who provide Assistive Technology services must have responded satisfactorily to the Waiver provider enrollment process and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information. Individuals providing services must have: - Bachelor's degree in a related technological field

			and at least one year of demonstrated experience providing adaptive technological assessment or training; or - A bachelor's degree in a related health or human service field with at least two years of demonstrated experience providing adaptive technological assessment or training; or - Three years of demonstrated experience providing adaptive technological assessment or training. Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with a disability, including functional evaluation of the individual in the individual's customary environment. - Knowledge and experience in the purchasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities. - Knowledge and/or experience in selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices. - Knowledge and/or experience in coordinating and using other therapies, interventions, or services with assistive technology devices. - Knowledge and/or experience in training or providing technical assistance for an individual with disabilities, or, when appropriate, the family of an individual with disabilities or others providing support to the individual. - Knowledge and/or experience in training and/or providing technical assistance for professionals or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities. In addition, individuals licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.
Assistive Technology			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider

Device Provider			enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Providers shall ensure that individual workers employed by the agency have been CORI checked and are able to perform assigned duties and responsibilities. - Providers of assistive technology must ensure that all devices and accessories have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate. In addition, providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Assistive Technology Agencies	Administrative Service Organization	Every 2 years
Individual Assistive Technology Provider	Administrative Service Organization	Every 2 years
Assistive Technology Device Provider	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
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 heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture, shoveling snow in order to provide safe access and egress. These services are provided only 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 capable of or 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 service.
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 Provider		Chore Provider Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Chore Provider Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services

			provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a chore services agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

			Chore Service Providers must have experience providing services to persons with disabilities. In addition, providers shall ensure that individual chore workers employed by the provider agency have been CORI checked, are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept people of differing abilities, different values, nationalities, races, religions, cultures and standards of living.
Individual Chore Provider			Individuals who provide Chore services must have responded satisfactorily to the Waiver provider enrollment process and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; and have ability to meet legal requirements in protecting confidential information. Individuals must be provided with information regarding the applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information.
Verification of Provider Qualifications			

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Chore Provider Agencies	Administrative Service Organization	Every 2 years
Individual Chore Provider	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Community Based Day Supports (CBDS)
☐ 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)**:**
Community Based Day Supports (CBDS) is designed to enable an individual to enrich their life and enjoy a full range of community activities by providing opportunities for developing, enhancing, and maintaining competency in personal, social interactions and community integration. The service may include career exploration, including assessment of interests through volunteer experiences or situational assessments; community integration 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 individuals of working age who may be on a pathway to employment, a supplemental service for individuals who are employed part-time and need a structured and supervised program of services during the time that they are not working, and for individuals who are of retirement age. Using a small group model, CBDS provides a flexible array of individualized supports through community activities that promote socialization, peer interaction and community integration.
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:
				Rehabilitation Agencies
				Human Service Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Rehabilitation Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the waiver provider enrollment

			process, which includes meeting requirements for staffing qualifications and training, and all prescribed operational policies and procedures, including, but not limited to: Program: - Understanding and compliance with all required policies, and procedures - Experience providing functional, community-based services and living skills training and understanding of the philosophy of maximizing independence, participant participation, community integration and a comprehensive blend of services; - Demonstrated experience and/or willingness to work effectively with the MassHealth agency or its designee and with the Case Managers responsible for oversight and monitoring of the participants receiving these services; - Adequate organizational structure to support the delivery and supervision of services in the community, including: - Ability to plan and deliver services - Demonstrated ability to produce timely, complete and quality documentation including but not limited to assessments, incident reports, progress reports and program-specific service plans Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to

			14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Staff and Training: - Individuals who provide CBDS services must meet all requirements for individuals in such roles, including, but not limited to: have been CORI checked, have a college degree plus experience in providing community-based services to individuals with disabilities, or at least five years comparable work experience providing community-based services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required. - Demonstrates a team approach to service delivery including the ability to define, track and monitor service interventions that meet participant goals and objectives - Ability to access relevant clinical support as needed - Experience recruiting and maintaining qualified staff; assurance that all staff will be CORI checked; policies/practices which ensure that: - Program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principles of participant choice Quality:

			- Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. Compliance with the licensure and/or certification standards of another Executive Office of Health and Human Services agency may be substituted for the above qualifications. For example Department of Developmental Services requirements at 115 CMR 7.00 & 8.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) or Department of Mental Health requirements at 104 CMR Subpart B (Department of Mental Health regulations for licensing and operational standards for mental health related community programs and which address protection from mistreatment and physical restraints) may be substituted for the above qualifications.
Human Service Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the waiver provider enrollment process, which includes meeting requirements for staffing qualifications and training, and all prescribed operational policies and procedures, including, but not limited to: Program: - Understanding and compliance with all required policies, and procedures - Experience providing functional, community-based services and living skills training and understanding of the philosophy of maximizing independence, participant participation, community integration and a comprehensive blend of services;

			- Demonstrated experience and/or willingness to work effectively with the MassHealth agency or its designee and with the Case Managers responsible for oversight and monitoring of the participants receiving these services; - Adequate organizational structure to support the delivery and supervision of services in the community, including: - Ability to plan and deliver services -Demonstrated ability to produce timely, complete and quality documentation including but not limited to assessments, incident reports, progress reports and program-specific service plans Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Staff and Training: - Individuals who provide CBDS services must meet all requirements for individuals in such roles, including, but

			not limited to: have been CORI checked, have a college degree plus experience in providing community-based services to individuals with disabilities, or at least five years comparable work experience providing community-based services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required. - Provider agencies must demonstrate: - A team approach to service delivery including the ability to define, track and monitor service interventions that meet participant goals and objectives; - Ability to access relevant clinical support as needed; - Experience recruiting and maintaining qualified staff, including assurance that all staff will be CORI checked; - Policies/practices which ensure that program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principles of participant choice; and that individuals who provide CBDS services receive effective training in all aspects of their job duties, including handling emergency situations. Quality: - Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. Compliance with the licensure and/or certification standards of another Executive Office of Health and Human Services agency may be substituted for the above qualifications. For example Department of Developmental Services

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

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Rehabilitation Agencies	Administrative Service Organization	Every 2 years
Human Service Agencies	Administrative Service Organization	Every 2 years

Service Specification

Service Type:

Other Service

Service:

Community Behavioral Health Support and Navigation

☐ 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)**:**

Community Behavioral Health Support and Navigation includes an array of services delivered by community based, mobile, paraprofessional staff, supported by a clinical supervisor, to participants with behavioral health needs whose psychiatric diagnosis or substance use disorder(s) interferes with their ability to access essential medical and behavioral health services. The services provided are tailored to the needs of the individual and are designed to ensure that the participant has access to and in fact utilizes needed behavioral health services. Community Behavioral Health Support and Navigation does not include clinical treatment services, but rather provides outreach and support services to enable participants to utilize clinical treatment services and other supports. Community Behavioral Health Support and Navigation assists the participant with attaining the goals in their plan of care, and works to mitigate barriers to doing so. 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 Case Manager during each scheduled reassessment as outlined in Appendix D-2-a.

Community Behavioral Health Support and Navigation services are designed to be maximally flexible in supporting participants to implement the goals in their plan of care and attain the skills and resources needed to successfully maintain community tenure. Such services may include:
- Fostering empowerment, recovery, and wellness, including developing recovery strategies, identifying and assisting participants in accessing self-help options, and creating crisis prevention plans and relapse prevention plans;
- Assisting participants in improving their daily living skills so they are able to perform them independently or access services to support them in doing so;
- Supporting service exploration and linkage;
- Providing temporary assistance with transportation to essential medical and behavioral health appointments while transitioning to community-based transportation resources (e.g., public transportation resources, PT-1 forms, etc.) - Assisting with connecting the participant to necessary behavioral health and other health care services (including, as applicable, supporting engagement with coordination provided by the participant's ACO or MCO);
- Providing linkages to recovery-oriented peer support and/or self-help supports and services;
- Assisting with self-advocacy skills to improve communication and participation in treatment/service planning discussions and meetings; and
- Collaborating with Emergency Services Programs/Mobile Crisis Intervention (ESP/MCIs) and/or outpatient providers; including working with ESP/MCIs to develop, revise and/or utilize participant crisis prevention plans and/or safety plans.

Community Behavioral Health Support and Navigation services may not duplicate, and are expected to complement other waiver and State Plan services that are being utilized by the individual and support the participant's attainment of their plan of care goals.

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:
				Community Behavioral Health Support and Navigation Providers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community Behavioral Health Support and Navigation Providers	Services are provided by agencies that provide mental health or substance use disorder services and are licensed within the Commonwealth of Massachusetts.		Agency Staffing and Supervision Requirements: - Agencies providing Community Behavioral Health Support and Navigation must employ a multi-disciplinary staff with established experience, skills, and training in the acute treatment of mental health and co-occurring mental health and substance use conditions, including a minimum of

			one fulltime master's or doctorate-level, licensed behavioral health clinician responsible for operation of the program and supervision of the staff. - In addition, there must be a psychiatric clinician available for psychiatric phone consultation within 15 minutes of request and for a face-to-face evaluation within 60 minutes of request, when clinically indicated. - Agencies providing Community Behavioral Health Support and Navigation must ensure that the service is accessible to participants seven days per week. An answering machine or answering service directing callers to call 911 or the ESP/MCI, or to go to a hospital emergency department (ED) does not meet this requirement. Individual Staff Requirements: Individuals who provide Community Behavioral Health Support and Navigation are mobile, community-based staff that must meet requirements for individuals in such roles, including, but not limited to: - have been CORI checked; - Bachelor's degree in a Human Services field and experience working in community settings with individuals with disabilities who have behavioral health needs; - training in and ability to handle emergency situations; - can set limits and communicate effectively with participants, families, other providers and agencies; - have ability to meet legal requirements in protecting confidential information; and - certification in CPR is required. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements)

			for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Agencies qualified as providers of the following services through the applicable state agency or other designated entity are considered to have met the above qualification requirements: - Community Based Family Supports (CBFS), through the Department of Mental Health (DMH) - Community Support Program (CSP), through MassHealth or a MassHealth-

			contract Managed Care Organization (MCO), Accountable Care Organization (ACO), or Integrated Care Organization (One Care) - Program of Assertive Community Treatment (PACT), through DMH - Behavioral Health Community Partners (BH CPs), through MassHealth

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community Behavioral Health Support and Navigation Providers	Administrative Service Organization	Every 2 years

Service Specification

Service Type:

Other Service

Service:

Community 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)**:**

Community 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. Community Family Training may also include training in family leadership, support for the family unit to adjust to the changes in the life of the family created by the disability of the participant, 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, and supports family members to adjust to the changes in their lives. 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 does not include individuals who are employed to care for the participant other than to support the education and training provided to the family and participant. Community Family Training may be provided in a small group format or the Family Trainer may provide individual instruction to a specific family based on the needs of the family to understand the specialized needs of the waiver participant. The one to one family training is instructional or psychoeducational rather than counseling. This service is available to those waiver participants who either live in the family home or receive less than 24 hours of support per day and regularly visit with their family.

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 Case Manager 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 Family Training Provider		Family Training Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
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 interview(s), two personal or professional references, and a Criminal Offense Record Inquiry (CORI). The applicant must have the ability to communicate effectively in the language and communication style of the family to whom they are providing training. The applicant must have experience in providing family leadership, self-advocacy, and skills training in independence. Individuals must be provided with information regarding the applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information. 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.
Family Training Agencies	If the agency is providing activities where licensure or certification is necessary, the applicant will have the necessary licensure/certifications. For mental health professionals such as Family Therapists, Rehabilitation Counselors, Social Workers, necessary licensure or certification requirements for those disciplines must be met.		Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all

			quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that comply with the applicable standards under 105 CMR 155.000 for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Family Training Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq. 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of

			M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. - Individuals who provide Family Training Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information. The agency must employ individuals who are able to effectively communicate in the language and communication style of the individual or family for whom they are providing the training. Staff members providing Family Training must have experience in promoting independence and in family leadership.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual Family Training Provider	Administrative Service Organization	Every 2 years
Family Training Agencies	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Day 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)**:**

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

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 Case Manager 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:
				Rehabilitation Facilities
				Human Service Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Rehabilitation Facilities			Any not-for-profit or proprietary organization that responds satisfactorily to the waiver provider enrollment process, which includes meeting requirements for staffing qualifications and training, and all prescribed operational policies and procedures, including, but not limited to: Program and Physical Plant: - Understanding and compliance with all required policies, procedures, and physical plant standards - Experience providing functional, community-based services and living

			skills training and understanding of the philosophy of maximizing independence, participant participation, community integration and a comprehensive blend of services; - Demonstrated experience and/or willingness to work effectively with the MassHealth agency or its designee and with the Case Managers responsible for oversight and monitoring of the participants receiving these services; - Adequate organizational structure to support the delivery and supervision of day services, including: - Ability to plan and deliver services in the prescribed settings - Demonstrated ability to produce timely, complete and quality documentation including but not limited to assessments, incident reports, progress reports and program-specific service plans - Demonstrated compliance with health and safety, accessibility standards and the ADA, as applicable. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office

			of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Staff and Training: - Demonstrates a team approach to service delivery including the ability to define, track and monitor service interventions that meet participant goals and objectives - Ability to access relevant clinical support as needed - Experience recruiting and maintaining qualified staff; assurance that all staff will be CORI checked; policies/practices which ensure that: - Program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principles of participant choice Quality: - Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required.

			Compliance with the licensure and/or certification standards of another Executive Office of Health and Human Services agency may be substituted for the above qualifications. For example Department of Developmental Services requirements at 115 CMR 7.00 & 8.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) or Department of Mental Health requirements at 104 CMR Subpart B (Department of Mental Health regulations for licensing and operational standards for mental health related community programs and which address protection from mistreatment and physical restraints) may be substituted for the above qualifications.
Human Service Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the waiver provider enrollment process, which includes meeting requirements for staffing qualifications and training, and all prescribed operational policies and procedures, including, but not limited to: Program and Physical Plant: - Understanding and compliance with all required policies, procedures, and physical plant standards - Experience providing functional, community-based services and living skills training and understanding of the philosophy of maximizing independence, participant participation, community integration and a comprehensive blend of services; - Demonstrated experience and/or willingness to work effectively with the MassHealth agency or its designee and with the Case Managers responsible for

			oversight and monitoring of the participants receiving these services; - Adequate organizational structure to support the delivery and supervision of day services, including: - Ability to plan and deliver services in the prescribed settings - Demonstrated ability to produce timely, complete and quality documentation including but not limited to assessments, incident reports, progress reports and program-specific service plans - Demonstrated compliance with health and safety, accessibility standards and the ADA, as applicable. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Staff and Training: - Demonstrates a team approach to service delivery including the ability to define, track and monitor service interventions that meet participant goals and objectives - Ability to access relevant clinical support as needed - Experience recruiting and maintaining qualified staff; assurance that all staff will be CORI checked; policies/practices which ensure that: - Program management and staff meet the minimum qualifications established by the MassHealth agency and understand the principles of participant choice Quality: - Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. Compliance with the licensure and/or certification standards of another Executive Office of Health and Human Services agency may be substituted for the above qualifications. For example Department of Developmental Services requirements at 115 CMR 7.00 & 8.00 (Department of Developmental Services (DDS) regulations for all DDS supports

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

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Rehabilitation Facilities	Administrative Service Organization	Annual for the first year and every 2 years thereafter
Human Service Agencies	Administrative Service Organization	Annual for the first year and every 2 years thereafter

Service Specification

Service Type:

Other Service

Service:

Home Accessibility 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 or the participants family, 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. Such adaptations include, but are not limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

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

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are

excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

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

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 Case Manager 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:

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

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

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

Provider Specifications

Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Home Accessibility Adaptations Provider (Self-Employed)		Architect/Design Agencies	
	Architect/Designer		Home Accessibility Adaptation Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Accessibility Adaptations Provider (Self-Employed)	If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any appropriate licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc.)		Any self-employed provider that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following: Providers shall submit to a CORI check and must be able to perform assigned duties and responsibilities. If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any appropriate licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc.)

			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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.
Architect/Design Agencies			Any not-for-profit or proprietary organization that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following: Providers shall ensure that individual workers employed by the agency have been CORI checkedand are able to perform assigned duties and responsibilities. Staff responsible for architectural drawings must be: Licensed architects, certified designers or draftsmen. 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular

			employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.
Home Accessibility Adaptation Agencies	If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc.)		Any not-for-profit or proprietary organization that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following: Providers shall ensure that individual workers employed by the agency have been CORI checked and are able to perform assigned duties and responsibilities. If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any appropriate licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc.) 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

Architect/Designer			Any self-employed provider that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following: Staff responsible for architectural drawings must be: Licensed architects, certified designers or draftsmen. Providers shall submit to a CORI checkand must be able to perform assigned duties and responsibilities. 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Accessibility Adaptations Provider (Self-Employed)	Massachusetts Rehabilitation Commission	Annually, or prior to utilization of service
Architect/Design Agencies	Massachusetts Rehabilitation Commission	Annually, or prior to utilization of service
Home Accessibility Adaptation Agencies	Massachusetts Rehabilitation Commission	Annually, or prior to utilization of service
Architect/Designer	Massachusetts Rehabilitation Commission	Annually, or prior to utilization of service

Service Specification						
Service Type: Other						
Service Name: Home Delivered Meals						
☐ 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)**:**						
Home Delivered Meals provide well-balanced meals to participants to maintain optimal nutritional and health status. Each meal should comply with Executive Order 509 (EO 509), Establishing Nutrition Standards for Food Purchased and Served by State Agencies, and be religiously and ethnically appropriate to the extent feasible. Home Delivered Meals service includes the preparation, packaging, and delivery of meals by trained and supervised staff. More than one meal may be delivered each day provided that proper storage is available in the home. Home delivered meals do not include or comprise a full nutritional regimen.						
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:
			Home Delivered Meal Providers	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Delivered Meal Providers			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process. - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties. - Availability/Responsiveness: Providers must be able to initiate services with little or

			no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. Home Delivered Meal Service Providers shall ensure that individuals employed by the provider agency who have direct contact with waiver participants have been CORI checked, and are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept people of differing abilities, different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Delivered Meal Providers	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Independent Living 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)**:**
Independent Living Supports ensures access to supportive services for persons who have intermittent, scheduled and unscheduled needs for various forms of assistance, but who do not require 24-hour supervision. It provides participants with services and supports in a variety of activities such as: activities of daily living (ADLs) and instrumental activities of daily living (IADLs), support and companionship, and emotional support, and

socialization. This service is provided by a site-based provider, and is available to participants who choose to reside in locations where a critical mass of individuals reside who require such support and where providers of such supports are available.

Independent Living Supports agencies recruit staff, assess their abilities, train and provide guidance, supervision and oversight for staff. Providers ensure scheduled services as well as intermittent, unscheduled support as needed by the participant. The provision of Independent Living Supports does not entail hands-on nursing care. This service is provided in accordance with a therapeutic goal in the service plan.

Independent Living Supports are intended to be provided in a multi-tenant building, including but not limited to such settings as elderly/disabled public housing. The concept is that a provider would secure office space in the building in which staff can be based (thus site-based), would have multiple regular waiver participants and other clients in need of home-based care to whom they provide services in the building, and would have staff who could be available at non-scheduled times to respond to participants who need support for issues that arise unexpectedly. The provider must have staff available at least 12 hours per day/seven days per week.

The service provider cannot be the owner of the building in which the services are delivered. Leases must not: include rules and/or regulations from a service agency as conditions of tenancy or include a requirement to receive services from a specific company; require notification of periods of absence, e.g. a person who is absent from a facility for more than 15 consecutive days, or discuss transfer to a nursing facility or hospital; include provisions for being admitted, discharged, or transferred out of or into a facility; or reserve the right to assign apartments and change apartment assignments.

Duplicative services, including, but not limited to waiver homemaker, personal care, adult companion, shared home supports, and supportive home care aide services, are not available to participants receiving Independent Living Supports.

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:
				Human Service Agencies
				Homemaker/Personal Care Agencies
				Home Health Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Human Service Agencies		Individuals employed by the agency providing personal care services must have one of the following:	Human Service Agencies qualified to provide personal care services may apply to become providers of Independent Living Supports. In addition to fulfilling all requirements as a Personal Care service provider the agency must

		- Certificate of Nurse's Aide Training - Certificate of Home Health Aide Training - Certificate of Supportive Home Care Aide Training - Certificate of 60-Hour Personal Care Training	demonstrate the ability to manage both scheduled and unscheduled needs and must be able to initiate services with little or no delay in the designated site. One provider will be selected from the applicants for each designated site. In addition, providers shall ensure that individuals employed by the agency have been CORI checked and are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).
Homemaker/Personal Care Agencies		Individuals employed by the agency	Homemaker/Personal Care Agencies qualified to provide personal care

		providing personal care services must have one of the following: - Certificate of Nurse's Aide Training - Certificate of Home Health Aide Training - Certificate of Supportive Home Care Aide Training - Certificate of 60-Hour Personal Care Training	services may apply to become providers of Independent Living Supports. In addition to fulfilling all requirements as a Personal Care service provider the agency must demonstrate the ability to manage both scheduled and unscheduled needs and must be able to initiate services with little or no delay in the designated site. One provider will be selected from the applicants for each designated site. In addition, providers shall ensure that individuals employed by the agency have been CORI checked and are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting

			and Protective Services Program regulations).
Home Health Agencies		Individuals employed by the agency providing personal care services must have one of the following: - Certificate of Nurse's Aide Training - Certificate of Home Health Aide Training - Certificate of Supportive Home Care Aide Training - Certificate of 60-Hour Personal Care Training	Home Health Agencies qualified to provide personal care services may apply to become providers of Independent Living Supports. In addition to fulfilling all requirements as a Personal Care service provider the agency must demonstrate the ability to manage both scheduled and unscheduled needs and must be able to initiate services with little or no delay in the designated site. One provider will be selected from the applicants for each designated site. In addition, providers shall ensure that individuals employed by the agency have been CORI checked and are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities)

			and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Human Service Agencies	Administrative Service Organization	Every 2 years
Homemaker/Personal Care Agencies	Administrative Service Organization	Every 2 years
Home Health Agencies	Administrative Service Organization	Every 2 years

Service Specification

Service Type:

Other Service

Service:

Individual Support and Community 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)**:**

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Health Care Agencies			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 - Individuals who provide Individual Support and Community Habilitation services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have a College degree and at least two years comparable community-based human services, life or work experience providing skills training services to individuals with disabilities, or at least five years comparable community-based work experience providing skills training services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required. - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for

			appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155.000 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by an Individual Support and Community Habilitation agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission

			regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.
Support Worker			Individuals who provide Individual Support and Community Habilitation services must have responded satisfactorily to the Waiver provider enrollment process, and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have a College degree and at least two years comparable

			community-based, life or work experience providing skills training services to individuals with disabilities, or at least five years comparable community-based work experience providing skills training services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; certification in CPR is required. Individuals must be provided with information regarding the applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information. 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

			Providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.
Human Service Agencies			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 - Individuals who provide Individual Support and Community Habilitation services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have a College degree and at least two years comparable community-based human services, life or work experience providing skills training services to individuals with disabilities, or at least five years comparable community-based work experience providing skills training services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; and certification in CPR is required. - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles

			of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155.000 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by an Individual Support and Community Habilitation agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to

			14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. Providers licensed, certified and qualified by DDS in accordance with 115 CMR 7.00 (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Health Care Agencies	Administrative Service Organization	Annually
Support Worker	Administrative Service Organization	Annually
Human Service Agencies	Administrative Service Organization	Annually

Service Specification

Service Type: Other

Service Name: Laundry

☐ 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)**:**

Laundry includes pick up, washing, drying, folding, wrapping, and returning of laundry.

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:
				Laundry Provider Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Laundry Provider Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process. - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate.

			- Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. Laundry Service Providers shall ensure that individual workers employed by the provider agency who have direct contact with waiver participants have been CORI checked, and are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept people of differing abilities, different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Laundry Provider Agencies	Administrative Service Organization	Every 2 years

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

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

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

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

These services are subject to the Service Limitations included in 130 CMR 432. 414 (A) and (B) (MassHealth Therapist Regulations that describe the service limitations for therapy treatment per day). No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of service as a comprehensive evaluation.

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

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

Provider Specifications

Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
		Occupational Therapist		Home Care Agencies
				Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Occupational Therapist	Occupational Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules).		
Home Care Agencies	The agency must be licensed as a Group Practice in		

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

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

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Occupational Therapist	Administrative Service Organization	Every 2 years
Home Care Agencies	Administrative Service Organization	Every 2 years
Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	Administrative Service Organization	Every 2 years

Service Specification

Service Type:

Other Service

Service:

Orientation and Mobility 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)**:**

Orientation and Mobility (O&M) services teach an individual with vision impairment or legal blindness how to move or travel safely and independently in their home and community and include (a) O&M assessment; (b) training and education provided to Participants; (c) environmental evaluations; (d) caregiver/direct care staff training on sensitivity to blindness/low vision; and (e) information and resources on community living for

persons with vision impairment or legal blindness. O&M Services are tailored to the individual's need and may extend beyond the home setting to other community settings as well as public transportation systems.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Certified Orientation and Mobility Specialist (COMS)		Human Service Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Orientation and Mobility Specialist (COMS)		Individual providers of Orientation and Mobility Services must have a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from an ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals) - certified university program.	Individuals who provide Orientation and Mobility services must have responded satisfactorily to the Waiver provider enrollment process and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked, have life or work experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; and have ability to meet legal requirements in protecting confidential information. Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual's customary environment. - Knowledge and/or experience in educating caregivers or direct care staff, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with vision impairment or legal

			blindness, in sensitivity to low vision/blindness. Individuals must be provided with information regarding the applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information.
Human Service Agencies		Individual providers and individuals employed by the agency providing Orientation and Mobility Services must have a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from an ACVREP(Academy for Certification of Vision Rehabilitation and Education Professionals)-certified university program.	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. Staff providing services must have: - Master's degree in special education with a specialty in orientation and mobility; or - Bachelor's degree with a certificate in orientation and mobility from an ACVREP certified university program Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional

			evaluation of the individual in the individual's customary environment. - Knowledge and/or experience in educating caregivers or direct care staff, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with vision impairment or legal blindness, in sensitivity to low vision/blindness. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Orientation and Mobility Specialist (COMS)	Administrative Service Organization	Every 2 years
Human Service Agencies	Administrative Service Organization	Every 2 years

Service Specification
Service Type:

Other Service

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

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 Case Manager 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:

Not to exceed 16 hours per week.

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

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

Provider Specifications

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Peer Support Agencies	Agency needs to employ individuals who 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.	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff

			members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of

			Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Peer Support Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F

			and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H. - Individuals who provide Peer Support Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; can handle emergency situations; can set limits, and communicate effectively with participants, other providers and agencies; have ability to meet legal requirements in protecting confidential information. The agency must employ individuals who are self-advocates and supporters and who are able to effectively communicate in the language and communication style of the individual for whom they are providing the training. Staff members providing Peer Support must have experience in providing peer support, self-advocacy, and skills training and independence.
Individual Peer Support Specialist			Applicants must have relevant competencies and experiences in Peer Support and posses appropriate qualifications to serve as staff as evidenced by interview(s), two personal and or professional references and a Criminal Offense Records Inquiry (CORI). The applicant must have the ability to communicate effectively in the language and communication style of the participant to whom they are providing training; Must have experience in providing peer support, self-advocacy, and skills training and independence; Minimum of 18 years of age; Be knowledgeable about what to do in an emergency; Be knowledgeable about how to report abuse and neglect; Must

			maintain confidentiality and privacy of consumer information; Must be respectful and accept different values, nationalities, races, religions, cultures and standards of living. Specific competencies needed by an individual provider to meet the support needs of the participant will be delineated in the Support Plan by the Team. Individuals must be provided with information regarding the applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq(The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information. 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include

			provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Peer Support Agencies	Administrative Service Organization	Every 2 years
Individual Peer Support Specialist	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Physical Therapy
☐ 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)**:**
Physical Therapy services, including the performance of a maintenance program beyond the scope of coverage in the State plan, provided by a licensed physical therapist. Services must be considered by the therapist to be necessary for the participant either to improve, develop, correct, rehabilitate, or prevent the worsening of the physical functions that have been lost, impaired or reduced as a result of acute or chronic medical conditions, congenital anomalies or injuries; or required to maintain or prevent the worsening of function. Services may also include the training and oversight necessary for the participant, family member or other person, to carry out the maintenance program. The provider qualifications specified in the State plan apply. Physical Therapy services must be authorized by the Case Manager in the service plan. This service is not subject to the Medical Referral Requirements found at 130 CMR 432.415 (MassHealth Therapist Regulations that describe the medical referral requirements necessary as a prerequisite to MassHealth payment) or the requirements for Prior Authorization found in the following regulations: 130 CMR 432.417 (MassHealth Therapist Regulations that describe the prior authorization process for therapy services) or 130 CMR 410.408 (MassHealth Chronic Disease and Rehabilitation Outpatient Hospital Regulations that describe the prior authorization process for therapy services) or 130 CMR 403.413 (MassHealth Home Health Agency Regulations that describe the prior authorization process for therapy services) or 130 CMR 430.601 (MassHealth Rehabilitation Center Regulations that describe the prior authorization process for therapy services). This service can not be provided in Adult Day Health or when the participant is receiving other services that include physical therapy as part of the program. MassHealth All Provider regulations at 130 CMR 450.140 through 149 detail the ESPDT requirements for MassHealth providers and the MassHealth provider manuals for therapists services lists EPSDT screening schedules at Appendix W.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

These services are subject to the Service Limitations included in 130 CMR 432. 414 (A) and (B) (MassHealth Therapist Regulations that describe the service limitations for therapy treatment per day). No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of service as a comprehensive evaluation.						
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E			☑	Provider managed
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Physical Therapist		Health Care Agencies	
			Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Health Care Agencies	The agency must be licensed as a Group Practice in accordance with 130 CMR 432.404 (MassHealth Therapist Regulations that describe the provider eligibility requirements for in-State therapy providers)or as a Rehabilitation Center in accordance with 130 CMR 430.600 (MassHealth Rehabilitation Center Regulations that define provider eligibility requirements and program rules) or as a Home Health Agency in accordance with 130 CMR 403.000 (MassHealth Home Health Agency regulations that define provider		

	eligibility requirements and program rules). Services must be performed by a Physical Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules).		
Physical Therapist	Physical Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules).		
Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	The hospital must be licensed as a Chronic Disease and Rehabilitation Inpatient Hospital in accordance with 130 CMR 435.000 (MassHealth Chronic Disease and Rehabilitation Inpatient Regulations that describe the provider eligibility requirements) or as a Chronic Disease and Rehabilitation Outpatient Hospital in accordance with 130 CMR 410.000 (MassHealth Chronic Disease and Rehabilitation		

	Outpatient Regulations that describe the provider eligibility requirements)		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Health Care Agencies	Administrative Service Organization	Every 2 years
Physical Therapist	Administrative Service Organization	Every 2 years
Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	Administrative Service Organization	Every 2 years

Service Specification

Service Type:

Other Service

Service:

Shared 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)**:**

Shared Home Supports is an option that matches a participant with a Shared Home Supports caregiver. This arrangement is overseen by a Residential Support Agency. The match between participant and caregiver is the keystone to the success of this model.

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

Shared Home Supports integrates the participant into the usual activities of the caregivers family life. In addition, there will be opportunities for learning, developing and maintaining skills which may include the areas of ADLs, IADLs, social and recreation activities, and personal enrichment. The Residential Support Agency provides regular and ongoing oversight and supervision of the caregiver.

The caregiver lives with the participant at the residence of the caregiver or the participant. Shared Home Supports provides daily structure, skills training and supervision, but does not include 24-hour care. Shared Home Supports agencies recruit caregivers, assess their abilities, coordinate placement of participant or caregiver, train and provide guidance, supervision and oversight for caregivers and provider oversight of participants living situations. The caregiver may not be a legally responsible family member.

Duplicative waiver and state plan services are not available to participants receiving Shared Home Supports services. Shared Home Supports services are not available to individuals who live with their immediate family unless the family member is not legally responsible for the individual and is employed as the caregiver, or the

immediate family member (grandparent, parent, sibling or spouse) is also eligible for shared home supports and had received prior authorization, as applicable. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment is specified in Appendix I-5.

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

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

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

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

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Residential Support Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Residential Support 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) or 104 CMR Chapter 28 (Department of Mental Health regulations governing Licensing and Operational Standards for Community Programs).	Residential Support Agencies Provider employees must have a High School diploma, GED or relevant equivalencies or competencies.	Residential Support Agencies must be licensed by the Department of Developmental Services. Residential Support Agencies Provider employees must possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offense Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living. Policies/Procedures: Providers must have policies that apply to and comply with the applicable standards under 105 CMR 155.000 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and

			investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a home health agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Residential Support Agencies	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Skilled Nursing
☐ 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 listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license. Skilled nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from skilled nursing services in the State plan. The differences from the State plan are as follows: 1) Agencies that provide Skilled Nursing services under the waiver do not need to meet the requirements for participation in Medicare, as provided in 42 CFR §489.28. MassHealth All Provider regulations at 130 CMR 450.140 through 149 detail the ESPDT requirements for MassHealth providers and the MassHealth provider manual for nursing services lists EPSDT screening schedules at Appendix W.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to one Skilled Nursing visit per week. The State may grant exceptions to the limit on a temporary basis to facilitate transitions to a community setting, to ensure that an individual at risk for medical facility admission is able to remain in the community, or to otherwise stabilize a participants medical condition.						
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E			☑	Provider managed
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Home Health Agencies
				Homemaker/Personal Care Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agencies	Skilled Nursing services must be performed by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license.		Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide

			program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Home Health Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). - Individuals who provide Skilled Nursing Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; experience providing services to individuals with

			disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information.
Homemaker/Personal Care Agencies	Skilled Nursing services must be performed by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license.		Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of

			consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Home Health Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). - Individuals who provide Skilled Nursing Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Home Health Agencies	Administrative Service Organization	Every 2 years
Homemaker/Personal Care Agencies	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Specialized Medical Equipment
☐ 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 includes: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. In addition to the acquisition of the Specialized Medical Equipment itself this service may include: - Evaluations necessary for the selection, design, fitting or customizing of the equipment needs of a participant - Customization, adaptations, fitting, set-up, maintenance or repairs to the equipment or devices - Temporary replacement of equipment - Training or technical assistance for the participant, or, where appropriate, the family members, guardians, or other caregivers of the participant on the use and maintenance of the equipment or devices. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. This service does not include vehicle modifications,home accessibility adaptations, or any devices provided through the Assistive Technology service.
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)	☑	Individual. List types:	☑	Agency. List the types of agencies:

(check one or both):	Individual Assistive Technology Provider	Medical Equipment Suppliers
		Pharmacies
		Assistive Technology Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Medical Equipment Suppliers			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 checkedand 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.
Individual Assistive Technology Provider			Individuals who provide Assistive Technology services must have responded satisfactorily to the Waiver provider enrollment process and must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information. Individuals providing services must have: - Bachelor's degree in a related technological field and at least one year of demonstrated experience providing adaptive technological assessment or training; or

			- A bachelor's degree in a related health or human service field with at least two years of demonstrated experience providing adaptive technological assessment or training; or - Three years of demonstrated experience providing adaptive technological assessment or training. Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with a disability, including functional evaluation of the individual in the individual's customary environment. - Knowledge and experience in the purchasing, or otherwise providing for the acquisition of assistive technology devices by individuals with disabilities. - Knowledge and/or experience in selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices. - Knowledge and/or experience in coordinating and using other therapies, interventions, or services with assistive technology devices. - Knowledge and/or experience in training or providing technical assistance for an individual with disabilities, or, when appropriate, the family of an individual with disabilities or others providing support to the individual. - Knowledge and/or experience in training and/or providing technical assistance for professionals or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.
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 checkedand 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.
Assistive Technology Agencies			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 checkedand are able to perform assigned duties and responsibilities. - Providers of specialized medical equipment and supplies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate. Staff providing services must have: - Bachelor's degree in a related technological field and at least one year of demonstrated experience providing adaptive technological assessment or training; or - A bachelor's degree in a related health or human service field with at least two years of demonstrated experience providing adaptive technological assessment or training; or - Three years of demonstrated experience providing adaptive technological assessment or training.

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

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Medical Equipment Suppliers	Administrative Service Organization	Every 2 years
Individual Assistive Technology Provider	Administrative Service Organization	Every 2 years
Pharmacies	Administrative Service Organization	Every 2 years
Assistive Technology Agencies	Administrative Service Organization	Every 2 years

Service Specification

Service Type:

Other Service

Service:

Speech Therapy

☐ 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)**:**

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

Speech Therapy services must be authorized by the Case Manager in the service plan. This service is not subject to the Medical Referral Requirements found at 130 CMR 413.419 (MassHealth Speech and Hearing Center Regulations that describe the medical referral requirements necessary as a prerequisite for MassHealth payment)or the requirements for Prior Authorization found in the following regulations: 130 CMR 413.408 (MassHealth Speech and Hearing Center Regulations that describes the prior authorization process for therapy services) or 130 CMR 432.417 (MassHealth Therapist Regulations that describe the prior authorization process for therapy services) or 130 CMR 410.408 (MassHealth Chronic Disease and Rehabilitation Outpatient Hospital Regulations that describe the prior authorization process for therapy services) or 130 CMR 403.413 (MassHealth Home Health Agency Regulations that describe the prior authorization process for therapy services) or 130 CMR 430.601 (MassHealth Rehabilitation Center Regulations that describe the prior authorization process for therapy services). This service can not be provided in Adult Day Health or when the participant is receiving other services that include speech therapy as part of the program.

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 Case Manager 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.

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

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

These services are subject to the Service Limitations included in 130 CMR 413. 418 (A) and (B)(MassHealth Speech and Hearing Center Regulations that describe the prior authorization process for therapy services). No more than one individual treatment and one group therapy session per day may be authorized. Payment will not be made for a treatment claimed for the same date of service as a comprehensive evaluation.

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

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

Provider Specifications				
Provider Category(s) *(check one or both)*:	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Speech/Language Therapy (Speech/Language Pathologist)		Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	
			Health Care Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	The hospital must be licensed as a Chronic Disease and Rehabilitation Inpatient Hospital in accordance with 130 CMR 435.000 (MassHealth Chronic Disease and Rehabilitation Inpatient Regulations that describe the provider eligibility requirements) or as a Chronic Disease and Rehabilitation Outpatient Hospital in accordance with 130 CMR 410.000 (MassHealth Chronic Disease and Rehabilitation Outpatient Regulations that describe the provider eligibility requirements)		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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.
Health Care Agencies	The agency must be licensed as a Speech and Hearing Center Group Practice in accordance with 130 CMR 413.404 (MassHealth Speech and		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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the

	Hearing Center Regulations that describe the provider eligibility requirements) or as a Group Practice in accordance with 130 CMR 432.404 (MassHealth Therapist Regulations that describe the provider eligibility requirements for therapy providers) or as a Rehabilitation Center in accordance with 130 CMR 430.600 (MassHealth Rehabilitation Center Regulations that define provider eligibility requirements and program rules) or as a Home Health Agency in accordance with 130 CMR 403.000 (MassHealth Home Health Agency regulations that define provider eligibility requirements and program rules). Services must be performed by a Speech/Language Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules).		requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

Speech/Language Therapy (Speech/Language Pathologist)	Speech/Language Therapist licensed in accordance with 130 CMR 432.000 (MassHealth Therapist Regulations that define provider eligibility requirements and program rules).		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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Chronic Disease and Rehabilitation Inpatient and Outpatient Hospital	Administrative Service Organization	Every 2 years
Health Care Agencies	Administrative Service Organization	Every 2 years
Speech/Language Therapy (Speech/Language Pathologist)	Administrative Service Organization	Every 2 years

Service Specification
Service Type:
Other Service
Service:
Supportive Home Care Aide
☑ 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)**:**
Supportive Home Care Aides perform personal care and/or homemaking services in accordance with waiver definitions, in addition to providing emotional support, socialization, and accompanying the participant to community activities and appointments. These services are provided to Participants with Alzheimer's Disease/Dementia or behavioral health needs.
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:
				Homemaker/Personal Care Agencies
				Human Service Agencies
				Home Health Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Homemaker/Personal Care Agencies		Individuals employed by the agency to provide supportive home care aide services must have one of the following: - Certificate of Home Health Aide Training - Certificate of Nurse's Aide Training	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide

			program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Homemaker/Personal Care Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). - Individuals who provide Supportive Home Care Aide Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; experience providing services to individuals with

			disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; certification in CPR is required. In addition to the required certificate, individual Supportive Home Care Aides must have completed at least one of the following: - An additional 12 hours of training in the area of serving participants with behavioral health needs; or - The 12-hour training developed by the Alzheimer's Association, Massachusetts Chapter on serving participants with Alzheimer's disease or related disorders. If the service involves transporting the participant, the Supportive Home Care Aide must have a valid driver's license and vehicle insurance.
Human Service Agencies		Individuals employed by the agency to provide supportive home care aide services must have one of the following: - Certificate of Home Health Aide Training - Certificate of Nurse's Aide Training	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists. - Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan

			goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Homemaker/Personal Care Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations).

			- Individuals who provide Supportive Home Care Aide Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; certification in CPR is required. In addition to the required certificate, individual Supportive Home Care Aides must have completed at least one of the following: - An additional 12 hours of training in the area of serving participants with behavioral health needs; or - The 12-hour training developed by the Alzheimer's Association, Massachusetts Chapter on serving participants with Alzheimer's disease or related disorders. If the service involves transporting the participant, the Supportive Home Care Aide must have a valid driver's license and vehicle insurance.
Home Health Agencies		Individuals employed by the agency to provide supportive home care aide services must have one of the following: - Certificate of Home Health Aide Training - Certificate of Nurse's Aide Training	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Providers are responsible for ensuring staff are trained on applicable regulations and policies governing waiver service delivery and the principles of participant centered care. Agencies must have established procedures for appraising staff performance and for effectively modifying poor performance where it exists.

			- Adherence to Continuous QI Practices: Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual participants by providing effective, efficient services. Providers must have the ability to meet all quality improvement requirements, as specified by the MassHealth agency or its designee and ability to provide program and participant quality data and reports, as required. - Availability/Responsiveness: Providers must be able to initiate services with little or no delay in the geographical areas they designate. - Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. - Policies/Procedures: Providers must have policies and procedures that include: Participant Not at Home Policy, Participant Emergency in the Home Policy; and that comply with the applicable standards under 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) for the prevention, reporting and investigation of patient abuse, neglect, and mistreatment, and the misappropriation of patient property by individuals working in or employed by a Homemaker/Personal Care Agency as well as policies that comply with applicable regulations of the Disabled Persons Protection Commission found at 118 CMR 1.00 to 14.00 (The State's Division Disabled Persons Protection Commission regulations that describe the purpose, rules, and process regarding abuse allegations for people with disabilities) and the Elder Abuse

			Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). - Individuals who provide Supportive Home Care Aide Services must meet requirements for individuals in such roles, including, but not limited to must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; have ability to meet legal requirements in protecting confidential information; certification in CPR is required. In addition to the required certificate, individual Supportive Home Care Aides must have completed at least one of the following: - An additional 12 hours of training in the area of serving participants with behavioral health needs; or - The 12-hour training developed by the Alzheimer's Association, Massachusetts Chapter on serving participants with Alzheimer's disease or related disorders. If the service involves transporting the participant, the Supportive Home Care Aide must have a valid driver's license and vehicle insurance.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Homemaker/Personal Care Agencies	Administrative Service Organization	Every 2 years
Human Service Agencies	Administrative Service Organization	Every 2 years
Home Health Agencies	Administrative Service Organization	Every 2 years

Service Specification

Service Type:

Other Service

Service:

Transitional Assistance 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)**:**

Transitional Assistance services are non-recurring personal household set-up expenses for individuals who are transitioning from a nursing facility or hospital or another provider-operated living arrangement to a community living arrangement where the person is directly responsible for their own set-up expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) assistance with housing search and housing application processes, (b) security deposits that are required to obtain a lease on an apartment or home; (c) assistance arranging for and supporting the details of the move; (d) essential personal household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (e) set-up fees or deposits for utility or service access, including telephone service, electricity, heating and water; (f) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (g) moving expenses; (h) necessary home accessibility adaptations; and, (i) activities to assess need, arrange for and procure needed resources related to personal household expenses, specialized medical equipment, or community services. Transitional Assistance services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Transitional Assistance services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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 Case Manager 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:

Transitional Assistance services include only those non-recurring set up expenses incurred during the 180 days prior to discharge from a nursing facility or hospital or another provider-operated living arrangement to a community living arrangement or during the period following such a transition during which the participant is establishing their living arrangement. Home accessibility adaptations are limited to those which are initiated during the 180 days prior to discharge. Participants may not receive devices through both the Transitional Assistance service and the Assistive Technology service.

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

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

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

Provider Specifications

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Business		Certified Business	Will meet applicable State regulations and industry standards for type of goods/services provided. 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 with M.G.L. Ch. 66A. Telehealth providers must also comply with the requirements of their particular employment relationship, to protect the privacy and security of the participant's protected health information. Specific requirements for providers can include provisions of M.G.L. Ch. 123B, Section 17; M.G.L. Ch. 6 Section 84; 42 CFR Part 431, Subpart F and M.G.L. c. 118E § 49; 42 CFR Part 2; and M.G.L. c. 93H.

Verification of Provider Qualifications

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

Service Specification
Service Type:
Other Service
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. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

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

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

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

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Transportation Provider Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Transportation Provider Agencies			Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following: - Driver and Vehicle Requirements: Verification of valid driver's license, liability insurance, written certification of vehicle maintenance, age of vehicles; passenger capacity of vehicles; RMV inspection; seat belts; list of safety equipment; air conditioning and heating; first aid kits; snow tires in winter; and two-way communication. - Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Established procedures for appraising staff performance and for effectively modifying poor performance where it exists.

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

			CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Providers must ensure that staff who transport must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; and communicate effectively with participants, families, other providers and agencies. Providers that are certified by the EOHHS Human Services Transportation brokerage service are considered to have met the requirements above.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Transportation Provider Agencies	Administrative Service Organization	Annually

Service Specification
Service Type:
Other Service
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)**:**
Adaptations or alterations to an automobile or van that is the waiver participants primary means of transportation in order to accommodate the special needs of the participant. Vehicle Modifications are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of Vehicle Modifications 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 individual.
2. Purchase or lease of a vehicle
3. Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the adaptations. Modifications to a paid caregivers vehicle or provider agency vehicle are excluded.

Funding for adaptations to a new van or vehicle purchased/leased by an individual and/or family can be made available at the time of purchase/lease to accommodate the special needs of the participant.

The need for Vehicle Modifications must be documented in the service plan and is subject to MRC rules.
1. The Case Manager must receive in advance for their review and recommendation the following information: a proposal detailing the request for funding and the completed Vehicle Modification Funding Request Form.
2. If the Case Manager recommends the proposal for funding, the request is then forwarded to MRC for review and recommendation of funding.

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

Cost not to exceed $25,000 over three year period.

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 Vehicle Modification Contractors		Vehicle Modification Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Vehicle Modification Agencies			Any not-for-profit or proprietary organization that becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following: Providers shall ensure that individual staff responsible for vehicle modifications are skilled in applicable mechanical, electrical, welding or electronics trades, and that they have current applicable licenses and/or certifications.
Independent Vehicle Modification Contractors			Any Independent Vehicle Modification Contractor who becomes qualified through the MRC open procurement process and as such, successfully demonstrates, at a minimum, the following:

			Providers shall ensure that individual responsible for vehicle modifications are skilled in applicable mechanical, electrical, welding or electronics trades, and that they have current applicable licenses and/or certifications.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Vehicle Modification Agencies	Massachusetts Rehabilitation Commission	Annually or prior to utilization of service
Independent Vehicle Modification Contractors	Massachusetts Rehabilitation Commission	Annually or prior to utilization of service

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:

State agency staff from Massachusetts Rehabilitation Commission (MRC)

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):
	In accordance with M.G.L. chapter 6, section 172C, the Commonwealth of Massachusetts requires entities to obtain Criminal Offender Record Information (CORI) checks on individuals before they can volunteer, be employed or be referred for employment in an entity providing services to elderly or disabled persons in their homes or in a community setting. CORI checks are statewide in scope. Compliance is verified as part of the credentialing and/or licensure process. MRC and the ASO are responsible for reviewing compliance as part of the Waiver service provider enrollment process and ongoing provider review processes.
○	**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):
	105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) establishes a registry to be maintained by the Massachusetts Department of Public Health which contains: 1) the names of individuals who are certified as nurse aides, and (2) sanctions, findings and adjudicated findings of abuse, neglect, and mistreatment of patients or residents and misappropriation of patient or resident property imposed upon or made against nurse aides, home health aides and homemakers for the abuse, neglect, mistreatment of patients or residents or misappropriation of patient or resident property. Each employer is responsible for screening potential employees against the abuse registry. Screening must be conducted for any position requiring homemaker, personal care, home health aide or nurse aide training. Provider agency compliance with 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation, and registry requirements) is verified as part of the credentialing process.
○	**No**. The state does not conduct abuse registry screening.

Required information from this page (Appendix C-2-c) is contained in response to C-5.

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.*
☑	**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.** Specify the controls that are employed to ensure that payments are made only for services rendered.
	Relatives, but not legal guardians, are permitted to provide waiver services. A relative may not be a family member (defined as a spouse or any legally responsible relative), and must meet all provider qualifications for the service being provided. Under these circumstances, relatives may provide any of the services included in this waiver without limit. Provider agencies are responsible for ensuring that every employee meets service-specific qualifications and must demonstrate compliance with this during on-site audits. All other requirements under this waiver apply, e.g., services must be provided in accordance with an approved plan of care.
○	Other policy. *Specify*:

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

Any willing and qualified provider has the opportunity to enroll as a provider of waiver services. Providers of waiver services available under this waiver will meet qualifications as specified in C-1. All waiver service providers, with the exception of Home Accessibility Adaptations, Transitional Assistance Services, and Vehicle Modification will enroll as MassHealth providers and the Administrative Service Organization will ensure they meet the applicable qualifications. Providers of Home Accessibility Adaptations, Transitional Assistance Services, and Vehicle Modification will be qualified by MRC.

Providers can access information through the MassHealth provider enrollment and credentialing website, which provides ready access to information regarding requirements and procedures to qualify as a waiver provider. Service providers can apply to enroll at any time. MRC has issued open procurements to solicit all willing and qualified providers of Home Accessibility Adaptations, Transitional Assistance Services, and Vehicle Modification. These procurements are posted on the Commonwealth's online procurement access and solicitation system.
.

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

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

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *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:	% of licensed or certified providers credentialed by the Provider Network Administration/Massachusetts Rehabilitation Commission that have corrected identified findings. (Number of licensed or certified providers that have corrected identified findings/ Total number of licensed or certified providers that have findings)

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

If 'Other' is selected, specify:

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

State:	
Effective Date	

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

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

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Administrative Service Organization	☐ *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:	% of licensed/certified providers credentialed by the Provider Network Administration/Massachusetts Rehabilitation Commission who continue to meet applicable licensure/certification requirements.(Number of licensed/certified providers who continue to meet applicable licensure requirements/Number of licensed/certified providers who are required to have applicable state licensure/certification)

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

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Administrative Services Organization	☐ *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:	% of providers licensed by DDS that continue to meet applicable licensure or certification standards. (Number of providers that continue to meet applicable licensure or certification standards/ Number of providers subject to licensure/certification)

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

If 'Other' is selected, specify:

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

Specify:	
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of agency providers licensed by DDS that have corrected identified deficiencies. (Number of providers that have corrected deficiencies/ Number of providers with identified deficiencies)
Data Source *(Select one) (Several options are listed in the on-line application):* **Provider performance monitoring**	
If 'Other' is selected, specify:	

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

Specify:	
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

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

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:	% of providers not subject to licensure or certification who are offering services who initially meet requirements to provide supports. (Number of providers not subject to licensure or certification who initially meet the qualification requirements to provide services/ Number of providers)		
Data Source *(Select one) (Several options are listed in the on-line application):* **Provider performance monitoring**			
If 'Other' is selected, specify:			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other*	☑ *Annually*	

State:	
Effective Date	

	Specify:			
	Administrative Services Organization	☐ *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:	% of providers who are not subject to licensure or certification who continue to meet qualifications to provide services. (Number of providers who continue to meet requirements/ Total number of providers not subject to licensure or certification)

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

If 'Other' is selected, specify:

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

	☐ *Sub-State Entity*	☐ *Quarterly*		☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*		
	Administrative Services Organization	☐ *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:	% of providers who are not subject to licensure or certification who have corrected identified findings. (Number of providers who are not subject to licensure or certification that have corrected all identified findings/ Total number of providers who are not subject to licensure or certification that have findings)

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

If 'Other' is selected, specify:

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

	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*	
	☐ *Sub-State Entity*	☐ *Quarterly*		☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*		
	Administrative Services Organization	☐ *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)

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:	% of DDS licensed/certified providers that have staff trained and current in required trainings including medication administration, CPR, first aid, restraint utilization and abuse/neglect reporting. (Number of DDS licensed/certified providers that have staff trained/ Number of DDS licensed/certified providers reviewed through survey and certification)

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

If 'Other' is selected, specify:

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

State:	
Effective Date	

	☐ *Other Specify:*

Performance Measure:	% of providers that are not subject to DDS licensure and/or certification that have been trained and are current in all required trainings. (Number of providers (not subject to DDS licensure and/or certification) that have been trained/ Number of providers reviewed)

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

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *State Medicaid Agency*	☐ *Weekly*	☑ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☑ *Other Specify:*	☑ *Annually*	
	Administrative Services Organization	☐ *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 Massachusetts Rehabilitation Commission, the Department of Developmental Services and MassHealth are responsible for ensuring effective oversight of the waiver program. As problems are discovered at the level of care entity, the Administrative Services Organization, or waiver service providers, MassHealth, MRC and DDS will ensure that a corrective action plan is created, approved and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, MassHealth is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☑ *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.*
	Massachusetts imposes an 84-hour per week limit on the following set of waiver services, separately, or in combination: Homemaker, Home Health Aide, Personal Care, Adult Companion, Individual Support and Community Habilitation, and Supportive Home Care Aide. The basis of the limit is to promote the use of appropriate sets of services in this waiver and to preclude use of this waiver for members who require services on a 24 hour basis, such as in a residential waiver. This limit may be adjusted as utilization patterns change. The State may grant exceptions to the limit on a 90 day basis in order to maintain a participant's tenure in the community, to provide respite to a caregiver who lives with the participant, to facilitate transitions to a community setting, to ensure that an individual at risk for medical facility admission is able to remain in the community, or to otherwise stabilize a participant's medical condition. Exceptions may also be granted for participants awaiting transition to a residential waiver. Participants are notified of the 84-hour per week limit during the service plan development process. Participants in need of personal assistance services in excess of the limit are

referred to other community-based alternatives, such as a residential waiver, Adult Foster Care or Assisted Living Residences.

Waiver participants may not receive per diem Day Services on the same day that they receive Community Based Day Supports (CBDS), Supported Employment or Pre-vocational Services. Waiver participants may receive partial per diem Day Services on the same day that they receive Community Based Day Supports (CBDS), Supported Employment or Pre-vocational Services. Day Services, CBDS, Supported Employment and Pre-vocational Services, in combination, are limited to no more than 156 hours per month, with each per diem of Day Services considered to be 6 hours, and each partial per diem considered to be 3 hours. CBDS, pre-vocational services, and supported employment may be used in combination on the same day. CBDS, Pre-vocational services, supported employment services, and Day Services may be used in combination as specified in a participant's Plan of Care up to the aggregate limit of 156 hours per month, with the limitations noted above.

This limit is based on historical experience providing Day Services in this waiver. This limit may be adjusted based on review of future utilization patterns. The State may grant individualized exceptions to the limit on a 30-day basis in order to maintain a participant's tenure in the community, to facilitate transitions to a community setting, or to otherwise facilitate the participant's successful engagement in community-based waiver services. Participants are notified of these limits during the service plan development process. Participants in need of additional support services will be referred to alternative waiver or state plan services to meet their needs.

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 Massachusetts Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency, convened an interagency workgroup to address how best to comply with the requirements of the federal Home and Community Based (HCB) settings requirements at 42 CFR 441.301 (c)(4)-(5). The Massachusetts Rehabilitation Commission (MRC), an agency within EOHHS that has primary responsibility for day-to-day operation of the MFP-CL waiver, was a member of the workgroup. MRC undertook a review of all their regulations, standards, policies, licensing requirements, and other provider requirements to ensure compliance of settings with the new federal requirements, as they apply within this waiver. The MFP-CL Waiver supports individuals who reside in their own homes or apartments, in homes and apartments with family members and other informal supports, or in a home or apartment of a caregiver with up to one additional waiver participant. These settings fully comply with the HCBS Regulations. MFP-CL Waiver Participants may receive the following waiver services outside their home: community-based day supports, day services, supported employment, and prevocational services settings (non-residential settings).

MRC's review and assessment process for these non-residential settings included: a thorough review of regulations, policies and procedures; waiver service definitions; provider qualifications and quality management and oversight systems to determine whether the systemic infrastructure was consistent with the principles of community integration; development of an assessment tool based on the exploratory questions that CMS published; and review of the existing non-residential settings to determine if these settings meet standards consistent with the HCB settings requirement.

As detailed in the Site-Specific Assessment section and summarized in Table 2 of the STP submitted to CMS in April 2022, all of the thirteen contracted day services providers and forty-three contracted supported employment providers have been determined by MRC to comply fully with the Community Rule. The systemic and site-specific review processes MRC undertook to determine these providers' compliance status are summarized in Main Module Attachment #2.

MRC conducts site visits of non-residential day services settings not licensed or certified by the Department of Developmental Services (DDS). For all such day services, MRC utilizes a monitoring tool to review each site and the activities/services provided for all day programs to monitor ongoing Community Rule compliance. Supported employment provider qualifications

are reviewed every two years to ensure continued compliance with requirements. In addition, MRC case managers monitor provider compliance through annual meetings with participants as part of the person-centered planning process.

If any of the ongoing monitoring indicates a need for a substantive change in the transition plan, MRC along with MassHealth will revise the STP, complete public input activities as described in Main Module Attachment #2, and resubmit the STP for CMS approval.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Plan of Care (POC)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(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*:
	Case Managers must have a Bachelor's degree in social work, human services, nursing, psychology, sociology or a related field. Candidates with a Bachelor's degree in another discipline must demonstrate experience or strong interest in the field of human services via previous employment, internships, volunteer activities and/or additional studies. Three years of experience working with elders and/or individuals with disabilities in community settings providing direct case management including performing assessments may be substituted for the degree requirement.
☐	**Social Worker** *Specify qualifications:*
☐	**Other** *Specify the individuals and their qualifications:*

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 plan development process is driven by the individual and facilitated by Case Managers utilizing a person-centered planning approach and assessment tool designed to promote enabling the individual to live as independently and self-sufficiently as possible and as desired. Case Managers must be aware of and know how to access a wide variety of community-based services, as well as work collaboratively with other agencies or individuals, as appropriate, in order to explain to participants the full array of waiver, Title XIX State Plan, and other services available to meet the participant's needs. Case Managers will work with the participant to identify who the participant wishes to include in the service planning process and the development of the Plan of Care (POC).

The Case Manager supports a participant through the entire service planning process. The Service Planning Process described in Appendix D produces the Waiver Plan of Care (POC) document.

The Case Manager has a discussion with the participant or guardian prior to the service plan meeting. At the participant's discretion, other team members such as family and staff also participate in this discussion. The discussion includes:

- An explanation of the service planning process to the participant/guardian and designated representative such as a family member.
- Identification of the person's goals, strengths, and preferences regarding services and Care Plan Team members.
- A review of all assessment materials, medical and service records and/or the past year's progress and the participant's ongoing needs.
- A review of waiver services, state plan and other services available to the participant and how they relate to and will support their needs and goals.
- Identification of additional assessments, if any, needed to inform the service planning process.

Other preparation includes at the direction of the participant, talking to people who know the participant well such as staff, friends, advocates, and involved family members. In selecting people to talk to, the Case Manager respects the participant's wishes about who is part of the service planning process. When participants cannot communicate their preferences, Case Managers collect information through observation, inference from behavior, and discussions with people who know the participant well. All conversations are respectful of the participant and focus on the person's strengths and preferences. The Case Manager also looks for creative ways to focus the team on the unique characteristics of the person and their situation. The Case Manager does this by helping team members think creatively about how they can better support the person within the context of the participant's strengths, abilities and preferences.
During the service planning consultation, the participant identifies who will be invited to the meeting. These individuals constitute the team members. In situations where personal and sensitive issues are discussed, certain team members may be invited to only part of the meeting, as the participant prefers. Any issue about attendance at the service planning meeting is addressed by the Case Manager based upon the preferences of the participant and or guardian.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the

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

Case Managers will follow standard procedures and time frames in performing the intake, assessment, case conferencing, service planning and review process that ensure participants' strengths, needs, risk factors, personal goals and preferences are identified and appropriately addressed. Throughout the following description of the service plan development process, any reference to the participant implies reference to the participant's guardian where one is in place.

Participant needs are identified beginning at referral and continuing through the person-centered service needs assessment and the POC development processes. Through the person-centered planning process and using a state-approved tool, the assessment gathers information on a participant's goals, capabilities, medical/skilled nursing needs, support/service needs and need for skill development and/or other training to enhance community integration and increase independence, including the opportunity to seek employment, engage in community life and control of personal resources. The service needs assessment reflects the residential setting that has been chosen by the waiver participant. The process also identifies informal supports available to the participant and all other resources that may be available to assist the participant in remaining in the community, achieving positive outcomes and avoiding unnecessary utilization of waiver services.

The initial service needs assessment is conducted by a Case Manager, and then based on this assessment the participant, if they agree, may be referred to other professionals, such as a registered nurse, psychiatrist, therapist or neuropsychologist for further assessment and identification of needs. This assessment includes information identified in the community supports risk screen which is completed at transition.

Those participants who have identified behavioral issues will undergo an initial behavioral assessment and, as indicated, periodic reviews. Should a behavior support plan be indicated it will be developed only by a licensed clinician and implemented under the clinician's guidance, with the informed consent of the participant or, when applicable, their guardian.

Behavior support plans should also include target behaviors that may also be addressed through prescribed psychotropic medications. Behavior support plans must always be cognitively accessible, and must be reviewed with and signed by the participant and, when applicable, their legal guardian.

Linked to the participant's vision, goals and needs, the Case Manager facilitates development of the service plan with the participant. Participant's guardians and other formal and informal supports identified by the participant are part of the service planning process. This may include providers with knowledge and history of serving the participant. The Case Manager is responsible for providing information about non-waiver services and supports to address identified needs and to prevent the provision of unnecessary or inappropriate waiver services,

coordinating and communicating service plans and/or changes to appropriate community agencies and ensuring that waiver participants have access, as appropriate, to waiver and Medicaid State plan services. The Case Manager also identifies other public benefits to ensure that waiver participant needs are met.

The Case Manager's responsibilities include: facilitating the service planning process and development of the POC with the participant and their guardian, ensuring the final plan is signed by the participant and addresses their expressed and assessed needs, monitoring the participant's satisfaction with the plan and assisting to ensure that participant receives the services in the plan, notification to participants/guardians, facilitating subsequent monitoring meetings, meeting routinely with the participant to assess the participant's progress towards identified goals and making POC changes with the participant as necessary or as requested by the participant. The Case Manager ensures that the participant receives a copy of the plan of care. The Case Manager also ensures that a 24-hour back up plan is created, and that the participant understands and is able to implement the 24-hour back up plan when necessary.

During the service planning process and development of the POC, the Case Manager identifies specialized assessments or evaluations that should be completed, and assists the participant to identify their preferred Care Plan Team members. The Case Manager explains programs and services to the participant/guardian, including explaining the opportunity to self-direct certain waiver services, and assists him or her in selecting waiver services and Medicaid state plan services which address the participant's needs and expressed goals.

The participant/guardian may choose to identify other people, for example a representative such as a family member or friend, to be present for the assessment visit and subsequent service planning meetings. The waiver participant/guardian may also choose to exclude individuals from the service plan development process. If the primary language of the program participant, or their legal guardian, is not English, the information in service plans must be translated into their primary language and/or explained with the assistance of an interpreter, including ASL. If the program participant is unable to read or exhibits other cognitive deficits (e.g. memory disorder) which may compromise their response to the service plan, and they do not have a guardian, alternative methods (e.g. audio-taping) shall be utilized in order to ensure that the information is cognitively accessible.

A Plan of Care that has been signed by the participant/guardian is required in order for the Case Manager to initiate authorization of waiver service. The Plan of Care is reviewed periodically with the participant and their Care Plan Team and is modified as needed or as requested and approved by the participant.

The participant will receive a quarterly visit by the Case Manager. The Case Manager may determine that more frequent visits would be beneficial and visit the participant more frequently if they agree. In addition, if the Case Manager becomes aware of changes in the participant's health condition or living circumstances, they may suggest that it would be beneficial for other clinical professionals to visit the participant. The Case Manager will maintain regular contact through a variety of means with the participant between these visits. The POC may be revised at any point by the Case Manager with the approval of the participant/guardian, based on changes in the participant's needs or circumstances.

The Case Manager will document reassessments of the waiver participant in the participant's file. All contact with the participant/guardian, family, vendors and any other persons involved with the participant is also documented in the file.

The Case Manager is responsible for any reasonable accommodations needed for the participant's and family's involvement in the service planning meetings. Accommodations may include personal care assistants, interpreters, peers, translators, physical accessibility, assistive devices, and transportation. These needs may be coordinated and accessed through a waiver service provider involved with the participant.

A very small subset of MFP waiver participants may meet the State's criteria for Targeted Case Management for the mentally ill. For such individuals, the Targeted Case Manager (TCM) would support the individual and coordinate services the person receives through the Department of Mental Health, including such elements as coordinating access to services that DMH provides or contracts for the provision of (which are not duplicative of waiver services), providing supportive counseling, or serving as the person's advocate/supporting the person to advocate for him or herself. The TCM will not play a central role in the planning, authorization or monitoring of waiver services for a participant. The administrative case manager will coordinate closely with the TCM in development of the service plan and in other relevant areas in order to ensure both seamless integration and coordination of waiver services with state agency-provided or -contracted services and, importantly, that neither planned/authorized services, nor case management functions are duplicative.

Administratively claimed case management functions will be limited to the establishment and coordination of Medicaid waiver and state plan services focused on the provision of long term services and supports in the community and are not provided through the Massachusetts Department of Mental Health. Administrative case management that will be claimed is an administrative activity necessary for the proper and efficient administration of the State Medicaid plan.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk assessment and mitigation are a core part of the service planning process. Through multiple assessments, specific to the participant, reviewed during the service planning process, potential risks to the participant's health and safety and the participant's ability to remain in the community are identified by the participant with the case manager's assistance. With the participant, the case manager facilitates with the rest of the Care Plan Team the development of a set of prevention strategies and responses that will mitigate these risks. Having the participant at the center of this process ensures that the responses are sensitive to their needs and preferences.

The participant's 24 hour back -up plan will specifically address contingencies, including the occasions when critical services are unavailable, when back-up transportation is required, and when emergency repair of adaptive equipment is required. The Case Manager obtains any existing participant risk plan. Potential risk areas identified through the assessment process and the service plan will identify services or interventions to mitigate those risks, as necessary and agreed to by the participant. Case Managers will work with the participant's service providers to ensure that the identified risks are appropriately managed. The individualized 24 hour back-up plan will identify agencies and informal supports that provide back-up. The Case Manager works

with the participant and their guardian/informal supports as appropriate to ensure they know the steps to take to activate the back-up plan as well as any role that they have agreed to fulfill in terms of providing emergency back-up and support.

As a component of their 24-hour back-up plan, participants who are self-directing their services will develop with the Case Manager, a plan to address issues related to their self-direction and to ensure their ability to obtain back-up services as needed. This plan addresses the potential pitfalls and contingencies that must be identified and agreed to with the participant, and is required to be included in both the 24-hour back-up plan and the participant's Agreement for Self Directed Supports. Broader risk issues related to the participant and their circumstances will be addressed as necessary and appropriate within and/or outside of the participant's POC and/or 24-hour back-up plan.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

As part of the plan of care development process, case management staff review with participants/guardians the range of waiver and non-waiver services available to address the individual's identified needs. The Case Manager works with the participant to identify any specific preferences or requirements, such as a worker who speaks a particular language. The Case Manager makes inquiries regarding the availability of workers, discusses options with the participant (including schedules), and works with the participant to identify the providers best able to meet the requirements and preferences of the waiver participant. The participant ultimately chooses which providers will deliver their services. The participant will be advised regarding how to raise concerns about providers and the Case Manager will provide information to the participant regarding how to lodge a complaint, how to seek assistance from the Case Manager, and how to raise issues with the case manager supervisor if they have a complaint about the Case Manager.

At each visit, Case Managers inquire as to the participant's satisfaction with both the services included in the POC and the service providers. The participant may, at any time, request a change of service providers or Case Manager.

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):

MRC maintains an electronic record for all participants which includes the individual service plan, POCs, the 24 hour backup plan, assessments, eligibility information, correspondence and any other information. Service Plans are reviewed for content, quality, and required components. The sample size is intended to meet requirements of a 95% confidence level and a +/-5% margin of error 95/5 response distribution. The sample will be randomly generated by a computerized formula which will generate the sample on a quarterly basis throughout the year and it will assure that the case manager supervisor reviews the Service Plans completed by Case Managers assigned to them.

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:*
	The person centered planning documents, Plans of Care and 24 hour backup plans are maintained electronically by MRC. Additionally, electronic service plan records are recorded by case management staff and maintained in the electronic system. All records are maintained for seven years after the date the case is closed.

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 Case Manager has overall responsibility for monitoring the implementation of the service plan to ensure that the participant is satisfied with waiver services, that they are furnished in accordance with the POC, meet the participant's needs and achieve their intended outcomes. This is done through periodic progress and update meetings and ongoing contact with the participant, their Care Plan Team, and other service providers as appropriate.

The participant will receive, at a minimum, a quarterly visit by the case manager. Visits are done primarily in person; telehealth may be used to supplement the scheduled in-person visit based on individual needs. The case manager may determine that more frequent visits would be beneficial and visit the participant more frequently if the participant agrees. If the case manager becomes aware of changes in the participant's health condition or living circumstances, they may suggest that it would be beneficial for other clinical professionals to visit the participant. In addition, the case manager will maintain regular contact with the participant through a variety of means between the in-person visits. The POC may be revised at any point by the case manager with the participant, based on changes in the participant's needs or circumstances.

The case manager will review with the participant the range of waiver and non-waiver services available to address the participant's identified needs and ensure access to services. At each in-person visit and telephone contact, the case manager will inquire as to the participant's satisfaction with both the services included in their POC and the service providers. The participant has free choice of service providers and may, at any time, request a change of service providers.

The case manager will ensure that a 24-hour back up plan is created and updated as needed, as a component of the participant's service plan, and that the participant, and their guardian/informal supports as appropriate, understands and is able to implement the 24-hour back up plan when necessary. Case managers will work with the participant's service providers to ensure that the identified risks are appropriately managed.

In addition there are several other quality management processes, conducted by other departmental staff as well as providers to assure that individual participants are getting the services they need and that their health and welfare is protected. These processes are described more fully in other appendices:
a) incident reporting and management (described in Appendix G)
b) investigations process (described in Appendix G)
c) "trigger" reports (described in Appendix G)
d) risk assessment and management system
e) annual standard contract review process
f) periodic progress and update meetings
g) ongoing contact with the participant and service providers.

Through the web-based incident reporting and management system, Case Managers are notified of incidents that occur for individuals on their caseload. The system, known as the Home and Community Services Information System (HCSIS) alerts Case Managers in a timely manner, to any reportable event. Case Managers are required to review and approve action steps taken by the reporting provider. Incidents may not be "closed" until such time as action steps have been

approved. In addition, Case Managers receive monthly "trigger" reports, which identify individuals who have reached a certain threshold of incidents. Case Managers are required to review all "trigger" reports to assure that appropriate action has been taken to protect the health and welfare of participants.

As an additional response to critical incidents or trends, MRC will undertake an internal Administrative Review in the event that an incident or series of incidents 1) have the potential to result in death or permanent or long lasting harm to an individual; or 2) have the potential to result in significant behavioral or psychiatric decompensation and/or psychiatric hospitalization; or 3) indicate a provider's or case manager's failure to follow policies and procedures and/or develop a plan to address known risks. The outcome of the Administrative Review may result in further actions based upon its findings and recommendations.

While MRC promotes empowerment and supports personal choice as a core value, the agency also strives for comprehensive service planning that is responsive to participant needs. Service planning involves the ongoing process of identification, assessment and mitigation of risk. Participants are informed of the identified or potential risks and are supported by their Care Plan Team around their interest and preference in the identification of community supports and strategies to minimize these risks while ensuring for maximum opportunities for self-sufficiency.

Frequency of direct contact with the waiver participant is at least quarterly, with additional visits based on individual needs. Contact is primarily done in person; telehealth may be used to supplement the scheduled in-person visit based on individual needs. The amount of contact is related to a number of variables including participant interest, whether the participant has a risk plan in place, the number of potential providers who have daily contact with the participant, the frequency of program monitoring activities within the provider site, the frequency and type of family monitoring etc. In response to incidents reported through HCSIS the system produces "trigger reports" which provide additional information to the Case Manager about the need to potentially increase direct in-person contact. Individuals with changing needs may be seen more frequently in order to ensure continuity and to monitor potential changing situations. Case Managers review progress notes from providers and maintain regular contact with providers of waiver services which also serves to inform the frequency of direct in-person contact. Individuals who have not received at least one waiver service monthly, receive direct in-person contact in the following month.

The service planning process includes backup plans to address contingencies which may impact the waiver participant. The Care Plan 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 Care Plan Team led by the Case Manager. As part of the person-centered service needs assessment and the POC review processes the safety assessment is reviewed and a determination is made about whether there is a need for a risk plan. The outcome of the safety assessment and the risk assessment determine the type of back-up plan required. Therefore, the back-up plans vary by person and by their circumstances. Secondly, all incidents are reported in HCSIS including the examples cited in the question. There is an on-call system in place utilizing a 24/7 response line which has access to participant backup plans.

Individuals and families are provided with information on who to contact in an emergency and how to access the hotline number. The Supervisory Tool is also used to uncover whether the back-up plans have been effective.

MRC uses the Supervisory Tool to monitor the access to all needed services on a quarterly basis. Case Manager Supervisors also routinely review Case Manager notes to monitor participant access to non-waiver services in the service plan including health services. Case Managers conduct quarterly reviews of the service plan and its continued efficacy in assisting individuals to reach their goals and objectives. Providers submit progress reviews and modifications may be made if deemed necessary.

b. Monitoring Safeguards. *Select one:*

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

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.

Performance Measure:	% of service plans that reflect needs identified through the assessment process. (Number of service plans that address needs identified during the assessment process/ Number of service plans reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **SC Supervisor Tool**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *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 with a 95/5 response distribution
		☐ *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*

State:	
Effective Date	

	☐ *Other Specify:*

Performance Measure:	% of service plans in which communication and contact has been maintained as required to assure that services are being provided and meet the person's needs. (Number of service plans in which communication and contact has been maintained as required to assure that services are being provided and meet the person's needs / Number of service plans reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **SC Supervisor Tool**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *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 with a 95/5 response distribution
	Case Management (CM) Entities	☐ *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*	☑ *Annually*

State:	
Effective Date	

Specify:	
	☐ *Continuously and Ongoing*
	☐ *Other Specify:*

Performance Measure:	% of service plans that have been developed in accordance with waiver requirements as indicated by the inclusion of all required components, including all required assessments, support strategies, choice forms, LOC & POC. (Number of service plans developed in accordance with waiver requirements as indicated by the inclusion of all required components/ Number of service plans reviewed)

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

If 'Other' is selected, specify: **SC Supervisor Tool**

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *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 with a 95/5 response distribution
		☐ *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:	
Effective Date	

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

Performance Measure:	% of service plans that reflect personal goals identified through the assessment process. (Number of service plans that address personal goals identified during the assessment process/ Number of service plans reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **SC Supervisor Tool**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *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 with a 95/5 response distribution
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

State:	
Effective Date	

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*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*

State:	
Effective Date	

	☐ *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: 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:	% 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):*	
If 'Other' is selected, specify: **SC Supervisor Tool**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *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 with a 95/5 response distribution
		☐ *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:*

State:	
Effective Date	

Performance Measure:	% of service plans that are completed and/or updated annually. (Number of service plans completed and/or updated annually/ Number of service plans reviewed)

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

If 'Other' is selected, specify: **SC Supervisor Tool**

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *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 with a 95/5 response distribution
		☐ *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:*

State:	
Effective Date	

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:	% of individuals who are receiving services according to the type, amount, frequency, duration and scope identified in their plan of care. (Number of individuals who are receiving services according to the type, amount, frequency, duration and scope in their plan of care/ Number of individual plans of care reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **SC Supervisor Tool**	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *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 with a 95/5 response distribution
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

State:	
Effective Date	

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:	% of service plans that contain documentation indicating that participant was informed of their choice between service providers and method of service delivery. (Number of service plans that contain documentation indicating that participant was informed of their choice between service providers and method of service delivery/ Number of service plans reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **SC Supervisor Tool**	

State:	
Effective Date	

	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 with a 95/5 response distribution
		☐ *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.

State:	
Effective Date	

Case Manager Supervisors will review a sample of service plans of each of the case managers they supervise utilizing the SC Supervisor Tool. The tool has two components. The first is a checklist that is completed with every service plan submitted for review and approval. The second is a qualitative review which includes discussion with the case manager as well as review of supplementary material. This will be done on a quarterly basis. Included will be a review of documentation (including case manager notes and the service plan) and discussion with the case manager to verify that service planning and implementation requirements have been met. Each indicator on the tool will be rated according to whether it met the applicable standard.

b. Methods for Remediation/Fixing Individual Problems

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

The Massachusetts Rehabilitation Commission, the Department of Developmental Services and MassHealth are responsible for ensuring effective oversight of the waiver program. As problems are discovered at the level of care entity, the Administrative Services Organization, or waiver service providers, MassHealth, MRC and DDS will ensure that a corrective action plan is created, approved and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, MassHealth is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	**Responsible Party** *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☑ **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.

State:	
Effective Date	

☑	**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.

State:	
Effective Date	

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

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

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

A variety of supports are available to assist participants who choose this model. The Case Manager determines whether the participant is able to carry out the responsibilities of an employer without assistance. Participants who require assistance must appoint a representative. Any participant may elect someone to act as their representative and assume responsibility for employer functions that the participant cannot or chooses not to perform. The Case Manager assists the participant and/or representative in POC development, identification of worker tasks and completion of required forms. In addition the Case Manager will provide or arrange for skills training to the participant and/or representative on employer functions and will link them to other needed resources such as worker training. Individuals who self-direct and hire their own workers will sign an Agreement for Self-Directed Supports and have the authority and responsibility to undertake the following tasks: recruit and hire workers, verify qualifications, determine workers duties, provide training and supervision, evaluate staff, maintain and submit time sheets, submit employee data to the Fiscal Management Service Agency (FMS) as required, and, if necessary, terminate a worker's employment. Once the POC is complete, information regarding the authorized frequency and duration of the participant-directed services in the POC is forwarded to a FMS.

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

The worker must have the FMS direct deposit payment into the worker's bank account in which case, the participant will notify the FMS to do so. The worker may choose to apply for a payroll debit card to receive payment.
The FMS is responsible for tracking time worked to enable MassHealth to calculate payments to be made in accordance with FLSA requirements, including but not limited to payments for overtime. In addition, the FMS will track the accumulation of earned paid time to enable MassHealth to make earned paid time payments and which satisfies the requirements of the Massachusetts sick time law at Massachusetts General Law chapter 149, section 148C.

The FMS is required to be utilized by participants and families who choose employer authority to hire their own staff and self-direct some or all of their waiver services in their POC. The FMS functions will be recognized as administrative costs.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

☑	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
○	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

☑	**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
☑	**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
☑	**The participant direction opportunities are available to persons in the following other living arrangements** *Specify* these living arrangements:
	Persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individuals' family or guardian has domain and control.

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*
	Self-direction opportunities will be available to all participants enrolled in the waiver. Participants must express their desire to self-direct services and may be assessed for their need for a surrogate to assist them to self-direct. The need for surrogacy will be assessed during the service planning process by the care planning team and reviewed annually. If it is determined the participant needs a surrogate, the participant will seek a voluntary surrogate from family, friends, or other sources. If there is no resource who can serve as a voluntary surrogate, the Case Manager will work with the participant to determine if Individual Support and Community Habilitation services can provide surrogacy support to the participant. The Case Manager will provide or arrange for skills training to the participant or participant's unpaid surrogate and assist the participant/surrogate in on-going management of the self-directed supports. Should evidence arise that a participant who is self-directing their services is no longer able to do so, they will be offered the option to have a surrogate, as described above, to assist with their self-direction decisions. If a participant who has been assessed to require surrogacy does not wish to use or continue to use a surrogate they will not be able to self-direct and will transition to receiving supports through a traditional provider. Appeal rights will be granted.

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

As part of the intake and waiver eligibility process, information about the waiver and opportunities for self-direction will be provided to each individual. The range of options will be discussed as part

of the person-centered planning process and throughout the implementation of the POC by the Case Manager. The Case Manager will provide written materials to the participant describing both the benefits and potential liabilities of self-direction, and the role of the Fiscal Management Service in managing these services. When a participant elects to self-direct some of their services, additional information and a handbook about the Fiscal Management Service (FMS) and the requirements for self-directing will be provided, including information about the Agreement for Self-Directed Supports. The FMS has the responsibility for providing fiscal services related to income tax and social security tax withholding, and state worker compensation taxes.

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one)*:

○	**The state does not provide for the direction of waiver services by a representative.**	
☑	**The state provides for the direction of waiver services by representatives.** Specify the representatives who may direct waiver services: *(check each that applies)*:	
	☑	**Waiver services may be directed by a legal representative of the participant.**
	☑	**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		The state's practice is to allow Waiver Participants the opportunity to self-direct their waiver services independently if they are able to do so, or with assistance if needed from a non-legal representative chosen by the Waiver Participant. The Case Manager will provide support as needed to the Waiver Participant to ensure that proper safeguards are in place to ensure effective oversight and implementation of the POC. The Waiver Participant and the Participant's non-legal representative delineate agreed upon responsibilities of the representative in the Agreement for Self-Directed Supports. The Case Manager will address any concerns they have about self-directed services through regular meetings with the Waiver Participant and their representative. In addition, meetings can occur anytime an issue or concern arises.

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 Support and Community Habilitation	☑	☐
Peer Support	☑	☐
Personal Care	☑	☐
Adult Companion	☑	☐
Chore Service	☑	☐
Homemaker	☑	☐

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:	
	Financial Management Service (FMS) will be provided through a financial management service entity. These services are procured in accordance with state procurement laws.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
	The FMS will be furnished as an administrative activity. The administrative fee is set by MassHealth through the FMS contract and is paid on a per person per day basis for each participant who chooses to self-direct. The FMS contract requires that MassHealth conduct an annual reconciliation of the fee to determine whether or not it is sufficient. Each human and social service organization that delivers services to the Commonwealth's consumers via contracts with state departments is required to complete and submit annual Uniform Financial Statements and Independent Auditor's Report (UFR). MassHealth uses each FMS's annual UFR to compare the FMS's reasonable expenditures for administrative tasks identified in the UFR and paid claims to determine if the FMS expenditures fall within 90% - 110% of the total MassHealth reimbursement. If the FMS reasonable expenditures exceed the reimbursement by more than 10% of what MassHealth has paid, then MassHealth will pay the FMS the amount exceeded, and the rate would most likely be increased. If the reconciliation process shows that FMS expenditures fall below 90% of what they were paid, then the FMS would owe MassHealth, and the rate would be decreased. If the expenditures fall within the 90% - 110% range then no action is needed and no money is either returned or paid out.	
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	
	Supports furnished when the participant is the employer of direct support workers:	
	☑	**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:*
		The FMS assists participants in verifying worker citizenship status and conducts the Criminal Offender Record Information (CORI) check. The worker may elect to have the FMS direct deposit payment into the worker's bank account in which case, the participant will notify the FMS to do so. The worker may also choose to receive their payment via a debit card. The FMS also provides periodic reports to the participant and case manager regarding utilization of participant-directed services.
	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*:
	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:*
		The FMS issues worker payments by automatic direct deposits, unless the worker is authorized to receive payment by payroll debit card, on a biweekly basis. The FMS also provides periodic reports to the participant and case manager regarding utilization of participant-directed services.
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	
	The State will manage the performance of the FMS via contract. The State will establish performance metrics as part of the FMS contract and will require that its FMS meet them and have an established process of remediation if they do not achieve them. Monthly FMS reports	

will reconcile expenditures for a participant with that participant's approved plan of care. The FMS is also required to maintain a log of complaints.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*	
	Each participant who desires to self-direct their services will be assessed to determine their capacity to do so and the types of supports that will be required to assist them. Each Participant will have a Case Manager to provide information and assistance to support self-direction. The Case Manager will monitor the implementation of the support plan and provide coordination and oversight of supports. The role of the Case Manager in individual planning is to support the person and other team members to develop and implement a plan that addresses the participant's needs and preferences. Case Managers support participants to be actively involved in the planning process, share information about choice of qualified providers and self-directed options, and assist with arranging supports and services as described in the plan. They also support the participant to monitor services and make changes as needed. The Case Manager may also support participants to: - hire, train and manage their employees; - develop emergency back up plans; and - access and develop self-advocacy skills. Case Managers are responsible for ensuring that participants understand their responsibilities under self-direction and that the participant has signed the Agreement for Self-Directed Supports.	
☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the 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:*	
	Each participant who desires to self-direct their services will be assessed by their case manager to determine their capacity to do so and the types of supports that will be required to assist them. Each Participant will have a Case Manager to provide information and assistance to support self-direction. The Case Manager supports the participant or their legal representative in arranging for, directing, and managing waiver services. Assistance is provided in identifying immediate and long-term needs, developing options to meet those needs and accessing identified waiver supports and waiver services. Participants or their representatives may also receive information on recruiting and hiring	

	direct service workers, managing workers and providing information on effective problem solving and communication. The Case Manager function includes providing information to ensure that the participant or representative understands the responsibilities of directing their own services; the extent of assistance needed by the participant is discussed by the team and specified in the service plan. The Case Manager will assist in developing the self-direction specifics of the POC to ensure that the needs and preferences are clearly understood and reflected in the plan and will ensure the participant receives skills training, if needed, to enable them to arrange for, direct and manage waiver services. The Case Manager will focus on the following sets of activities in support of participant-directed services: - Support the individual to recruit, train and hire staff; - Facilitate community access and inclusion opportunities; - Monitor and assist the individual participant when revisions to the POC are needed; and - Support the participant in working with the Fiscal Management Service to recruit, screen, hire, train, schedule, monitor and pay support workers.

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:

Repeated efforts will be made by the Case Manager to sustain the participant in their self-direction of services. If after multiple efforts, the waiver participant voluntarily chooses to terminate this method of receiving services, it is the Case Manager's responsibility to arrange for and ensure continuity of services/supports through traditional providers to meet the individual's health and welfare needs outlined in their participant-centered plan of care. When appropriate, the Case Manager will work with the participant to adjust the POC to ensure that it meets the needs and desires of the participant and to ensure health and safety during the transition from participant-directed services to more traditional provider based services.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

In the case of an involuntary termination of participant direction, the individual and the support team meet to develop a transition plan and modify the Waiver Plan of Care. The Case Manager ensures that the participants' health and safety needs are met during the transition, coordinates the transition of services and assists the individual to choose a qualified provider to replace the directly hired staff.

Although the State will work to prevent situations of involuntary termination of self-direction, they may be necessary. Reasons for involuntary termination of self-direction will include (but not be limited to) such things as refusal on the part of the participant to be involved in the development

and implementation of the Individual Service Planning Process, the participant authorizing payment for services or supports that are not in accordance with the plan of care, the participants commission of fraudulent or criminal activity associated with self-direction, demonstration that the participant requires a surrogate to ensure adequate management of workers, but declines such surrogate when informed one is necessary in order to self-direct, on-going inability to locate, supervise, and retain employees, and/or to submit time-sheets in a timely manner, and other individual circumstances that may preclude continued self-direction.

Each participant who self-directs will have an Agreement for Self-Directed Supports describing the expectations of participation. As part of this agreement, the individual acknowledges that the authorization and payment for services that are not rendered could subject them to Medicaid fraud charges under state and federal law. Breach of any of the requirements with or without intent may disqualify the individual from self-directing-services. Termination of the participant's self-direction opportunity may be made when a participant or representative cannot adhere to the terms of the Agreement for Self-Directed Supports.

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	201	
Year 2	213	
Year 3	222	
Year 4 (only appears if applicable based on Item 1-C**)**	232	
Year 5 (only appears if applicable based on Item 1-C**)**	242	

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:
☑	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑	**Recruit staff**
☐	**Refer staff to agency for hiring (co-employer)**
☑	**Select staff from worker registry**
☑	**Hire staff (common law employer)**
☑	**Verify staff qualifications**
☐	**Obtain criminal history and/or background investigation of staff** Specify how the costs of such investigations are compensated:
☑	**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3. Specify the state's method to conduct background checks if it varies from Appendix C-2-a:**
	Criminal background checks are conducted in accordance with processes outlined in 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.

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.

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:

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Waiver applicants and participants are afforded the opportunity to request a fair hearing disputing actions under the MFP-CL Waiver in all instances when: (1) they are not provided the choice of home and community-based services as an alternative to institutional care; (2) they are denied participation in the MFP-CL Waiver; (3) there is a denial, suspension, reduction or termination of services, including a substantial failure to implement the services contained in their Individual Service Plan, within the terms and conditions of the MFP-CL Waiver as approved by CMS.

Individuals are informed in writing of the procedures for requesting a Fair Hearing as part of the waiver entrance process. If entrance to the waiver is denied, the person is given formal written notice of the denial and information about how to request a Fair Hearing to appeal the denial of entrance to the waiver. In order to ensure that individuals are fully informed of their right to Fair Hearing, the written information will be supplemented with a verbal explanation of the Right to Fair Hearing when necessary. Appellants are notified that they can seek judicial review of the final decision of the hearing officer in accordance with M.G.L. c. 30A (the Massachusetts Administrative Procedures Act). It is up to the individual to decide whether to request a Fair Hearing.

Whenever an action is taken that adversely affects a waiver participant post-enrollment (e.g., services are denied, reduced or terminated), the participant is notified in writing by letter of the action on a timely basis in advance of the effective date of the action. The notice includes information about how the participant may appeal the action by requesting a Fair Hearing and provides, as appropriate, for the continuation of services while the participant's appeal is under consideration. Copies of notices are maintained in the person's record. It is up to the participant to decide whether to request a Fair Hearing.

The notices regarding the right to appeal in each instance provides a brief description of the appeals process and instructions regarding how to appeal. In addition, the participant’s plan of care is accompanied by right-to-appeal information, as described above, as well as a cover letter that includes contact information for a Case Management staff person who is available to answer questions or to assist the individual in filing an appeal. Regulations of the Executive Office of Administration and Finance at 801 CMR 1.02 et seq. (Executive Office for Administration and Finance regulations establishing standard adjudicatory rules of practice and procedure), shall govern MFP-CL Waiver appeal proceedings.

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).

MRC and DDS utilize a web-based incident reporting system, based upon the Pennsylvania Home and Community Services Information System (HCSIS) system. The incident reporting system provides invaluable information regarding individual incidents, immediate and long range actions taken as well as aggregate information that informs analyses of patterns and trends. Providers are required to report incidents when they occur and MRC case managers are required to report incidents when they learn about them if they have not already been reported. Incidents are classified as requiring either a minor or major level of review. Deaths, physical and sexual assaults, suicide attempts, certain unplanned hospitalizations, missing person, injuries, are examples of incidents requiring a major level of review. Suspected verbal or emotional abuse, theft, property damage, and behavioral incidents in the community are examples of incidents requiring a minor level of review. The HCSIS system is an integrated event system and as such medication occurrences, and any unauthorized use of restraints or restrictive interventions are also reported. These processes are more fully described in this appendix. Incidents classified as requiring a minor level of review must be reported within 3 business days. Minor incidents may be elevated to major, if determined necessary. Incidents requiring a major level of review must be reported within 1 business day, and the provider has the responsibility to immediately report major incidents by phone or e-mail to the case manager. Immediate and longer term actions steps are delineated and must be reviewed and approved by the case manager for minor incidents and by case manager supervisory staff for major incidents. An incident cannot be considered closed until all appropriate parties agree on the action steps to be taken and all required approvals have been completed. Standard management reports for purposes of follow up on provider and systemic levels are provided to MRC waiver administrative staff on a monthly

basis. Aggregate data regarding specific incident types are reported annually. The reports detail both the number of incidents as well as the rate of incidents.

In addition to the incident reporting system, all alleged instances of abuse or neglect, exploitation, and/or death must be reported to the Disabled Persons Protection Commission (DPPC) for all individuals between the ages of 18 and 59 and to the Executive Office of Elder Affairs for individuals over the age of 59. DPPC is the independent State agency responsible for screening and investigating or referring for investigation all allegations of abuse or neglect, exploitation, and/or death for individuals with disabilities between the ages of 18 and 59. Mandated reporters, as well as individuals and families, report suspected cases of abuse or neglect, exploitation, and/or death directly to the DPPC. DPPC reviews all reports, then determines and assigns investigation responsibility.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

All waiver service providers are required as part of their core responsibility to inform all participants and families of their right to be free from abuse, neglect, and/or exploitation as well as the appropriate agency to whom they should report allegations of abuse, neglect or exploitation. Individuals and their families are given the information both verbally and in writing. As part of their role, case managers also inform individuals about how to report alleged cases of abuse or neglect.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

As mentioned in G-1-b, MRC and provider staff, have responsibility to respond to and determine the necessity of taking additional action or referring information about incidents to other authorities. MRC has overall responsibility for review of incidents and for managing the appropriate response of the various providers.

Minor and major incidents must be reported by the staff person observing or discovering the incident. An incident requiring a major level of review must be immediately reported verbally to the case manager. The incident must also be entered into the electronic web based system (HCSIS). A major incident must be reported through HCSIS within 1 business day; a minor incident within 3 business days. The initial report is reviewed by the case manager to assure that immediate actions have been taken to protect the individual. The provider must also submit a final report which includes the follow up action steps that will be taken beyond those already identified. Both minor and major incident reports are reviewed by the case manager. Major incidents are escalated to the MRC administrative level for review. The final report, which includes action steps, must be agreed upon by both the provider and MRC. If MRC does not concur with the action steps, the report is sent back to the provider for additional action. Incident reports are considered closed only after there is consensus among the parties as to the action steps taken and all required reviews and approvals are completed.

For those participants between the ages of 18 and 59, incidents that rise to the level of a reportable event, i.e. allegation of abuse, neglect, exploitation and/or death potentially subject to

investigation, are reported to the Disabled Persons Protection Commission (DPPC). DPPC receives and reviews all reports and makes the determination as to whether a reported event meets the criteria to require an investigation. It then refers the case to the appropriate agency for investigation. DPPC can decide to conduct the investigation itself, refer the case to the MRC or DDS for investigation, or refer the case to law enforcement entities as the circumstances require. If a report filed suggests that a crime may have been committed, the report is sent to the office of the District Attorney with jurisdiction by the DPPC as a referral. Should the DA decide to pursue the matter criminally, the civil investigation is put on hold, protective services are provided as deemed necessary and law enforcement is assigned to investigate. All reports of abuse, neglect, exploitation and/or death are processed by trained, experienced staff. When deemed necessary, immediate protective services or action steps are put into place by the investigator to ensure that the individual is safe while the investigation is completed. In addition, collaboration between the protective service investigator and the case manager regarding these protective services or action steps, during and after the investigation, ensures ongoing oversight and monitoring of remediation. Once referred for investigation, initial findings are sent to the DPPC within 10 days and the completed investigation report is due to the DPPC 30 days after the date the report was filed. By regulation and upon request, the alleged victim, the alleged abuser, and the Reporter can receive a copy of the report. For participants 60 years old or older, all such incidents are reported to the Executive Office of Elder Affairs, which then enters a process similar to that described above by the DPPC. For those investigations where concerns are identified related to service delivery, the MRC clinical waiver team reviews the precipitating incident or report to determine the need for an administrative review. Administrative review would expand the review of a situation beyond an individual caregiver or incident to ensure that the overall support system is sufficiently meeting the needs of participants.

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.

MRC in collaboration with DDS has responsibility for day-to-day operational oversight and management of the critical incident system. MRC as the operating agency for this waiver is responsible for overseeing the reporting of and response to critical incidents and interacting with all waiver service providers in communicating policy and procedural requirements and providing any needed training on incident reporting and follow-up responsibilities.

Oversight of the incident management system occurs on three levels- the individual, the provider and the system. As previously mentioned, the incident reporting and management system is a web-based system. As such, incidents are reported by staff according to clearly defined timelines. The system generates a variety of standard management reports that allow for tracking of timelines for action and follow up as well as for tracking of patterns and trends by individual, location, and provider. On an individual level, case managers are responsible for assuring that appropriate actions have been taken and followed up on. On a provider level, MRC waiver supervisory staff track patterns and trends by location and provider. On a systems level, MRC waiver supervisory staff track patterns and trends in order to make service, policy and procedure improvements. MRC will forward data on incidents related to specific providers to the Administrative Services Organization (ASO) so that it can incorporate these data into the re-credentialing process for the providers that it credentials. In addition, incidents, patterns, and trends are communicated to MRC leadership as appropriate.

In addition, “trigger” reports based upon 10 thresholds are disseminated to each case manager monthly. This serves as an additional safeguard to assure that responsible staff are aware of and

have taken appropriate action when there are a series of incidents that reach the trigger threshold, and to follow up on potential patterns and trends for the individuals they support.

Finally, on a quarterly basis, a random sample of "trigger" reports are selected and reviewed by the MRC waiver administrative and supervisory staff. The sample gets reviewed to determine whether appropriate action was taken, whether the actions were consistent with the nature of the incident and whether additional actions are recommended.

Appendix G-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:
	No use of restraints or seclusion are allowed in the MFP waivers, thus, all such use is unauthorized. While extremely rare, the unauthorized use of a restraint must be reported by providers in the HCSIS restraint reporting system. Providers must also report these incidents to DPPC which screens all allegations of abuse, neglect, exploitation and/or death . Regulations requiring investigation of all reports of abuse and neglect, exploitation and/or death, which would include the unauthorized use of restraints may be found at 118 CMR 5.00 (Regulations for the state's Disabled Persons Protection Commission [the Commission] that define the requirements for abuse investigations conducted by the Commission and the review and oversight standards to be used by the Commission). Case managers review to assure that no unauthorized procedures are utilized during the course of their visits. Review of data reported on incidents provides case managers and supervisors with information that is used to detect any use of restraints or seclusion.
○	**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

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.

MRC has very stringent standards pertaining to the use of restrictive interventions. These interventions would only be considered for use in Shared Home Supports and Day Programs. MRC requires that any interventions designed to modify behavior in these two settings must be the least restrictive and least intrusive. Interventions are subject to stringent reviews and safeguards. Interventions that are intrusive or restrictive are used only as a last resort and are subject to the highest level of oversight and monitoring.

For example, restrictive interventions may include placing an alarm on a door to alert staff to participants who are prone to elopement and where this would represent concerns for the participant's safety.

Current important safeguards in the MRC policies pertaining to restrictive interventions include that all behavior plans must be developed and overseen by a licensed clinician with expertise in behavioral supports and management. These plans must include a clear description of the behaviors to treat, specification of how the behavior will be measured, a functional analysis of the antecedents and consequences, the duration and type of intervention, other less restrictive alternatives that have been tried, the name of the treating clinician and a procedure for monitoring, evaluating and documenting the use of the intervention. No plan may deny an individual adequate sleep, a nutritionally sound diet, adequate bedding, adequate access to bathroom facilities and adequate clothing. All plans must be in written form, must be consented to by the participant and/or the guardian and must be included in their care planning process. For those providers who also have an established human rights committee, this additional level of review should be completed as another safeguard to further address any concerns prior to the implementation of the behavior plan.

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:

While the use of restrictive practices is limited to only two waiver services, the Massachusetts Rehabilitation Commission has the primary responsibility for the monitoring and oversight of these restrictive interventions. In addition to the previously mentioned reviews by the treating clinician, the care plan team, and the human rights committee (where applicable), the use of restrictive interventions is also monitored in the following ways:
1) Case managers conduct quarterly visits with participants and during each visit ensure that behavior plans are being appropriately implemented by the provider and overseen by the treating clinician.
2) In addition, case managers review the monthly progress reports from providers where data related to the utilization and effectiveness of the behavior plan must be reported.

DPPC receives, through protective service reports or provider complaints, reports of unauthorized use of restrictive interventions for participants served through the Waiver. Regulations requiring investigation of all reports of abuse, neglect, exploitation and/or

death which would include the unauthorized use of restrictive interventions, may be found at 118 CMR 5.00 (Regulations for the state's Disabled Persons Protection Commission [the Commission] that define the requirements for abuse investigations conducted by the Commission and the review and oversight standards to be used by the Commission).

In addition, as noted above, incident reporting through the use of the HCSIS incident reporting system is utilized to identify systemic as well as isolated issues, which would include unauthorized use of restrictive interventions, within the service system serving Waiver participants. Regular review and aggregation of data reported on incidents provides managers with information that is used to detect unauthorized use of restrictive interventions.

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

☑	**The state does not permit or prohibits the use of seclusion** Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
	No use of restraints or seclusion are allowed in the this waiver, thus, all such use is unauthorized. While extremely rare, the unauthorized use of seclusion must be reported by providers as an incident in the HCSIS incident reporting system. Providers must also report these incidents to DPPC which screens all allegations of abuse, neglect, exploitation and/or death. Regulations requiring investigation of all reports of abuse and neglect, exploitation and/or death, which would include the unauthorized use of seclusion may be found at 118 CMR 5.00 (Regulations for the state's Disabled Persons Protection Commission [the Commission] that define the requirements for abuse investigations conducted by the Commission and the review and oversight standards to be used by the Commission). Case managers review to assure that no unauthorized procedures are utilized during the course of their visits. Review of data reported on incidents provides case managers and supervisors with information that is used to detect any use of restraints or seclusion.
○	**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced 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.

For this waiver, only providers of respite services have responsibility for assisting participants with their medications. These services are overseen by the State Agency that licenses or certifies the specific respite setting in which the participant receives respite services.

The Department of Public Health is responsible for oversight of Hospitals and Nursing Facilities. Licenses for these facilities are renewed every two years. In addition, the Department of Public Health conducts investigations into reported complaints, which would include any complaints regarding medication management.

Medication management in Assisted Living Residences is overseen by the Executive Office of Elder Affairs in accordance with 651 CMR 12.00, the Department of Elder Affairs regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts. Assisted Living Residences are re-certified every two years.

Medication management in Department of Developmental Services (DDS) Licensed Respite Facilities is overseen by DDS in accordance with 115 CMR 7.00 (DDS regulations for all DDS supports and services provided by public and private providers). Providers are overseen annually or every two years depending on the level of licensure by the DDS Office of Quality Enhancement, Survey and Certification staff.

In all of these settings, oversight of medications is conducted as part of the overall licensure/certification process and includes review of medication administration policies. Through site visits and reviews of medication records, the licensing/certifying State Agencies detect harmful practices and intervene appropriately.

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.

State oversight and follow-up of medication management is conducted as part of the licensing or certification process for the applicable respite care setting. Oversight is provided in accordance with 105 CMR 130.00 (Department of Public Health Hospital Licensure

Regulations that describes the standards for the maintenance and operations of hospitals in Massachusetts), 105 CMR 150.00 (Department of Public Health regulations covering licensing of long-term care facilities), 130 CMR 408.000 (MassHealth Adult Foster Care regulations that define provider eligibility requirements and program rules), 651 CMR 12.00 (Department of Elder Affairs regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts), and MGL c. 94C (the Massachusetts Controlled Substances Act)and MGL c. 112 s. 74 and 74A (which address the regulation of certain professions).

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

○	Not applicable (*do not complete the remaining items*)
☑	**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medication administration would be provided only in Respite settings as defined in Appendix C-2-c. State oversight and follow-up of medication administration is conducted in accordance with 105 CMR 130.00 (Department of Public Health Hospital Licensure Regulations that describes the standards for the maintenance and operations of hospitals in Massachusetts), 105 CMR 150.00 (Department of Public Health regulations covering licensing of long-term care facilities), 651 CMR 12.00 (Department of Elder Affairs regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts), MGL c. 94C (the Massachusetts Controlled Substances Act) and MGL c. 112 s. 74 and 74A (which address the regulation of certain professions).

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:
	The Massachusetts Department of Public Health (DPH) for all DPH licensed facilities and the Executive Office of Elder Affairs for Assisted Living Residences. Pharmacy errors are reported to the Board of Registration in Pharmacy.
	(b) Specify the types of medication errors that providers are required to *record:*
	All medication errors in DPH licensed facilities must be recorded. DPH requires a Medication Occurrence Report when there is an event that results from the breach of one of the 5 "R's", namely right individual, right medication, right time, right dose and right route. There are 5 types of reportable occurrences - "the 5 wrongs" are wrong individual, wrong medication (which includes administering medication without an order), wrong time (which includes a forgotten dose), wrong dose and wrong route.\
	(c) Specify the types of medication errors that providers must *report* to the state:
	Medication Occurrence Reports must be submitted to DPH within 24 hours of the incident for any reportable medication occurrence in a DPH licensed facility. A reportable occurrence is any medication error followed by a medical intervention, illness, injury or death. The DPH maintains a designated 24 hour hotline to receive all Medication Occurrence reports. An Assisted Living Residence must report to the Certification Unit at Elder Affairs the occurrence of an incident or accident that has or may have a significant negative effect on a resident's health, safety or welfare. This includes medication errors with an adverse effect requiring medical attention. These reports must be made by telephone and in writing within 24 hours after the occurrence of the incident or accident. Telephone reports are made to a dedicated voice mail line at Elder Affairs and written reports must be faxed to a designated Elder Affairs incident report email address. Reports must include: the nature of the incident or accident; any remedial action taken; the Resident's status at the time the report is made to Elder Affairs; a list of other parties or agencies contacted; and other information as specified in the Assisted Living Certification Standards. Assisted Living staff must document all assistance with medication, including whether or not the participant took the medication and, when applicable, the reason why medication was not taken.
○	**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.** Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

As indicated in Appendix G-3-b, there are four State Agencies with specific oversight responsibility for the services and providers that are involved in medication management under this Waiver. Actions by the appropriate State Agency may range from quality improvement plans and corrective action plans and follow-up, to termination/nonrenewal of a license or certification. To the extent MRC or the ASO becomes aware of issues either through incident reports or other means, separate actions by MRC may be undertaken in relation to the provider's continuing inclusion within the MFP provider network. MRC may also take joint action with the responsible State Agency.

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:	% of participants who received information about how to report abuse and/or neglect (Number of participants who received information about how to report abuse and/or neglect/ Number of participants reviewed)

Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify: **SC Supervisor Tool process**			
	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% with 95/5 response distribution
		☐ *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:	No. and rate of substantiated investigations by type. (Number of substantiated investigations by type/ Number of total adults served and rate per 100 adults)

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

If 'Other' is selected, specify: **HCSIS/MRC Investigations Database**

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

	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:	% of intakes screened in for investigation of abuse where the need for protective services were reviewed as recommended. (Number of intakes

	screened in for investigation of abuse where the need for protective services were reviewed/ Total number of intakes where a review for protective services were recommended by the senior investigator)

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

If 'Other' is selected, specify: **HCSIS/MRC Investigations Database**

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *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:	% 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: **Provider performance monitoring**

	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*	
	Administrative Services Organization	☐ *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 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:	% of action/safety plans implemented. (number of action/safety plans implemented for substantiated investigations/ Number of action/safety plans written)		
Data Source *(Select one) (Several options are listed in the on-line application):*			
If 'Other' is selected, specify: **HCSIS/MRC Investigations Database**			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *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	***Frequency of data aggregation and analysis:***

State:	
Effective Date	

(check each that applies	*(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:	% of incident "trigger" reports that have had follow up action taken. (Number of incidents that reach the "trigger" threshold for which action has been taken/ Total number of incidents that reach the "trigger" threshold)

Data Source *(Select one) (Several options are listed in the on-line application):* **Critical events and incident reports**

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*	uses a 90% confidence interval and a range of +/- 10% with a finite population correction for the population enrolled in the waiver.
		☑ *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)

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:	% of restrictive interventions that were reported appropriately. (Number of restrictive interventions reported appropriately/ Number of restrictive interventions)
Data Source *(Select one) (Several options are listed in the on-line application):* **Critical events and incident reports**	
If 'Other' is selected, specify:	

	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:*

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:	% of participants who have identified a primary care provider. (Number of individuals with a documented primary care provider/ Number of individuals reviewed)
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **SC Supervisor Tool process**	

	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% with 95/5 response distribution
		☐ *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 Massachusetts Rehabilitation Commission, the Department of Developmental Services and MassHealth are responsible for ensuring effective oversight of the waiver program. As problems are discovered at the level of care entity, the Administrative Services Organization, or waiver service providers, MassHealth, MRC and DDS will ensure that a corrective action plan is created, approved and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, MassHealth is responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii. **Remediation Data Aggregation**

	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 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.

MassHealth's (the Medicaid Agency) quality management strategy is designed to assure that essential safeguards are met with respect to health, safety and quality of life for waiver participants. While there are multiple approaches in place that comprise a robust system, the overall quality management and improvement system continues to evolve and improve. MassHealth has put in place an overarching approach and plan for quality management and improvement across Massachusetts' home and community based services waivers. This plan ensures that the state is able to stratify information to relate to each specific waiver program it operates. The strategy is based on the following key operational principles:

1. The system is designed to create a continuous loop of quality assessment and initiation of improvement including the identification of issues, notification to concerned parties, remediation, follow-up analysis of patterns and trends, and improvement activities.

2. Quality is measured based upon a set of outcome measures agreed upon by waiver stakeholders, which are based on the fundamental purposes of the waiver, CMS assurances, Massachusetts' regulations, and quality goals.

3. The system also assesses quality by measuring health and safety for participants and places a strong emphasis on other quality of life indicators including participant access, person-centered planning and service delivery, rights and responsibilities, community inclusion, participant satisfaction and participant involvement.

Three Tiers of Quality Management

The Quality Management and Improvement System approaches quality from three perspectives: the individual, the provider and the system. On each tier the focus is on the discovery of issues, remediation of identified issues, and system improvement. MassHealth in collaboration with the Massachusetts Rehabilitation Commission (MRC) and the Department of Developmental Services (DDS) have oversight responsibility for all aspects of the Waiver Quality Management and Improvement System for this waiver and the Moving Forward Plan – Residential Supports Waiver, Acquired Brain Injury Residential Habilitation Waiver and the Acquired Brain Injury Non-Residential Habilitation Waiver. Specific areas of oversight include: Level of Care Determination, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability to ensure that direct service providers, the contracted LOC entity, contracted ASO entity and Case Managers are in compliance with applicable standards, policies and procedures.

Systems level improvement efforts are organizationally structured to occur on multiple levels within DDS and MRC. The DDS Office of Quality Management maintains overall responsibility for designing and overseeing the waiver's QMIS and assuring that appropriate data are collected, disseminated, and reviewed, and that service improvement targets are established for participants in these Waivers. The DDS Assistant Commissioner for Quality Management reports in a direct line to the Commissioner, in order to maintain independence from the Operational Services Division.

The Waiver Unit of MRC is part of the Community Living (CL) Division, which is housed at the agency's central office and operates on a statewide basis. The Waiver Unit can draw from staffing and expertise available from other units within the CL Division, as well as resources from the larger agency, including the Analytics and Quality Assurance Department. The Director of Community Supports & Operations is a member of the agency's senior leadership team and reports directly to the MRC Deputy Commissioner. It is ultimately the Waiver Unit Director, who reports directly to The Director of Community Supports & Operations, who is accountable for assuring that identified service improvement efforts are implemented and reviewed.
DDS works collaboratively with MRC to obtain and aggregate data from all sources including providers, the level of care entity and the ASO and make available system-wide data, analysis of such data, and reports to OOM in order to facilitate the discovery, remediation planning and overall system quality improvement strategies.

Processes for trending, prioritizing and implementing system improvements

Tier I: The Individual Level

MRC, in collaboration with DDS, utilizes the reporting capabilities of HCSIS and Meditech to assess and monitor important outcomes pertaining to individuals, providers and the overall system, and to review patterns and trends and establish service improvement targets.

On an individual level, the Home and Community Services Information System (HCSIS) previously described in Appendix G, collects information regarding incidents, medication occurrences, investigations and deaths. This is a web-based system that has been in use by DDS since 2006 and has been adapted to incorporate incident types specific to individuals in this Waiver. The HCSIS system includes a Service Coordinator Supervisor Tool which collects aggregate information regarding the development, implementation and oversight of the service planning process and development of the POC through the review of a sample of individuals and their plans.

In addition, MRC, in collaboration with DDS, utilizes data and reports available through various sources, including the Meditech database and data from the Level of Care entity that provides both individual and aggregate information regarding eligibility determinations, level of care determinations and re-determinations.

Tier II-The Provider Level

The next level of the Medicaid Agency's quality management and information system relates to ensuring, on an ongoing basis, that providers are qualified and are performing effectively. Providers of Home Accessibility Adaptations and Vehicle Modifications are credentialed, recredentialed, and overseen by MRC. For all other waiver services described in Appendix C providers are credentialed and recredentialed by the ASO. Aggregate data from these processes are collected, reviewed, and analyzed to determine whether there are any patterns or trends that merit the establishment of service improvement initiatives.

Tier III- The System Level

With the current complement of HCBS waivers in Massachusetts, processes have been and continue to be established to support and enhance quality oversight. MassHealth, MRC and DDS are working to ensure that the quality management strategies and infrastructure implemented for the operation of this waiver are consistent with those related to the other HCBS waivers.

MassHealth, MRC and DDS review and evaluate measures related to provider capacity and capability; provider qualifications, performance and compliance with applicable standards and requirements; safeguards/critical incident management; client satisfaction; and system performance and wherever appropriate align applicable performance measures with those in other waivers. Data gathered from all sources and processes previously noted are analyzed and reviewed by a variety of stakeholders and through a variety of committees. The goal of these processes is to assure that both internal and external stakeholders review essential aggregate data on an ongoing basis in order to improve services and supports for all Waiver participants.

As a starting point, DDS, MRC and MassHealth are committed to assuring the ongoing integrity of data obtained through various collection mechanisms. There are several groups that oversee the standards and quality related to the Meditech database and HCSIS. These groups function to continually review and agree upon the business processes as well as the definitions and interpretations that guide the system in order to ensure data integrity and consistency.

A Statewide Systemic Risk Review Committee (SRRC) composed of staff from DDS Operations, Investigations, human rights, survey and certification, risk management and health services meet regularly to review aggregate data generated from HCSIS. With research support of the University of Massachusetts Medical School/Center for Developmental Disabilities Evaluation and Research (CDDER), aggregate reports analyzing specific incident types are generated. The reports are based on queries that SRRC determines helpful in analyzing the data. The reports are reviewed by SRRC and form the basis for identifying patterns and trends that may lead to specific service improvement targets. Examples of service improvement targets directly related to analysis of HCSIS data include, but are not limited to, a major falls prevention initiative, and an initiative to reduce medication occurrences. The SRRC membership and purview is expanded, as needed, to include the review and analysis of data related to participants in this waiver.

Aggregate data on incidents, particularly for frequently occurring issues, are disseminated to MRC supervisory and leadership staff quarterly (for frequently occurring incidents). These reports show data on incidents by both number and rate. Case Managers supervisory staff also receive monthly reports on individuals who have reached a threshold of specifically designated incidents that then trigger a review by the Case Manager. These reports enable staff to identify patterns and trends with respect to particular individuals they support, to "connect the dots" between different incidents and to assure that all necessary follow up steps have been taken. As part of the on-going quality assurance process, MRC administrative and supervisory staff do a quarterly review of a random sample of individuals who have reached the "trigger" threshold. The review looks into whether appropriate follow up actions were taken consistent with the issues identified. This process includes individuals in this waiver.

MRC, DDS and MassHealth also analyze death reports and mortality reviews within waivers and across waivers, related to the number of deaths, the age, gender, and cause of death of individuals served by these waivers. The results of these analyses will enable MRC, DDS and MassHealth to determine whether there are any patterns and trends, particularly with respect to preventable deaths.

As an important component of its commitment to stakeholder and participant input, MRC established an ABI, MFP, TBI Waiver Stakeholder Advisory Committee to obtain valuable input from constituents. This committee currently consists of representatives including ABI, MFP, TBI waiver participants, ABI, MFP and TBI case managers, provider agencies, participant family members and individuals with brain injuries. The committee plays an advisory role and assists in evaluating waiver program performance. Specifically, it reviews data and reports generated from the previously mentioned data systems, e.g. HCSIS, Death Reporting and provider credentialing, to determine whether any service improvement projects should be initiated.

We have consolidated the reporting for this waiver with ABI Non-Residential Habilitation (MA.40702) (see H.1.b.ii).

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:

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.

MassHealth, MRC and DDS have a strong commitment to a quality management system which continuously evaluates the processes in place to monitor waiver activities and participant outcomes. As this Waiver created a new mechanism to provide HCBS to a population that previously was largely not able to access these services through publicly-funded programs, MassHealth, MRC and DDS have the opportunity to put in place best practices experienced in other HCBS waivers. The cornerstone of this quality management system is the collaboration among MassHealth, MRC and DDS.

A goal of the waiver quality management system is to obtain concrete discovery data which, when aggregated and analyzed, allows for identification of any assurance areas which need immediate quality improvement strategies to remedy the findings The DDS Office of Quality Management, has primary responsibility for monitoring the effectiveness of system design changes. Implementation of strategies to meet service improvement targets can occur on a variety of levels depending upon the nature of the target. Senior Staff from DDS and MRC review and evaluate the effectiveness of service improvement targets and system design changes on an ongoing basis. In addition, previously mentioned groups, notably, the Systemic Risk Review Committee and the ABI/MFP/TBI Stakeholder Advisory Committee review progress towards achieving targets and making mid-course corrections, if necessary.

Reviews of the effectiveness of service improvement targets are also conducted by CDDER. As an independent research and policy support to DDS, CDDER has conducted several formative and summative evaluations of specific initiatives. Methods have included focus groups, surveys and evaluation of specific indicators related to the service improvement target.

MassHealth, DDS and MRC are committed to working with stakeholders, including participants, to ensure an effective quality management strategy for the Waiver program which utilizes participant-focused quality indicators. The ABI/MFP/TBI Waiver Stakeholder Advisory Committee meets twice a year and reviews performance, system design changes and assessments. This Committee reviews quality

management data as well as other aspects of the quality management strategy for the Waiver program to identify and support the ways MassHealth, DDS and MRC can assess and ensure for the highest quality services. Other meetings with stakeholders (i.e., providers, advocates and families) are conducted on an ad-hoc basis throughout the year. Stakeholder involvement and communication are welcomed and encouraged through the formal Committee as well as ad-hoc meetings.

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

In collaboration with MassHealth, MRC and DDS are committed to evaluating the processes and systems in place which comprise our quality management strategy.

The Office of Quality Management within DDS in close collaboration with MRC has primary day to day responsibility for assuring that there is an effective and robust quality management system. DDS and MRC work closely with internal and external stakeholders and make recommendations regarding enhancements to the QMIS system on an ongoing basis.

DDS and MRC continue to work with CDDER to evaluate the effectiveness of its QMIS system and to make recommendations for improvements.

As part of the evaluation of the Quality Improvement Strategy, MassHealth, DDS and MRC we analyzed reporting across several waivers and, and as noted above, consolidated the reporting for the ABI Non-Residential Habilitation (MA.40702) and MFP Community Living (MA.1027) Waivers. Our ongoing evaluation supports the determination that because these waivers continue to 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 alignment in participant services, participant safeguards and quality management;
2. The quality management approach is the same across these two waivers including:
a. methodology for discovering information with the same HCSIS system and sample selection,
b. remediation methods,
c. pattern/trend analysis process, and
d. all of the same performance indicators;
3. The provider network is the same; and
4. Provider oversight is the same.

For performance measures based on sampling the sample size unless noted differently will be based on a simple random sample of the combined populations with a confidence level of a 95% confidence level and a +/- 5% margin of error 95/5 response distribution.

All measures, methodologies and data systems are fully aligned.

The ABI Non-Residential Habilitation (MA.40702) and MFP Community Living (MA.1027) Waivers operate on similar waiver cycles with only one month difference between the effective dates for these waivers. The combined evidence report will be based on the schedule for the MFP Community Living Waiver (MA.1027). Because the state has moved the reporting up by one month for MA.40702 (one month earlier), there is no loss of data.

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):*

- No
- Yes *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- HCBS CAHPS Survey;
- NCI Survey;
- NCI AD Survey;
- 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)MassHealth engages an Administrative Service Organization (ASO) to recruit qualified direct service providers who are in good financial standing for all waiver services except those qualified and contracted for by MRC. The waiver services for which providers are qualified/contracted by MRC include Home Accessibility Adaptations, Transitional Assistance Services and Vehicle Modifications. All direct service providers execute MassHealth Provider Agreements. As part of the Single State Audit, the auditor reviews samples of waiver claims and activity, as noted below. Waiver service providers must comply with audit requirements specified in 808 CMR 1.00: Compliance, Reporting and Auditing for Human and Social Services. In addition, the ASO is required to have an annual independent audit.

(b) The integrity of provider billing data for Medicaid payment of waiver services is managed by the Massachusetts Medicaid Management Information System (MMIS). MassHealth confirms the delivery of services, the units of services and the cost of all services through contract and invoice management prior to submitting claims to Medicaid. MassHealth establishes rates for each waiver service. MMIS sets payment ceilings to ensure integrity of payment and also confirms each participant's Medicaid waiver eligibility as a condition of payment.

(c) The Executive Office of Health and Human Services is responsible for conducting the financial audit program.

The 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 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.

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.)*

a.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:	Service claims are coded and paid for in accordance with the specified reimbursement methodology and only for services rendered. % of claims submitted to and paid by MMIS will be monitored and reported to MassHealth and MRC by the ASO using remittance advices. (Approved and paid MMIS claims/Total service claims submitted)
Data Source *(Select one) (Several options are listed in the on-line application):* Financial records (including expenditures)	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☑ *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:	Service claims are coded and paid for in accordance with the specified reimbursement methodology and only for services rendered. % of claims for services with the Financial Management Service (FMS) that are filed appropriately. (Approved claims filed with the FMS/Total number of claims filed with the FMS)
Data Source *(Select one) (Several options are listed in the on-line application):* Financial records (including expenditures)	
If 'Other' is selected, specify:	

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

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:	Services are coded and paid for in accordance with the reimbursement methodology. (number of services with rates derived from and consistent with rate regulations/ Number of services for which claims were submitted)

Data Source *(Select one) (Several options are listed in the on-line application):* Financial records (including expenditures)
If 'Other' is selected, specify:

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

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

The Administrative Service Organization reviews all claims prior to submission. The ASO will submit quarterly reports to MRC. Data are aggregated and analyzed annually to ensure services are billed in accordance with established waiver service payment rates.

b. Methods for Remediation/Fixing Individual Problems

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

MRC is responsible for ensuring that provider billing is in accordance with the services authorized in the service plan. The Administrative Service Organization (ASO) will ensure that services are billed in accordance with the established rate for the service provided. If any discrepancy is noted the ASO will report the error to MassHealth and/or MRC and/or service provider and the services will only be claimed upon reconciliation of the discrepancy. Claims that cannot be reconciled with payment vouchers or other service documentation will be reported to the Massachusetts Rehabilitation Commission and will be denied.

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. The HCBS rate regulation was last updated effective April 1, 2021. 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. The rates for all waiver services in this waiver were established in accordance with the above statutory requirements. Additional information on the rate development for each waiver service follows.

The waiver rates can be found in EOHHS waiver services regulations 101 CMR 359.00 (Rates for Home and Community Based Services Waivers). The regulation can be found on the MassHealth website: www.mass.gov/eohhs/gov/departments/masshealth/ 101 CMR 359.00 establishes rates for waiver services based on and tied to existing rate setting methodologies for similar/same services when possible. As such, the rates for waiver services in this waiver are established in one of four ways, as follows:

1.For waiver services in which there is a comparable Medicaid state plan rate, the waiver service rate was established in regulation at the comparable Medicaid state plan rate after public hearing pursuant to MGL Chapter 118E, Section 13D. All Medicaid state plan rates were established in regulation pursuant to this same statutory requirement. Medicaid State Plan rates are developed using provider cost data submitted to the Center for Health Information and Analysis (CHIA) in accordance with provider cost reporting requirements under 957 CMR 6.00: Cost Reporting Requirements. The provider cost data is used to calculate rates that meet the statutory rate

adequacy requirements noted above. There are no differences in the rate methodology between these state plan and waiver services. No additional CAF was used for the waiver services using the comparable state plan rate. This applies to the following waiver services:

Skilled Nursing (set in accordance with 101 CMR 350.00 Home Health Services; Rates for Skilled Nursing Services)

Occupational, Physical and Speech Therapy (101 CMR 350.00: Rates for Home Health Services for agency services and 101 CMR 339.00 Rates for Restorative Services out-of-office visit rates for Individual Providers)

Home Health Aide and Supportive Home Care Aide (101 CMR 350.00: Rates for Home Health Services)

Specialized Medical Equipment (101 CMR 322.00: Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment)

Transportation (101 CMR 327.00 Ambulance and Wheelchair Van Services)

Non-agency Personal Care (101 CMR 309.00: Services for the Personal Care Attendant Program)

2.For waiver services where there is a comparable EOHHS Purchase of Service (POS) rate, the waiver service rate was established in regulation at the comparable POS rate 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 for particular services by determining the average for each line item across all providers. In determining the rates for the services noted below, , EOHHS used the most recent complete state fiscal year UFR available and determined 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 EOHHS POS rate for the following waiver services:

Community Based Day Supports (101 CMR 415.00: Rates for Community-Based Day Support Services)

Community Behavioral Health Support and Navigation (101 CMR 444.00: Rates for Certain Substance-Related and Addictive Disorders Programs)

Community Family Training (101 CMR 414.00: Rates for Family Stabilization Services; Family Training rate)

Individual Support and Community Habilitation (101 CMR 423.00: Rates for Certain In-Home Basic Living Supports)

Peer Support (101 CMR 414.00: Rates for Family Stabilization Services)

Shared Home Supports (101 CMR 411.00: Rates for Certain Placement, Support and Shared Living Services)

Supported Employment (101 CMR 419.00: Rates for Supported Employment Services)

Assistive Technology - evaluation and training (101 CMR 423.0**0:** Rates for Certain In-Home Basic Living Supports)

3. For waiver services in which there is no comparable state plan or EOHHS POS rate, a rate for the waiver service was developed and established under 101 CMR 359.00 after public hearing pursuant to MGL Chapter 118E, Section 13D, and as described below.

For Adult Companion, Agency Personal Care, Chore Services, Homemaker Services, and Supportive Home Care Aide, rates were developed using applicable agency data from April 2019 for comparable services provided through the Executive Office of Elder Affairs (EOEA) Home Care Program, which provides elders in the Commonwealth with long term services and supports that enable them to live in the community, and is the largest purchaser of these services. Home Care Program services include Adult Companion, Agency Personal Care, Chore Services, Homemaker Services, and Supportive Home Care Aide. For these services, the median of contracted service prices was used as the rate. The methodology and data sources used in this analysis were consistent with the method used previously in past analysis. Calculations were performed using SAS statistical software.

The rate for Laundry services will be established under 101 CMR 359.00 after public hearing pursuant to MGL Chapter 118E, Section 13D, and based on applicable agency data for this service provided through the Executive Office of Elder Affairs (EOEA) Home Care Program. The rate will be based on the median of contracted service prices, consistent with the methodology noted for the services above.

Rates for Home Delivered Meals will be established under 101 CMR 359.00 after public hearing pursuant to MGL Chapter 118E, Section 13D, and based on the rate currently in place through Appendix K authority.

Rates for Day Services, Independent Living Supports and Prevocational Services set in 101 CMR 359.00 were updated from prior rates by applying a prospective CAF of 2.14%, with a base period of 2020 Q2 and a prospective rate period of 2020 Q3 through 2022 Q2. The CAF is based on the Massachusetts Consumer Price Index for Spring 2019 optimistic forecast provided by IHS Markit Economics.

Rates for Orientation and Mobility services set in 101 CMR 359.00 were updated using calendar year (CY) 2019 Medicare Resource-Based Relative Value Scale system, which calculates service rates by multiplying the CY2019 Medicare conversion factor, a standard dollar value, by the Medicare-assigned relative value units for the service.

4. Assistive Technology (devices), Home Accessibility Adaptations, Respite, Transitional Assistance, and Vehicle Modification are paid at Individual Consideration (IC). Where IC rates are designated, the appropriate payment rate is determined in accordance with the following standards and criteria established in 101 CMR 359.00:
(a) the amount of time required to complete the service or item;
(b) the degree of skill required to complete the service or item;
(c) the severity or complexity of the service or item;
(d) the lowest price charged or accepted from any payer for the same or similar service or item, including, but not limited to any shelf price, sale price, advertised price, or other price reasonably obtained by a competitive market for the service or item; and
(e) the established rates, policies, procedures, and practices of any other purchasing governmental unit in purchasing the same or similar services or items. All costs that are not eligible for federal financial participation, such as room and board, are specifically excluded from the rate computation of any waiver services.

The waiver case manager will inform the participant of the availability of information about waiver services payment rates and 101 CMR 359.00.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Administrative Service Organization reviews all claims prior to submission, comparing the services billed with the services authorized in the waiver Plan of Care (POC). If any discrepancy is noted, the ASO will report the error to MRC and/or the service provider and the services will only be claimed upon reconciliation of the discrepancy. Claims that cannot be reconciled will be reported to MRC and denied. Once reconciled, the ASO will submit claims for all services (except Home Accessibility Adaptation, Transitional Assistance Services and Vehicle Modifications) to the MMIS which will process and pay claims as appropriate. Prior to payment, the MMIS system verifies each participant's MassHealth eligibility. Claims payments will be made directly to the waiver service providers. Payment of provider claims for waiver services are made in accordance with Medicaid timeframes and promptness requirements.

Providers of Home Accessibility Adaptations, Transitional Assistance, and Vehicle Modifications are reimbursed by MRC on a monthly basis subsequent to the provision of services and upon receipt of an invoice. MRC reviews and approves invoices in accordance with the participants' plans of care based on information from case managers, via the Electronic Invoice Management System (EIM) or the Massachusetts Management Accounting and Reporting System (MMARS). Home Accessibility Adaptations, Transitional Assistance Service and Vehicle Modifications expenditure reports are then generated and processed, and are submitted to MMIS to determine Federal Financial Participation (FFP) amounts. Claims for Home Accessibility Adaptations, Transitional Assistance Services, and Vehicle Modifications are adjudicated through the state's approved MMIS system. Once the claims have been adjudicated through the CMS approved MMIS system, which validates that the claims are eligible for FFP, the expenditures for waiver services are reported on the CMS 64 report. On a routine basis, at a minimum, quarterly, the claims data is electronically submitted to MMIS for claim editing and processing for eligible participants and expenditures.

When a participant chooses one of the Participant Directed Services listed in Appendix E-1, the Participant Directed Service will be included in the participant's Plan of Care (POC). The POC will include the frequency and duration of the authorized Participant Directed Service. The participant will submit their timesheet weekly to the Financial Management Service (FMS) for each worker who provided Participant Directed Services. The FMS will then submit a claim to MMIS for the Participant Directed Service. MMIS will generate payment to the FMS. The worker may elect, as most workers do, to have the FMS direct deposit payment into the worker's bank account in which case, the participant will notify the FMS to do so.

Providers may bill Medicaid directly. Direct billing instructions are provided upon request.

c. Certifying Public Expenditures *(select one)*:

○	**No. State or local government agencies do not certify expenditures for waiver services.**
☑	**Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.** *Select at least one:*
☑	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	Expenditures for Home Accessibility Adaptations, Transitional Assistance Services and Vehicle Modifications services are funded from annual legislative appropriations to the Executive Office of Health and Human Services. Claims for these services are adjudicated through the state's approved MMIS system. Rates are based on the total costs for and utilization of waiver services. Once the claims have adjudicated through the CMS approved MMIS system, which validates that the claims are eligible for Federal Financial participation, the expenditures for waiver services are reported on the CMS 64 report. MRC is the agency that certifies public expenditures for the waiver services specified above. Expenditures are certified annually utilizing cost report data. The state's contractor, the Public Provider Reimbursement Unit at the University of Massachusetts Medical School (UMMS) Center for Health Care Financing, reviews cost reports and identifies allowable costs and disallowable costs (such as room and board). MRC makes payments to private providers with whom they contract. These providers retain 100% of the payment.
☐	**Certified Public Expenditures (CPE) of Local Government Agencies**. Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Massachusetts Medicaid Management Information System (MMIS) maintains date specific eligibility on Medicaid waiver participants. Only service claims for participants whose MassHealth waiver eligibility is verified are submitted for payment processing. The case manager will validate that the service was included in and authorized by the participant's approved plan of care, and was, in fact, provided.

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:
	For Participant Directed Services, the participant submits timesheets for workers to the Financial Management Service (FMS). The FMS reviews time sheets for participant-directed services, verifies that they are in accordance with the Plan of Care and submits claims to MMIS for payment. The FMS contract includes performance metrics and the submission of monthly reports reconciling expenditures for each participant with their approved service plan. The Medicaid agency conducts an annual monitoring visit to the FMS. The state will implement use of an electronic visit verification (EVV) system for certain services in

	accordance with the 21st Century Cures Act; the FMS will continue to review time sheets, including those submitted through the use of an EVV system.
☐	**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.*

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:

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:
	Expenditures for all waiver services are funded from annual legislative appropriations to the Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency. EOHHS then transfers to MRC 100% of the funds for specific waiver services (Home Accessibility Adaptations, Transitional Assistance, and Vehicle Modification services. MRC is organized under EOHHS and subject to its oversight authority. As indicated in Appendix A-1, it is a separate agency established by and subject to its own enabling legislation. The transfer of funds and requirements for each party are specified in an Interagency Service Agreement (ISA) between EOHHS and MRC. MRC uses the funds to make payments for these services to private providers contracted through MRC. These providers retain 100% of the payment. MRC certifies public expenditures for these services (Home Accessibility Adaptations, Transitional Assistance Services, and Vehicle Modifications services). Expenditures are certified annually utilizing cost report data. The state's contactor, the Public Provider Reimbursement Unit at the University of Massachusetts Medical School (UMMS) Center for Health Care Financing, reviews cost reports and identifies allowable costs and disallowable costs (such as room and board). Claims for these services are adjudicated through the state's approved MMIS system. Rates are based on the total costs for and utilization of waiver services. Once the claims have adjudicated through the CMS-approved MMIS system, which validates that the claims are eligible for Federal Financial participation, the expenditures for waiver services are reported on the CMS 64 report.
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

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, waiver services may be provided in residential settings, other than the personal home of the individual, on a respite basis or when a participant receives Shared Home Supports.

Room and board expenses for clients receiving Shared Home Supports services are excluded from Federal Financial Participation.

The Executive Office of Health and Human Services (EOHHS) has developed rates that are used to pay for Shared Home Supports. EOHHS developed the Shared Home Supports rates by examining an amalgamation of existing rates for comparable service components and an analysis of provider cost data. All room and board costs are excluded from the rate computation.

When the Shared Home Supports Participant lives in the caregiver's home, they are responsible for payment of room and board directly to the caregiver.

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:

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

State:	
Effective Date	

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)*:							
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	67,085.57	28,800.02	95,885.59	185,916.44	21,365.13	207,281.57	111,395.98
2	69,360.16	29,721.62	99,081.78	191,865.77	22,048.81	213,914.58	114,832.80
3	71,612.70	30,672.72	102,285.42	198,005.47	22,754.37	220,759.84	118,474.42
4	74,038.66	31,654.24	105,692.90	204,341.65	23,482.51	227,824.16	122,131.26
5	76,487.87	32,667.18	109,155.05	210,880.58	24,233.95	235,114.53	125,959.48

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: Hospital	Level of Care: Nursing Facility
Year 1	1343	788	555
Year 2	1418	832	586
Year 3	1483	870	613
Year 4 (only appears if applicable based on Item 1-C)	1548	908	640
Year 5 (only appears if applicable based on Item 1-C)	1613	946	667

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) for each year is based on actual length of stay as reported in the WY 20 CMS 372 report.

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:

Factor D costs are based on the following:
- Number of Users: The estimated number of users for the majority of waiver services is based on average utilization from WY 18-21, except as noted below.

Day Services-Partial Day and Home Delivered Meals utilization was based on WY 21 as authorized through Appendix K authority.

Community-Based Day Supports and Orientation and Mobility Services utilization was based on WY 20 because there was not consistent utilization across all four years.

Respite and Community Family Training utilization was based on WY 19 because there was not consistent utilization across all four years.

Independent Living Supports utilization is estimated at 1% because there was no prior utilization.

Laundry Service utilization is estimated at 2% for WY1, 4% for WY2, 6% for WY3, 8% for WY4, and 10% for WY5, based on anticipated ramp-up of this new service.

Assistive Technology – evaluation and training and device utilization was based on the DDS Adult ID Waiver, with 2% utilization in WY1 and an additional 2% for each of the other waiver years.

- Average Units per User: The average units per user for the majority of waiver services is based on average utilization from WY 18-21, except as noted below.

Day Services-Partial Day and Home Delivered Meals units per user were based on WY 21 as authorized through Appendix K authority.

Community-Based Day Supports and Orientation and Mobility Services units per user were based on WY 20 because there was not consistent utilization across all four years.

Respite and Community Family Training units per user were based on WY 19 because there was not consistent utilization across all four years.

Independent Living Supports units per user were based on 1 unit per day, adjusted for average length of stay.

Laundry Service units per user were based on utilization in the Frail Elder Waiver.

Assistive Technology - evaluation and training and device units per user were based on utilization in the DDS Adult ID waivers.

- Average Cost per Unit: The average cost per unit is based on rates established in 101 CMR 359.00 Rates for Home and Community Based Services Waivers. For services with multiple rates the unit rate reflects a blended average of the actual rates for these services in WY 21. For services with no utilization in WY21, rates were based on the average rate for the most recent year with utilization.

Day Services-Partial Day and Home Delivered Meals rates are based on WY 21 as authorized through Appendix K authority.

Laundry Services rate was based on WY 20 average rate in the Frail Elder Waiver trended forward to WY 1.

Assistive Technology - evaluation and training and device rates were based on DDS Adult ID Waiver rates.

- Trend: Average costs per unit described above are trended forward by 3.2% annually, beginning in Waiver Year 1, based on the Medical Consumer Price Index for the first six months of calendar year 2022.

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 a weighted average annualized cost from WY 20. 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 (i.e., the annualized value of Factor D' for each waiver year was multiplied by the average length of stay [ALOS] for that waiver year and divided by 365).

The weighted average cost from WY 20 was trended forward by 3.2% annually, based on the Medical Consumer Price Index (CPI) for the first six months of calendar year 2022 (according to BLS CPI-All Urban Consumers, US City Average, Medical Care, 2022 Calendar Year average of the first six months).

In summary, the WY1 baseline estimate for Factor D' is calculated as follows:

D' = [Average Annualized D' x (WY 1 ALOS ÷ 365)] x 1.032

As Factor D' costs are based on WY 20 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.

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:

The comparable facility population is based on MassHealth members residing in a nursing home or chronic/rehabilitation hospital for 180 or more consecutive days (only 1 day of the stay need have occurred in the current waiver year.) The facility population is separated into two subgroups, Nursing Facility or Chronic/Rehabilitation Hospital.

Factor G is derived from a weighted average (based on the expected proportion of waiver participants at each level of care over the 5 year waiver period as indicated in Appendix J-2-a) of Waiver Year 2020 annualized actual average cost per member per year for a comparable population.

Factor G costs are trended forward from the base year of 2020 by 3.2% annually, based on the Medical Consumer Price Index for the first six months of calendar year 2022 (according to BLS CPI-All Urban Consumers, US City Average, Medical Care, 2022 Calendar Year average of the first six months). 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 (i.e., the annualized value of Factor G for each waiver year was multiplied by the average length of stay [ALOS] for that waiver year and divided by 365).

In summary, the WY1 baseline estimate for Factor G is calculated as follows:

G = 1.032 x [((% of Waiver Population at Nursing Facility LOC x Nursing Facility Annualized G) + (% of Waiver Population at Hospital LOC x Hospital Annualized G)) x WY1 Factor D ALOS ÷ 365]

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:

The comparable facility population is based on MassHealth members residing in a nursing home or chronic/rehabilitation hospital for 180 or more consecutive days (only 1 day of the stay need have occurred in the current waiver year.) The facility population is separated into two subgroups, Nursing Facility or Chronic/Rehabilitation Hospital.

Factor G' is derived from a weighted average (based on the expected proportion of waiver participants at each level of care over the 5 year waiver period as indicated in Appendix J-2-a) of Waiver Year 2020 annualized actual average cost per member per year for non-facility Medicaid State Plan costs for a comparable population.

Factor G' costs are trended forward from the base year of 2020 by 3.2% annually, based on the Medical Consumer Price Index for the first six months of calendar year 2022 (according to BLS CPI-All Urban Consumers, US City Average, Medical Care, 2022 Calendar Year average of the first six months). 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 (i.e., the annualized value of Factor G' for each waiver year was multiplied by the average length of stay [ALOS] for that waiver year and divided by 365).

In summary, the WY1 baseline estimate for Factor G' is calculated as follows:

G' = 1.032 x [((% of Waiver Population at Nursing Facility LOC x Nursing Facility Annualized G') + (% of Waiver Population at Hospital LOC x Hospital Annualized G')) x WY1 Factor D ALOS ÷ 365]

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
Home Health Aide
Homemaker
Personal Care
Prevocational Services
Respite
Supported Employment
Adult Companion
Assistive Technology
Chore Service
Community Based Day Supports (CBDS)
Community Behavioral Health Support and Navigation
Community Family Training
Day Services

Home Accessibility Adaptations
Home Delivered Meals
Independent Living Supports
Individual Support and Community Habilitation
Laundry
Occupational Therapy
Orientation and Mobility Services
Peer Support
Physical Therapy
Shared Home Supports
Skilled Nursing
Specialized Medical Equipment
Speech Therapy
Supportive Home Care Aide
Transitional Assistance Services
Transportation
Vehicle Modification

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**
Home Health Aide	15 min.	444	4,913	$7.48	$16,316,662.56
Homemaker	15 min.	536	1,649	$6.48	$5,727,438.72
Personal Care	15 min.	480	3,437	$6.36	$10,492,473.60
Prevocational Services - 15 min.	15 min.	4	558	$11.77	$26,270.64
Respite	15 min.	4	52	$119.95	$24,949.60
Supported Employment	15 min.	15	939	$17.86	$251,558.10
Adult Companion	15 min.	771	7,297	$5.19	$29,198,872.53
Assistive Technology Total:					$82,584.90
Assistive Technology - devices	Item	27	5	$290.62	$39,233.70
Assistive Technology – evaluation and training	15 min.	27	80	$20.07	$43,351.20
Chore Service	15 min.	44	278	$8.83	$108,008.56
Community Based Day Supports (CBDS)	15 min.	28	375	$5.35	$56,175.00
Community Behavioral Health Support and Navigation	15 min.	3	39	$11.26	$1,317.42
Community Family Training	15 min.	2	157	$6.78	$2,128.92
Day Services Total:					$482,143.04
Day Services	Per Diem	34	76	$141.11	$364,628.24
Day Services	Partial Per Diem	15	108	$72.54	$117,514.80
Home Accessibility Adaptations	Item	145	4	$5,082.81	$2,948,029.80
Home Delivered Meals	Unit	319	58	$30.82	$570,231.64
Independent Living Supports	Per Diem	13	291	$86.56	$327,456.48
Individual Support and Community Habilitation	15 min.	954	1,079	$11.64	$11,981,820.24
Laundry	Per Order	27	36	$30.17	$29,325.24
Occupational Therapy	Visit	224	36	$77.75	$626,976.00
Orientation and Mobility Services	15 min.	2	34	$40.22	$2,734.96

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**
Peer Support	15 min.	3	912	$7.83	$21,422.88
Physical Therapy	Visit	293	36	$73.89	$779,391.72
Shared Home Supports	Per Diem	15	296	$79.35	$352,314.00
Skilled Nursing	Visit	343	27	$94.32	$873,497.52
Specialized Medical Equipment	Item	945	11	$192.69	$2,003,012.55
Speech Therapy	Visit	36	38	$79.91	$109,316.88
Supportive Home Care Aide	15 min.	29	3,608	$7.90	$826,592.80
Transitional Assistance Services	Per Episode	327	4	$2,831.46	$3,703,549.68
Transportation	One-way trip	360	60	$102.43	$2,212,488.00
Vehicle Modification	Item	6	3	$7,224.00	$130,032.00
GRAND TOTAL:					$90,268,775.98
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1,343
FACTOR D (Divide grand total by number of participants)					$67,214.28
AVERAGE LENGTH OF STAY ON THE WAIVER					291.20

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**
Home Health Aide	15 min.	469	4,913	$7.72	$17,788,400.84
Homemaker	15 min.	566	1,649	$6.69	$6,244,004.46
Personal Care	15 min.	507	3,437	$6.56	$11,431,187.04
Prevocational Services - 15 min.	15 min.	4	558	$12.15	$27,118.80
Respite	15 min.	4	52	$123.79	$25,748.32
Supported Employment	15 min.	16	939	$18.43	$276,892.32
Adult Companion	15 min.	814	7,297	$5.36	$31,837,102.88
Assistive Technology Total:					$179,914.80
Assistive Technology - devices	Item	57	5	$299.92	$85,477.20
Assistive Technology – evaluation and training	15 min.	57	80	$20.71	$94,437.60
Chore Service	15 min.	47	278	$9.11	$119,031.26
Community Based Day Supports (CBDS)	15 min.	29	375	$5.52	$60,030.00
Community Behavioral Health Support and Navigation	15 min.	4	39	$11.62	$1,812.72
Community Family Training	15 min.	2	157	$7.00	$2,198.00
Day Services Total:					$527,801.76
Day Services	Per Diem	36	76	$145.63	$398,443.68
Day Services	Partial Per Diem	16	108	$74.86	$129,358.08
Home Accessibility Adaptations	Item	153	4	$5,245.46	$3,210,221.52
Home Delivered Meals	Unit	337	58	$31.81	$621,758.26
Independent Living Supports	Per Diem	14	291	$89.33	$363,930.42
Individual Support and Community Habilitation	15 min.	1,008	1,079	$12.01	$13,062,460.32
Laundry	Per Order	57	36	$31.14	$63,899.28
Occupational Therapy	Visit	237	36	$80.24	$684,607.68
Orientation and Mobility Services	15 min.	2	34	$41.51	$2,822.68
Peer Support	15 min.	3	912	$8.08	$22,106.88
Physical Therapy	Visit	309	36	$76.25	$848,205.00
Shared Home Supports	Per Diem	16	296	$81.89	$387,831.04
Skilled Nursing	Visit	362	27	$97.34	$951,401.16
Specialized Medical Equipment	Item	998	11	$198.86	$2,183,085.08
Speech Therapy	Visit	38	38	$82.47	$119,086.68

State:	
Effective Date	

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**
Supportive Home Care Aide	15 min.	31	3,608	$8.15	$911,561.20
Transitional Assistance Services	Per Episode	346	4	$2,922.07	$4,044,144.88
Transportation	One-way trip	380	60	$105.71	$2,410,188.00
Vehicle Modification	Item	6	3	$7,455.17	$134,193.06
GRAND TOTAL:					$98,542,746.34
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1,418
FACTOR D (Divide grand total by number of participants)					$69,494.18
AVERAGE LENGTH OF STAY ON THE WAIVER					291.20

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
Home Health Aide	15 min.	490	4,913	$7.97	$19,186,738.90
Homemaker	15 min.	592	1,649	$6.90	$6,735,835.20
Personal Care	15 min.	530	3,437	$6.77	$12,332,299.70
Prevocational Services - 15 min.	15 min.	4	558	$12.54	$27,989.28
Respite	15 min.	4	52	$127.75	$26,572.00
Supported Employment	15 min.	17	939	$19.02	$303,616.26
Adult Companion	15 min.	851	7,297	$5.53	$34,339,900.91
Assistive Technology Total:					$289,890.80
Assistive Technology - devices	Item	89	5	$309.52	$137,736.40
Assistive Technology – evaluation and training	15 min.	89	80	$21.37	$152,154.40
Chore Service	15 min.	49	278	$9.40	$128,046.80
Community Based Day Supports (CBDS)	15 min.	31	375	$5.70	$66,262.50
Community Behavioral Health Support and Navigation	15 min.	4	39	$11.99	$1,870.44
Community Family Training	15 min.	2	157	$7.22	$2,267.08
Day Services Total:					$575,886.88
Day Services	Per Diem	38	76	$150.29	$434,037.52
Day Services	Partial Per Diem	17	108	$77.26	$141,849.36
Home Accessibility Adaptations	Item	160	4	$5,413.31	$3,464,518.40
Home Delivered Meals	Unit	353	58	$32.83	$672,161.42
Independent Living Supports	Per Diem	15	291	$92.19	$402,409.35
Individual Support and Community Habilitation	15 min.	1,054	1,079	$12.39	$14,090,725.74
Laundry	Per Order	89	36	$32.14	$102,976.56
Occupational Therapy	Visit	248	36	$82.81	$739,327.68
Orientation and Mobility Services	15 min.	2	34	$42.84	$2,913.12
Peer Support	15 min.	3	912	$8.34	$22,818.24
Physical Therapy	Visit	323	36	$78.69	$915,007.32
Shared Home Supports	Per Diem	16	296	$84.51	$400,239.36
Skilled Nursing	Visit	378	27	$100.45	$1,025,192.70
Specialized Medical Equipment	Item	1,044	11	$205.22	$2,356,746.48
Speech Therapy	Visit	39	38	$85.11	$126,133.02

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**
Supportive Home Care Aide	15 min.	32	3,608	$8.41	$970,984.96
Transitional Assistance Services	Per Episode	361	4	$3,015.58	$4,354,497.52
Transportation	One-way trip	398	60	$109.09	$2,605,069.20
Vehicle Modification	Item	6	3	$7,693.74	$138,487.32
GRAND TOTAL:					$106,407,385.14
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1483
FACTOR D (Divide grand total by number of participants)					$71,751.44
AVERAGE LENGTH OF STAY ON THE WAIVER					291.20

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Health Aide	15 min.	512	4,913	$8.23	$20,702,202.88
Homemaker	15 min.	618	1,649	$7.12	$7,255,863.84
Personal Care	15 min.	554	3,437	$6.99	$13,309,645.02
Prevocational Services - 15 min.	15 min.	4	558	$12.94	$28,882.08
Respite	15 min.	5	52	$131.84	$34,278.40
Supported Employment	15 min.	18	939	$19.63	$331,786.26
Adult Companion	15 min.	888	7,297	$5.71	$36,999,292.56
Assistive Technology Total:					$416,776.40
Assistive Technology - devices	Item	124	5	$319.42	$198,040.40
Assistive Technology – evaluation and training	15 min.	124	80	$22.05	$218,736.00
Chore Service	15 min.	51	278	$9.70	$137,526.60
Community Based Day Supports (CBDS)	15 min.	32	375	$5.88	$70,560.00
Community Behavioral Health Support and Navigation	15 min.	4	39	$12.37	$1,929.72
Community Family Training	15 min.	2	157	$7.45	$2,339.30
Day Services Total:					$614,711.52
Day Services	Per Diem	39	76	$155.10	$459,716.40
Day Services	Partial Per Diem	18	108	$79.73	$154,995.12
Home Accessibility Adaptations	Item	167	4	$5,586.54	$3,731,808.72
Home Delivered Meals	Unit	368	58	$33.88	$723,134.72
Independent Living Supports	Per Diem	15	291	$95.14	$415,286.10
Individual Support and Community Habilitation	15 min.	1,100	1,079	$12.79	$15,180,451.00
Laundry	Per Order	124	36	$33.17	$148,070.88
Occupational Therapy	Visit	258	36	$85.46	$793,752.48
Orientation and Mobility Services	15 min.	2	34	$44.21	$3,006.28
Peer Support	15 min.	3	912	$8.61	$23,556.96
Physical Therapy	Visit	338	36	$81.21	$988,163.28
Shared Home Supports	Per Diem	17	296	$87.21	$438,840.72
Skilled Nursing	Visit	395	27	$103.66	$1,105,533.90
Specialized Medical Equipment	Item	1,089	11	$211.79	$2,537,032.41
Speech Therapy	Visit	41	38	$87.83	$136,839.14

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Supportive Home Care Aide	15 min.	34	3,608	$8.68	$1,064,792.96
Transitional Assistance Services	Per Episode	377	4	$3,112.08	$4,693,016.64
Transportation	One-way trip	415	60	$112.58	$2,803,242.00
Vehicle Modification	Item	6	3	$7,939.94	$142,918.92
GRAND TOTAL:					$114,835,241.69
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1,548
FACTOR D (Divide grand total by number of participants)					$74,182.97
AVERAGE LENGTH OF STAY ON THE WAIVER					291.20

Waiver Year: Year 5 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Health Aide	15 min.	533	4,913	$8.49	$22,232,160.21
Homemaker	15 min.	644	1,649	$7.35	$7,805,376.60
Personal Care	15 min.	577	3,437	$7.21	$14,298,504.29
Prevocational Services - 15 min.	15 min.	5	558	$13.35	$37,246.50
Respite	15 min.	5	52	$136.06	$35,375.60
Supported Employment	15 min.	18	939	$20.26	$342,434.52
Adult Companion	15 min.	926	7,297	$5.89	$39,798,859.58
Assistive Technology Total:					$558,509.00
Assistive Technology - devices	Item	161	5	$329.64	$265,360.20
Assistive Technology – evaluation and training	15 min.	161	80	$22.76	$293,148.80
Chore Service	15 min.	53	278	$10.01	$147,487.34
Community Based Day Supports (CBDS)	15 min.	33	375	$6.07	$75,116.25
Community Behavioral Health Support and Navigation	15 min.	4	39	$12.77	$1,992.12
Community Family Training	15 min.	2	157	$7.69	$2,414.66
Day Services Total:					$658,699.28
Day Services	Per Diem	41	76	$160.06	$498,746.96
Day Services	Partial Per Diem	18	108	$82.28	$159,952.32
Home Accessibility Adaptations	Item	174	4	$5,765.31	$4,012,655.76
Home Delivered Meals	Unit	383	58	$34.96	$776,601.44
Independent Living Supports	Per Diem	16	291	$98.18	$457,126.08
Individual Support and Community Habilitation	15 min.	1,146	1,079	$13.20	$16,322,248.80
Laundry	Per Order	161	36	$34.23	$198,397.08
Occupational Therapy	Visit	269	36	$88.19	$854,031.96
Orientation and Mobility Services	15 min.	2	34	$45.62	$3,102.16
Peer Support	15 min.	3	912	$8.89	$24,323.04
Physical Therapy	Visit	352	36	$83.81	$1,062,040.32
Shared Home Supports	Per Diem	18	296	$90.00	$479,520.00
Skilled Nursing	Visit	411	27	$106.98	$1,187,157.06
Specialized Medical Equipment	Item	1,135	11	$218.57	$2,728,846.45
Speech Therapy	Visit	43	38	$90.64	$148,105.76

Waiver Year: Year 5 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Supportive Home Care Aide	15 min.	35	3,608	$8.96	$1,131,468.80
Transitional Assistance Services	Per Episode	393	4	$3,211.67	$5,048,745.24
Transportation	One-way trip	433	60	$116.18	$3,018,356.40
Vehicle Modification	Item	7	3	$8,194.02	$172,074.42
GRAND TOTAL:					$123,618,976.72
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					1,613
FACTOR D (Divide grand total by number of participants)					$76,639.17
AVERAGE LENGTH OF STAY ON THE WAIVER					291.20