

Responses to Comments Received on the Revised Massachusetts Statewide HCBS Transition Plan

July/August 2016

The CMS final rule related to Home- and Community-Based Services (HCBS) for Medicaid-funded long-term services and supports provided in residential and non-residential home and community-based settings (the “Community Rule”) took effect March 17, 2014. States were required to submit transition plans to CMS within one year of the effective date indicating how they would comply with the new requirements ensuring participants have access to and are integrated into the broader community. In December 2014, CMS issued guidance on how the Community Rule applies to non-residential services such as employment and day services.

Massachusetts first submitted its Statewide Transition Plan (STP) regarding residential HCBS services to CMS in a letter dated March 2, 2015, followed by an addendum that addressed non-residential services in a letter dated September 3, 2015. Prior to these submissions, the state gathered public comments on the STP and the addendum during two public comment periods, including three public forums. In total, 323 individuals or agencies submitted comments in writing, through e-mail, mail, and written testimony. Summaries of the comments received and the state’s response to these comments for all previously submitted materials are posted below.

In November 2015, the state received feedback from CMS addressing both the first STP submission and the addendum, and in response informally submitted a revised draft of the STP to CMS in February 2016. CMS provided additional, informal feedback in May 2016. On July 8, 2016 the state posted for public comment a further revised version of the STP that included updates responsive to all feedback and guidance received from CMS. The public comment period was open from July 8, 2016 through August 10, 2016, and included a public forum held in Worcester, Massachusetts on August 3, 2016. Regarding the revised STP, 37 individuals or agencies submitted comments in writing through email or through oral testimony at the public forum. The input received and the state’s response to input is summarized below. Please note that the comments received are grouped below according to the section of the STP they most directly address.

Public Input

Comment 01

Two commenters noted that the STP accurately represents the collaborative work DDS has done with stakeholders, including family members, in reviewing and improving standards and practices in non-residential day and employment support settings.

Response

The state appreciates the feedback and commends DDS and the stakeholder community for their ongoing collaboration in these areas. DDS will continue to work with stakeholders as the state implements the components of the STP.

Comment 02

A commenter requested that DDS include families of individuals who cannot self-advocate in stakeholder conversations as the agency moves forward with work to improve services to individuals, including individuals on the autism spectrum.

Response

The state welcomes self-advocates and families of individuals who cannot self-advocate to participate in the ongoing dialogue about and work to continue to review and improve standards and practices in both residential and non-residential settings. As noted in the STP, DDS provides periodic updates to stakeholders, including autism advocacy organizations and family advocates, via email. Recent stakeholder discussions have focused largely on non-residential day and employment support settings. Prior to submitting evidentiary packages for settings ultimately identified as requiring heightened scrutiny review, the state will involve stakeholders in the review of evidence related to each setting's compliance with all of the requirements of the Rule.

Systemic assessment

Comment 03

One commenter suggested that the proposed DDS regulation regarding locks on bedroom doors, referenced in the STP, be adjusted to reflect that where a modification to the Rule's requirement is in place, such a decision would be evaluated regularly to determine whether a change to a locked bedroom unit is suitable in the future. The commenter also suggested that the state define the term "clinical contraindication" in the context of when a modification to the Rule's requirements may be permissible. The commenter further noted that the STP does not specifically address the use of alarmed bedroom doors in community-based residential settings, and expressed concern that the use of alarmed doors creates an institutional-like environment with the effect of confining residents to their bedrooms. The commenter recommended that the STP

should provide that door alarms may only be used when clinically indicated, and that that standard be specifically defined in the STP.

Response

DDS's requirements for the person-centered planning process, addressed in 115 CMR 6.20 *et seq.* confirm that such a decision would be part of the person centered planning process. Individual service plans must be evaluated and updated at least annually and would include evaluation of any type of restriction. The state agrees that determinations of need for modification of the rights and protections required under the Rule—whether regarding lockable bedroom doors or any other aspect of individual rights, autonomy, choice, and independence—must not be made casually. As specified in the STP, any such modifications must be based on clinically-assessed need, and must be discussed and documented in the person-centered planning process. While 'clinical contraindication' (or related terms, such as 'where clinically contraindicated') is not defined in the STP, it is spelled out more specifically in guidance issued by DDS and will also be incorporated into ISP guidance documents. No change is needed to the STP.

Comment 04

Several commenters, including family members, advocates, and providers, expressed concern that rigid implementation of the Rule's requirements under §441.301(c)(4)(vi)(F) could jeopardize the health and safety of waiver participants and undermine their ability to succeed in community living. Specifically, these commenters cited health and safety risks of unrestricted access to food and locks on bedroom doors. Many comments noted that absent a clinical indication that a restriction could safely be removed or relaxed, testing an individual's continued need for a given restriction by removing such restriction would unduly risk the individual's safety. One commenter, noting the safety risk to individuals with Prader Willi Syndrome (PWS) of unrestricted access to food for even short periods of time, requested that any reference in the STP to "access to food at any time" include a qualifier that would exempt individuals diagnosed with PWS from this requirement.

Response

The state agrees with commenters that on an individual basis, certain restrictions based on clinically-assessed needs may be appropriate and needed to support successful, safe, and healthy community living for waiver participants. While HCBS services must be delivered in accordance with the Rule's requirements, individuals' health and welfare remain a primary focus in the delivery of HCBS waiver services, consistent with the standards for quality within each HCBS waiver. Where there is a documented, clinically-assessed need for certain restrictions, services should not be delivered, nor should provider-owned or controlled settings implement modifications under the Rule, in a manner that fails

to protect a participant's health or safety. The STP does not propose removing a restriction to "test" whether the restriction is no longer necessary. It is appropriate, however, that the individual's team re-visit the restriction periodically to make sure that it remains clinically appropriate and does not become a "standing order."

Comment 05

A commenter noted that the DDS regulation at 115 CMR 7.03, cited to in the STP's regulatory crosswalk in Table 1, does not appear to align with the headings and subsection numbering listed in the crosswalk (Individual Outcomes).

Response

Indeed, as noted in Table 3 of the STP and described in the Systemic Assessment narrative, DDS was in the process of revising its regulations at 115 CMR Chapter 7.00, including a public notice and comment period, simultaneous to EOHHS's work to revise and receive public comment on the STP. The updated citation for the regulatory provisions formerly at 115 CMR 7.03 is now 115 CMR 7.04. The subsection headings and regulatory language were modified to reflect evolving standards and more clearly align with the Rule's requirements.

Table 1 of the STP has been updated accordingly.

Comment 06

One commenter expressed concern that MRC HCBS waiver regulations and policies are or were inadequate to ensure compliance with the Rule, describing exceptions within the MRC policies that would allow restrictions related to individual rights. The commenter felt that the STP should reflect a plan to update the MRC policies to address the components of the Community rule, and also inquired whether policies currently being developed by DDS for the ABI and MFP residential services waivers will apply across all MRC-operated HCBS waivers, including the Traumatic Brain Injury (TBI) waiver.

Response

It is not clear from the comment which version(s) of the MRC policy documents were being referenced. As the commenter noted, MRC recently revised its Provider Policy Manual to include all the requirements of the Community Rule. Details are provided in the regulatory crosswalk found in Table 1 of the STP. Where provision in MRC policies is made for modifications to the Rule's requirements, the policies clearly require that any modification must be based on clinically-assessed need and discussed and documented as part of the person-centered planning process. No change is needed to the STP regarding this comment.

Comment 07

One commenter identified a perceived gap in the STP concerning the Rule's requirement that HCBS participants be offered choice of non-disability-specific residential options.

Response

The state agrees with the commenter that HCBS waiver participants must have meaningful choices regarding residential options. The person-centered planning process is the best forum for identification and discussion of such individualized options, including non-disability specific settings. Requirements for the person-centered planning process as they relate to specific provisions of the Community Rule are identified in Table 3 (Regulatory Crosswalk) of the STP. As part of the person-centered planning process, DDS requires that service coordinators discuss the array of residential options at least annually at the time of the ISP as well as on an on-going basis. This includes a discussion of the many options available to an individual including home ownership, shared living and self-direction. Details about the service planning process are not included as part of the STP; no change is required.

Comment 08

One commenter stated that changes to the DDS incident reporting system reflected a weakening of the protections afforded to individuals and guardians, and that the STP should contain an explanation of proposed revisions to DDS's incident reporting system for CMS review.

Response

Changes to the DDS incident reporting regulations were recently the subject of public hearings. These regulatory changes actually represented a strengthening of the existing incident reporting system. For instance, the changes include a shift from a paper to an electronic process, a more detailed description of what categories of incidents must be reported, and a multi-step review and approval process by DDS staff. In addition, the regulations require providers to determine what incidents guardians and family members would like to be notified about, thus maintaining, not in any way weakening the right of guardians to be informed of an incident pertaining to their family member. The state does not agree with the necessity to incorporate these changes into the description in the STP.

Comment 09

One commenter expressed concern that the STP does not reflect potential future changes to DDS's human rights system—in particular regarding the required composition of representatives on providers' Human Rights Committees—and recommended that the STP be updated to address such revisions if they are adopted.

Response

The STP is a reflection of the current state of the DDS human rights system. Any proposed changes to the DDS regulations governing human rights committees would be subject to the provisions of M.G.L. c.30A, including notice and opportunity for public comment. No change in the STP is required.

Comment 10

A commenter recommended that DDS post a description of the selection process for and a list of names of council members on the Statewide Quality Council, which is discussed in the systemic assessment section of the STP.

Response

The state agrees with this suggestion, and in the near future will make public information regarding the Statewide Quality Council.

Comment 11

One commenter, while commending the state's participation in the National Core Indicators Survey on adult consumer experiences, expressed concern that NCI Survey data may indicate that many Massachusetts service recipients are experiencing significant isolation, based on survey results of reported loneliness.

Response

The state notes that loneliness and isolation are not synonymous, and cautions readers against drawing a direct connection between the two. DDS has participated in the National Core Indicator Survey for many years. Because responses to the survey are anonymous, expressions of loneliness on the part of respondents cannot be dealt with on an individual basis. Nonetheless, DDS takes the cumulative responses from NCI surveys very seriously, and has initiated several approaches to supporting individuals to engage in activities that assist them to make connections. Increasing friendships and relationships, however, is approached through the ISP process as well as provider involvement in building connections with individuals they are supporting. For example, the "Widen the Circle" initiative consists of a group of self-advocates, families and organizations working to help individuals with disabilities establish more friendships with people of all abilities. This initiative is planning workshops, toolkit presentations and outreach. "Creating Our Common Wealth" is a leadership training initiated in 2015 to develop the future leaders in Massachusetts focused on regional and group activities designed to support individuals with disabilities to be actively engaged with community life. Following the initial meeting of this group, DDS initiated discussions to bring a small group of self-advocates, families, providers and DDS staff together to work on this important complement to provide additional guidance and policy regarding social inclusion. "Widen the Circle" and "Creating Our Common Wealth" are also working together. In addition, the

Statewide Quality Council has explored this important area and continues to discuss and offer recommendations to assist individuals to make new friendships and maintain existing ones. No change in the STP is required.

Comment 12

One commenter expressed support for language in DDS's recent policy stating that DDS will not license, fund, or support new residential development with characteristics that isolate individuals receiving HCBS from the broader community.

Response

DDS appreciates the commenter's strong support, and will continue to support the development of new residential supports that encourage and foster the ability of individuals to be fully integrated into the life of others in the community.

Comment 13

Two commenters expressed concern about the STP's incorporation of DDS's policy 2014-1, in particular because of the policy's directive that DDS "will not license, fund, or support new residential development with characteristics that isolate individuals receiving HCBS services from the broader community." One of the two commenters expressed disappointment that the revised STP retains the focus from earlier drafts on achieving compliance in part by shifting away from center-based service settings and larger group homes, noting that community integration is not necessarily achieved by virtue of a setting being small. The second of the two commenters requested that the DDS Policy be revised to reflect the measured approach of the Rule regarding intentional community settings such as farmsteads, campuses, and gated communities. This comment emphasized that whether such developments have or do not have the qualities of an institution and the qualities of home and community-based settings should be determined on a case-by-case basis following a heightened scrutiny process. It was noted in the comment that most people without disabilities are free to choose to participate in a variety of communities that share something in common with them, such as church or school communities, regardless of where they live, and to freely associate with different groups of people. The commenter felt that the Policy's prevention of licensure or funding for intentional community-type settings abridges this choice for people who are disabled and receive HCB services.

Response

The State continues to emphasize the achievement of outcomes with respect to integration, access, choice and control for all settings. The policy referenced by the commenter supports the premise that integration is more likely to be successful if settings do not set individuals apart by virtue of their physical configuration and size. Existing residential settings that have been identified as requiring substantive changes to comply have developed transition plans and will

be submitted to CMS as appropriate in light of CMS's March 2019 FAQs Guidance on Heightened Scrutiny, to determine whether they meet the requirements of the Community Rule. The DDS policy, however, addresses the State's option to affirmatively support development that will enhance the ability of individuals living in HCBS Waiver settings to meet the requirements of the Rule. **The STP was changed to reflect CMS's March 2019 FAQs Guidance on Heightened Scrutiny.**

Comment 14

One commenter emphasized that the goals of the Rule and STP must be implemented with fidelity to person-centered, individualized planning and service delivery. This comment noted that current practice reflects inconsistent adherence to true person-centered planning, resulting in some participants being disempowered in choosing where they live and what services they receive. The commenter recommended providing caseload relief for service coordinators so they can spend the time it takes to engage participants in supported decision making, and including peer delivery of participant surveys in the on-going monitoring process to increase accuracy of quality data regarding the person-centered planning process.

Response

The State agrees with the commenter regarding the importance of the person centered planning process. The State fully supports the central role individuals play in developing their goals and in choosing where they live, work and recreate. Evidence of this support can be seen in all the ISP documents including "I" is for Individual, a document designed to help people participant in the development of their plans. The state respectfully disagrees with the comment about caseloads and believes that current caseloads do not preclude service coordinators from supporting individuals to be at the nexus of all decision making. No change in the STP is required.

Comment 15

One commenter inquired whether individuals would be forced to accept locks on bedroom doors, and whether guardians would have a voice in the decision about locks.

Response

As described in the STP, DDS and MRC are in the process of implementing the Rule's requirement for locks on bedroom doors as a fundamental aspect of the right to privacy. While individuals may choose to not *use* their lock, the presumption is that individuals must have lockable bedroom doors. However, as noted in the STP, any specific situation in which the fundamental right to privacy is contraindicated and having a lockable bedroom door is contraindicated, the modification will be discussed with the participant and guardian (where one is in

place) through the person-centered planning process, and their agreement obtained and documented. No change in the STP is required.

Comment 16

A commenter wrote in support of the STP's inclusion of a requirement for written tenancy agreements in residential settings in order to prevent providers of group homes from evicting residents with minimal notice. Others expressed concern that the state's plan for implementation of the requirement for written tenancy agreements falls short of ensuring the same protections that are available for individuals not receiving HCBS services. In this vein, one commenter requested that DDS policy be revised to prohibit pre-hearing transfers; both requested that the STP be updated to incorporate DDS's guidelines for providers; and one suggested revisions to guidelines pertaining to the inclusion of reference to federal and state laws as well as additional protection against terminations.

Response

DDS issued Guidance to Providers regarding compliance with the Rule; an assumption of the Guidance was that there was not a "one-size-fits-all" lease or residency agreement for every setting, and that providers needed to determine, in consultation with counsel, the type of agreement applicable to the setting, and that individuals or guardians would need to agree to the terms. For this reason, no template was created. However, the Guidance re-enforced for providers that in settings where landlord tenant law applies, a legally enforceable agreement is required that provides the same responsibilities and protections from eviction that tenants have under the state's landlord tenant law. The guidance also re-enforced that in settings where landlord tenant law does not apply, a lease, residency agreement or other form of written agreement is required for each participant and that any such document must provide protections that address eviction processes and appeals comparable to state landlord tenant law. **The STP has been updated** to include a link to the Guidance in Table 1. Regulatory Crosswalk.

Comment 17

One commenter questioned the adequacy of MRC's licensing of residential settings in the ABI-RH waiver and therefore the state's determination of compliance status for residential settings across several waivers.

Response

As stated in the STP, DDS (not MRC) is responsible for licensing of all residential settings in the ABI-RH waiver. All residential sites were reviewed and findings individually determined. The state is confident that across all waivers, the

processes and findings reported in the Site-Specific Assessment section fully align with the Community Rule and CMS guidance.

Comment 18

One commenter suggested that the state’s use of a “separate entity” to credential non-residential programs in MRC waivers is not reasonable because the credentialing entity has “no specific relation to the Rule.”

Response

The state respectfully disagrees with this comment. As the state’s contracted agent for provider network administration, the University of Massachusetts Medical School (UMMS) is specifically responsible for credentialing providers according to standards which are established by the state and which are consistent with the Community Rule. No change in the STP is required.

Site-specific Assessment and Heightened Scrutiny

Comment 19

Several commenters expressed concern that the Rule, and therefore the STP, would force the closure of residential settings that fall under categories identified in §441.301(c)(5)(v) without regard to the level of actual community integration such sites afford their residents. The commenters emphasized the positive—and in their view critical—aspects of residential settings, including campus-like settings. Examples provided included on-site, real-time, specialized staff support including DDS-Licensed Practical Nurses and trained behaviorists for individuals with intellectual disabilities, as well as peer-based socialization while maintaining integration in the broader community. These commenters requested that such settings be evaluated in-person prior to the state determining their compliance status.

Response

As described in the STP, the state has identified residential settings that require substantive changes and further review by the state to determine if they are able to meet the Rule. The state is currently working with these providers on a site-by-site basis and will not make a final determination as to their compliance status until their compliance transition plans have been fully implemented or the providers and the state mutually decide that a site cannot come into compliance. Once the state has determined whether each site complies with the Rule, the state will prepare and submit evidentiary packages to CMS if review under the heightened scrutiny process is warranted according to the March 2019 FAQs Guidance on Heightened Scrutiny. An on-site review by DDS staff will be part of the process. The state’s review process will utilize the revised licensure and

certification tool, which places a heavy emphasis on the outcomes pertaining to access, integration, choice, control and rights. **The STP was changed to reflect CMS's March 2019 FAQs Guidance on Heightened Scrutiny.**

Comment 20

One commenter expressed lack of confidence in the determination that no settings require heightened scrutiny. Another commenter, concerned that the STP does not identify settings that will be submitted for heightened scrutiny, and, noting the absence from the STP of evidentiary packages for heightened scrutiny review, requested that the STP be updated to identify the residential settings found to require significant modifications to come into compliance with the Rule. It was suggested that these settings should all be subject to heightened scrutiny review, that the STP should present the results of the provider self-assessment tool and other documentation regarding DDS' determination that these settings require significant modifications to comply with the Rule, and that DDS should solicit comment from stakeholders on those results. The commenter also expressed concern that the timeline for submitting settings to CMS for heightened scrutiny is too short to allow for CMS's review prior to the March 2019 compliance deadline.

Response

The STP does not identify the providers or list addresses of the settings that are currently implementing compliance transition plans in order to protect the privacy of the residents of these settings. Where the state is still in the process of working with the providers as described in detail in the site-specific assessment section and summarized in Table 3 of the STP, the state is not at this time putting forward these providers to CMS for heightened scrutiny review. Rather, once each setting's transition plan is fully implemented the state will make a final determination of the setting's compliance with the Rule and, will submit an evidentiary package to CMS for heightened scrutiny as warranted, consistent with CMS's March 2019 FAQs Guidance on Heightened Scrutiny—unless the state ultimately determines the setting cannot achieve full compliance or the setting provider chooses to cease serving HCB waiver participants. The evidentiary package will provide the rationale and supporting evidence behind the state's determination that the setting, although having certain institutional characteristics, should be an acceptable setting under the Rule. Prior to submitting any setting to CMS for heightened scrutiny, the state will, as required, involve stakeholders in the review of evidence related to the setting's compliance with all of the requirements of the Rule. In doing so, the state will ensure that the privacy of residents, including but not limited to personal information regarding home addresses, health status, disability, and MassHealth member status, is

protected without compromise. **The STP was changed to reflect CMS’s March 2019 FAQs Guidance on Heightened Scrutiny.**

Comment 21

A commenter questioned the adequacy of the site assessment process for DDS residential settings because the finding that most of the settings require minor modification to achieve compliance with the Rule is inconsistent with the commenter’s own conclusions based on the locations and operational details of “many of these dwellings.”

Response

As the commenter noted, the findings reported in the STP are based on a multi-faceted assessment process described in the STP. The state believes that the review process comports with the requirements of assessment and validation described by CMS in its guidance to states regarding the site-specific assessment process. No change is required in the STP.

Comment 22

One commenter stated that residential settings located proximate to closed institutions cannot meet the requirements of the Rule due to lingering stigma in the community. The commenter requested clarification from CMS as to whether, for purposes of identifying settings that have the qualities of an institution and therefore require heightened scrutiny, closed institutions should be treated as “institutions.”

Response

The state respectfully disagrees. Guidance from CMS to MassHealth officials clearly indicated that the definition of an “institution” refers to an open, operational one, not one that has closed. Where the Rule identifies proximity to a public institution as an institution-like quality, CMS defined “public institution” as an inpatient facility that is financed and operated by a government entity. This definition does not include closed facilities, as by virtue of being closed they are not being operated by a government (or any other) entity and do not house any individuals as inpatients. No change in the STP is required.

Comment 23

One commenter noted that while the STP stated that virtually all residential settings in the DDS- or MRC-operated waivers require implementation of locks and written tenancy agreements to fully comply with the Rule, one section of the STP implied that no MRC residential providers need to make changes in order to comply.

Response

The commenter correctly understood the systemic assessment section of the STP as describing a universal need for implementation of locks on bedroom

doors and written lease agreements among DDS and MRC residential providers. **Language regarding MRC’s findings has been updated in the Site-Specific Assessment section of the STP** to clarify that while MRC’s assessment of its 42 residential habilitation providers found compliance with all other aspects of the Rule, all of those providers were considered to need changes in order to fully comply.

Comment 24

One commenter noted that determining a residential setting to be “institutional” is a prejudicial approach.

Response

Throughout the STP, use of the term “institutional” corresponds to the regulatory language in §441.301(c)(5) that specifically describes “locations that have qualities of an institutional setting” in the context of the requirement for heightened scrutiny. We regret any misunderstanding caused by the use of the term “institutional.” No change in the STP is required.

Comment 25

With respect to non-residential services, several commenters noted agreement with the principles and intent of, as well as the transition activities described in the STP, but stated that lack of funding to support compliance transition activities represents a major barrier to successful implementation. Along these lines, some commenters pointed to the funding needs identified in the Blueprint for Success in contrast to legislative appropriations levels in recent budget years. Furthermore, one commenter proposed that I/DD providers should be exempt from the compliance monitoring described in the STP unless the Massachusetts legislature funds designated budget items at requested levels. Another commenter called for comprehensive rate review for CBDS to support specific staffing levels the commenter asserts are necessary to provide truly community-integrated CBDS services.

Response

CMS created a five-year transition period and subsequently extended it to end in March 2022, for compliance with the Community Rule, providing “sufficient transition time for states to comply.” The state is committed to achieving full compliance with CMS’s Community Rule by March 2022 and believes that it has a head start with such initiatives as DDS’s Blueprint for Success. While many elements of the Community Rule do not require financial resources in order to reach fruition, the state recognizes that some of the changes required to meet the Rule may require additional funding. DDS is working closely with providers that need to make modifications in order to meet the Rule. As CMS established the March 2022 deadline for compliance with the Rule without exception, the

state is not positioned to exempt specific providers from compliance or compliance monitoring as required by the Rule. No change in the STP is required.

Comment 26

Three commenters questioned whether the DDS licensing and certification processes for residential settings are adequate to assure 100% compliance of all residential settings with the Community Rule.

Response

The DDS licensing and certification process has always been a rigorous one, which even prior to the publishing of the Community Rule, focused on important outcomes in the lives of the individuals it supports. Once the Community Rule was published, DDS convened a representative workgroup of self-advocates, family members, providers, DDS staff and external stakeholders to review its tools with an eye towards strengthening existing indicators and creating new ones which assured that all of the components of the Rule, including access, integration, choice, control and rights were incorporated. The tool was broadly distributed to both internal and external stakeholders, piloted, and implemented in August 2016. All providers of residential and day settings will be held to the revised standards, and DDS is confident that the process meets both the spirit and intent of the Community Rule. No change in the STP is required.

Comment 27

Two commenters recommended that the STP include additional information on the assessment process for group homes with five or more residents, due to their concern that such residential settings do not foster integration. The commenters felt that the STP should require that residents of such group homes be offered the choice to relocate to smaller settings and outline a timeline for transition steps.

Response

DDS does not have a separate process for evaluating group homes with five or more residents. Rather, the licensure and certification process applies to all settings regardless of their size. The process focuses on outcomes in individuals' lives such as integration, access, choice, control and rights. While the State recognizes that these outcomes may be more readily achieved in smaller, more individualized settings, size alone does not guarantee nor preclude the achievement of positive outcomes. As part of the person-centered planning process, DDS requires that service coordinators discuss the array of residential options at least annually at the time of the ISP as well as on an on-going basis. This includes a discussion of the many options available to an individual

including home ownership, shared living and self-direction. No change is required in the STP.

Comment 28

One commenter suggested that two- and three-family homes should be considered single group homes and be subject to more critical review as “congregated” settings of people with disabilities, especially where more than one multi-family group home is adjacent to each other on the same or abutting streets. The commenter expressed concern that such proximity is inconsistent with the spirit and intent of the Rule.

Response

The state does not view two- and three-family homes as congregated settings. DDS licenses each unit separately and assures a separation of staff and living spaces. As neighborhood saturation is an issue the state is mindful of, DDS does not typically locate multi-family homes side-by-side. Consideration is also given to the characteristics of a neighborhood. In urban areas such as Boston, Springfield or Worcester, two and three family homes are common. Therefore, establishing a similar home for individuals that DDS supports does not represent a congregate setting but rather blends in with the rest of the neighborhood, and provides for individual participant preference that reflects the feel of the neighborhood. No change in the STP is required.

Comment 29

Two commenters expressed their view that group employment settings as a category are inconsistent with the spirit of the Rule due to isolation and stigmatization associated with group placement. One of the commenters referenced the definition of integration under the Workforce Innovation and Opportunity Act (WIOA) in requesting that the STP be revised to indicate a clear preference for individual integrated employment over group employment as well as to articulate clear criteria for group employment going forward.

Response

The State has made significant strides in moving away from segregated employment settings through the development and implementation of the Employment Blueprint. The DDS Employment First Policy has very clear language about individual, integrated employment being the first and preferred service outcome for individuals. All sheltered workshops closed as of July 1, 2016. Group employment settings do not, in and of themselves, translate to isolated and stigmatizing options. In fact, the definition of group supported employment places an emphasis on work in an integrated environment, with the opportunity for individuals to have contact with co-workers, customers, supervisors, and others without disabilities. Since the closure of all sheltered

workshops, DDS has shifted its focus to both group employment and community based day services. Efforts are underway with providers to assure that all individuals in group employment settings are earning minimum wage or above and that settings promote integration with non-disabled workers. No change in the STP is required.

Comment 30

One commenter cited the need for additional explanation regarding the finding of compliance that resulted from MRC's assessment of 42 residential habilitation providers, noting that the use of restrictions by those providers appeared inconsistent with the requirements of the Rule.

Response

The Process subsection in the Site-Specific Assessment section of the STP describes in detail the process MRC used to assess its 42 residential habilitation providers. As MRC's revised provider manual (cited and linked to in Table 1 of the STP) makes clear, any restriction or modification of the Community Rule's requirements must be based on individual assessed need and must be discussed and documented as part of the person-centered planning process. The state is confident that MRC's processes and findings reported in the Site-Specific Assessment section are fully aligned with the Community Rule and CMS guidance. No change in the STP is required.

Comment 31

One commenter expressed concern that the STP does not address the assessment process for non-24 hour residential settings, as is described for 24-hour residential settings.

Response

Residential settings that provide less than 24-hour supports are licensed by DDS as individualized home supports. Individualized home supports are less apt to be provider controlled and generally allow for significant access and integration with the greater community. As part of the review of settings, DDS reviewed the licensure status of individualized home supports and based on these reviews, found them to be in conformance with the elements of the Rule.

Comment 32

One commenter questioned the adequacy of the review process for non-residential settings. Specifically, the commenter raised questions about "two EOHHS funded sheltered workshop programs [that] have received a waiver to remain open beyond [the June 30, 2016] date" for phase-out of sheltered workshops that is specified in the STP.

Response

DDS does not consider the two programs referenced to be sheltered workshops. These programs serve the needs of individuals with unique safety issues, where there is a need to support both community integration and public safety through a comprehensive and coordinated array of clinical services, case management supports integrated with a variety of production work and employment activities, skill development and enrichment experiences. Due to safety and supervision needs, the level of integration and inclusive opportunities will be offered with the appropriate supports and incorporated into individuals' ISPs. No change in the STP is required.

Comment 33

A commenter noted support for the state's move to ensure 100% employment compensation at or above minimum wage by June 30, 2018, but expressed concern about the state's approach to ensuring meaningful integration in group employment settings.

Response

The STP provides a detailed explanation of action steps taken to assure compliance with the Rule (see the Remedial Actions/Actions related to compliance section of the Site-specific Assessment section of the STP). **The STP has been updated to reflect that the state completed its development and distribution of clear definitions, standards, and criteria for integration for group employment and CBDS.**

Comment 34

One commenter raised concerns with the use of the CBDS survey as described in the STP, and called for large-scale data collection from people with disabilities, their families, or advocates in order to fully assess challenges in CBDS settings to ensure meaningful interactions with surrounding communities and persons without disabilities. The commenter urged the state to formulate specific benchmarks in collaboration with stakeholders on what constitutes a meaningful day and integrated day and pre-employment services within CBDS. Two additional commenters made similar requests for revisions to the STP to incorporate such benchmarks and standards. One of these commenters specifically requested that such standards should reflect the expectation that every effort must be made to ensure that individuals of working age in CBDS have a pathway to employment.

Response

The State agrees with recommendations to formulate specific benchmarks regarding what constitutes a meaningful day, and has delineated in the STP the steps that are in process to develop clear standards to guide CBDS services and

to which providers will be held accountable. Since the STP was last posted for public comment, the CBDS guidelines have been finalized, distributed, and implemented. **The STP has been updated to reflect that the state completed its development and distribution of clear definitions, standards, and criteria for integration for group employment and CBDS.**

Comment 35

Three commenters asserted that the STP should address day program settings where State Plan services are supplemented with waiver services, to enable an individual to participate in the State Plan service.

Response

The comment relates to State Plan day habilitation programs, which provide clinical supports not included in day and employment services available through a Waiver Program. As implied in the comment, in Massachusetts, day habilitation programs are state plan services not subject to the Community Rule. Day Habilitation Supplement, a waiver service, is available for individuals who, in addition to the clinical supports provided in day habilitation programs, need enhanced individualized supports to enable them to successfully access and fully benefit from state plan day habilitation services. Day Habilitation Supplement is specifically designed to support individuals with clinical needs to take part in Day Habilitation activities outside of their home and in the community, which they would not be able to do without the Supplement. Day Habilitation Supplement is a mechanism to support access to day habilitation state plan services, and for participants to take advantage of a state plan benefit they choose to utilize. No change in the STP is required.

Comment 36

A commenter expressed concern that inadequate protections for autonomy, choice, and tenancy are in place in some Placement Service settings, and therefore questioned the finding that such settings comply fully with the Rule.

Response

As part of the review of settings, DDS reviewed the licensure status of placement services and based on these reviews, found them to be in conformance with the elements of the Rule. No change in the STP is required.

Comment 37

A commenter emphasized that people with severe autism and/or other complex needs may need to access center-based support during the day to succeed in day activities, including CBDS and employment activities.

Response

The state agrees with the commenter that every waiver participant is unique and that for some individuals, appropriately supporting their community-based activities necessarily includes clinical or other supports during the day. For all HCBS waiver participants, the person-centered planning process includes comprehensive assessment of the individual's strengths, goals, and needs. An assessed need such as that described in the comment would be documented in the person-centered planning process and reflected in the individual's service plan. There is nothing in the STP that would preclude individuals with severe autism from accessing CBDS or employment activities. Rather, as with all decisions regarding appropriate services and supports, the person centered planning process is the vehicle through which all individual decisions are derived. No change in the STP is required.

Ongoing Monitoring

Comment 38

One commenter suggested that the STP would be improved by including greater detail regarding the ongoing monitoring that will take place to ensure that settings identified by DDS as requiring changes to achieve compliance implement the needed changes consistent with the Rule.

Response

The STP addresses ongoing monitoring and the details of compliance transition activities separately. For details regarding transition milestones for settings identified as requiring changes to achieve compliance, please see the section labeled "Remedial Actions/Actions Related to Compliance" within the Site-Specific Assessment section of the STP as well as Table 3 (Summary of Transition Plan Tasks and Timelines). "Ongoing monitoring" in the STP refers specifically to the processes and structure of monitoring of all settings to ensure that, once compliance is achieved, it is maintained on an ongoing basis. No change in the STP is required.

Comment 39

One commenter suggested that the STP identify which DDS Area Office staff conduct visits to residential settings to ensure adequate oversight of the individual rights protections required under the Community Rule. The comment also noted that Area Office staff should be required to speak with the guardian, where one is in place, as part of group home visits, especially in cases where individuals have severe intellectual disabilities and/or are unable to express themselves with words, gestures, signs, assistive technology, or augmentative communication devices.

Response

The STP identified the many different quality assurance and oversight activities in which DDS is engaged. It is important that all of the processes outlined in the STP be viewed in their entirety as contributing to the overall DDS oversight and monitoring processes. The Area Office Site Visit, which is required to occur every other month, is but one aspect of DDS's broad quality assurance and oversight activities. While it is typically conducted by the Service Coordinator, the Area Office Site Visit can also be conducted by the Area Office Program Monitor, Clinical Director or other designated staff. Regardless of who conducts the review, a standardized process is used. It does not, nor is it intended to provide an extensive review of every element of the Community Rule. No change in the STP is required.

Participant Relocation

Comment 40

Two commenters suggested that the STP should describe in greater detail the process for communicating information needed for a participant to have, and be supported in making a meaningful choice if relocation to a compliant provider/setting is necessary. The commenter also requested clarification of the timeline according to which an individual could choose to remain in a setting that cannot comply with the Rule's requirements.

Response

As noted in the STP, any waiver participant who resides or receives services in a setting that is determined unable to comply with the Rule will be supported through the person-centered planning process to choose a new provider or setting. In such circumstances, an individual could choose to remain in a non-compliant site if they choose to no longer participate in the waiver. No change in the STP is required.

Other

Comment 41

A commenter noted that the requirement in state regulation for room and board charges for individuals receiving 24/7 residential services (50% of earned income after the first \$65) does not align with federal public housing or federal subsidized housing income/rent requirements, and identified this difference as providing a disincentive to engage in competitive employment contrary to the Rule's requirements.

Response

The regulations for charges for care provide for payment of 75% of unearned income but allow both a \$65 disregard and payment of only 50% of earned income. The DDS regulations are also consistent with MassHealth financial

eligibility rules found at 130 CMR 520.012 Community Earned Income Deductions. The state respectfully disagrees with the assertion that the room and board charges discourage waiver participants from pursuing competitive employment. We note that the federal subsidies cited by the commenter address rent only, while room and board charges for individuals receiving 24/7 residential services include board, as the name suggests. No change in the STP is required.

Comment 42

One commenter requested that the state curtail the practice of school districts placing students with disabilities in sheltered workshops or segregated group employment programs, noting that while such programs are outside the scope of the Rule, the students in such programs are at highest risk for referral as adults to potentially segregated or isolating group employment programs that fall within the scope of DDS regulatory authority.

Response

The placement of students with disabilities falls within the jurisdiction of Local Education Authorities, subject to state law. DDS has made strides in eliminating sheltered workshops for adults, which will preclude school districts from referring students to sheltered workshops for adult services. No change in the STP is required.

Comment 43

A commenter expressed concern that aspects of the STP would have the effect of privatizing services for HCB service recipients. In particular, the commenter felt that the person-centered planning process puts control over an individual's funds into the hands of private companies, and that the system-wide shift to smaller group homes diverts taxpayer money appropriated for the developmentally disabled into an under-regulated, corporate-run service system.

Response

The state respectfully disagrees with this commenter. The state system of residential and day supports includes private and public providers of services. Nothing in the STP steers an individual into either type of service. All decisions regarding accessing services are based on individual preferences with respect to types of living situations, geographic location, choice of roommates, and availability. Further, supporting individuals to live in smaller residential settings has no impact on the oversight processes. All settings, regardless of size, are regulated by the same set of standards and processes. No change in the STP is required.

Comment 44

One commenter suggested that access to medical and dental care in integrated settings would be improved by reviewing Medicaid payment rates for dental and medical services and including variable payment for case coordination.

Response

While this comment raises an important issue, the Medicaid rates for dental and medical services are beyond the scope of the STP. No change in the STP is required.

Comment 45

Three commenters noted that transportation—specifically, the lack of generic or “para” transportation—remains a barrier to meaningful community integration for HCB service recipients in both residential and non-residential settings.

Response

The state continues to work to improve transportation options for individuals served through its HCBS waivers. Several of the provider transition plans include funding for the cost of new vans/cars, and DDS’ revised licensure and certification tool incorporates indicators that measure a provider’s availability of transportation as well as creative options utilized to support better transportation modes. No change in the STP is required.

Comment 46

One commenter made specific recommendations to improve access to HCB services for elders, including that managed HCB services should not be mandated for waiver participants; that the state should add 1915(i) and 1915(k) SPAs to leverage additional federal funding for community living benefits for elders; that the Massachusetts Frail Elder Waiver should be amended to include residential support services and self-directed care, and allow spouses as caregivers; and that independent agents should remain a standard feature of all waivers.

Response

The comments address issues beyond the scope of the STP, which relates specifically to the state’s plan to ensure compliance with the Community Rule in existing settings by March 2022 and ongoing. No change in the STP is required.

Comment 47

One commenter requested at the August 3rd, 2016 public forum that the state refrain from using “Bureaucratese” in describing the scope of the STP and the initial and final approval processes.

Response

The state appreciates the commenter's remark and will continue to strive to make its STP-related materials as user-friendly as possible. No change in the STP is required.