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:

Updating descriptions of operational and administrative processes to reflect current procedures and systems.

Updating descriptions of operational and administrative processes to reflect current staffing and structure at MRC.

Updating Appendix C-5: Home and Community-Based Settings in response to guidance received from CMS in recent renewals about how to complete this section.

In Appendix G-3, updating details relating to the structure of Massachusetts' Medication Administration Program as regulated by the Massachusetts Department of Public Health.

Updating the Appendix J estimates for service utilization and spending through the 5-year renewal period.

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report has not been finalized for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been finalized. Upon expiration of the Appendix K amendment, Massachusetts will gather and submit any outstanding 372 reports as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 report(s) within a timeframe between 90 days and up to 6-months (to be negotiated with the state) of receiving the final quality review report and 372 report acceptance decision.

The state will not use funding from section 9817 of the American Rescue Plan Act of 2021 for the changes associated with this waiver renewal.

None of the changes in this waiver renewal are related to the state's unwinding activities as a result of the COVID-19 public health emergency.

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

State:	
Effective Date	

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.

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*): Traumatic Brain Injury Waiver

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.0359	
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)		

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

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

E. **Proposed Effective Date:** 7/1/24

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 Level of Care

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

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

Select one:

☑	**Not applicable**
☐	**Applicable**

Check the applicable authority or authorities:

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

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

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

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

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Goals and Objectives:
The Massachusetts Traumatic Brain Injury Waiver (TBI) program supports individuals with TBI who are at a nursing facility or chronic/rehabilitation hospital level of care to live in their homes or other community settings. This program supports the choice of individuals with TBI to remain in the community and provides services that help them to avoid or delay institutional placement.

Organizational Structure:
The Massachusetts Rehabilitation Commission (MRC), a state agency within the Executive Office of Health and Human Services, 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, through MassHealth, oversees MRC's operation of the waiver.

Case Management and Service Delivery:
Case Management for the TBI Waiver is provided by staff of MRC. MRC is responsible for participant needs assessment, service plan development, and service authorization activities. Clinical determination of eligibility and level of care redetermination is conducted by MRC clinicians.

TBI Waiver Services will be provided pursuant to an Individual Service Plan (ISP) that is developed based on person-centered principles with the Waiver participant. Individual waiver services will be authorized pursuant to the ISP and delivered through qualified contracted direct service providers.

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report has not been finalized for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been finalized. Upon expiration of the Appendix K amendment, Massachusetts will gather and submit any outstanding 372 reports as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 report(s) within a timeframe between 90 days and up to 6-months (to be negotiated with the state) of receiving the final quality review report and 372 report acceptance decision.

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:

We will update this section post public comment period.

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:	3rd 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:	Butler				
First Name:	Maureen				
Title:	Director, Statewide Head Injury Program				
Agency:	Massachusetts Rehabilitation Commission				
Address:	600 Washington St				
Address 2:					
City:	Boston				
State:	MA				
Zip :	02211				
Phone:	857-303-6984	**Ext:**		☐	**TTY**
Fax:					
E-mail:	Maureen.Butler@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:	Levine				
First Name:	Mike				
Title:	Assistant Secretary and Director of MassHealth				
Agency:	Executive Office of Health and Human Services				
Address:	One Ashburton Place				
Address 2:					
City:	Boston				
State:	Massachusetts				
Zip:	02108				
Phone:	617-573-1600	**Ext:**		☐	**TTY**
Fax:	617-573-1894				
E-mail:	Mike.Levine@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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Below is the state's response to the Formal Request for Additional Information received on 7/15/21.

1)
The following services may be provided via telehealth: Individual Support and Community Habilitation, Supported Employment, Adult Companion, Transitional Assistance, and Day Services.

•Individual Support and Community Habilitation

•Supported Employment

•Adult Companion

Language has been added to each of the service definitions of the 3 services above:

This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the 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.

•Day Services

Language has been added to the service definition of the service above:

This service is primarily delivered in person; telehealth may be used to supplement the scheduled in-person services 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.

•Transitional Assistance

Language has been added to the service definition of the service above:

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

2)

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

MRC and MassHealth have well established processes to ensure the health and safety of waiver participants. The assessment and person-centered planning processes continue to be the mechanisms by which the health and welfare of waiver participants are reviewed. This review will ensure that appropriate considerations for waiver participants' health and safety were part of the person-centered

planning process and confirm whether the telehealth delivery of service model can meet their needs and ensure health and safety. The review will also ensure that waiver participants' services were delivered in the same amount, frequency, and duration that was identified in the Plan of Care, regardless of the method of service delivery. Appendix D and Appendix G describe the safeguards that the state has established to assure the health and welfare of waiver participants regardless of the service delivery method.

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

Participants' needs and preferences will drive the delivery of services, via the person-centered planning process. Participants will be able to choose the mix of in-person and telehealth service delivery that best meets their needs and preferences. If the individual chooses telehealth service delivery for some combination of services, the person-centered planning team will ensure that the services are appropriate in amount, frequency, and duration and that they adequately meet the participant's needs and goals for independence and community integration. Services will be provided to participants according to their assessed needs and person-centered Plan of Care, which may incorporate delivery of services either as a hybrid approach of some remote and some in-person, or fully in-person.

Frequency of face-to-face contact with the participant is based on the participant's individual needs and preferences. While this service may be provided via telehealth, it is within the context of regular contact with the case manager including an in-person visit at least twice annually. Case managers maintain regular contact with providers of waiver services which also serves to inform the frequency of direct in-person contact.

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

The person-centered planning process will address participants' needs including community integration regardless of the service delivery method. Providing waiver services via telehealth is a way to offer avenues for community integration that might not have otherwise existed. For example, waiver participants may now have access to providers in other parts of the state they would be unable to access physically.

Frequency of face-to-face contact with the participant is based on the participant's individual needs and preferences. While this service may be provided via telehealth, it is within the context of regular contact with the case manager including an in-person visit at least twice annually. Case managers maintain regular contact with providers of waiver services which also serves to inform the frequency of direct in-person contact.

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

Telehealth delivery is not utilized for ADL supports so there is no inherent privacy concern in instances of toileting, dressing, etc. Just as with in-person service delivery, services are delivered on a scheduled

basis and therefore participants may prepare for engagement with the provider. All devices used for telehealth purposes are entirely within the control of the participant at all times. Education and training related to privacy and the use of the device are available to participants and the need for such training is identified during the person-centered planning process.

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

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

Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 6 Section 84, to protect the privacy and security of the participant's protected health information.

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

State:	
Effective Date	

Attachments to Application: 1

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)*	The Massachusetts Rehabilitation Commission. While MRC is organized under EOHHS & subject to its oversight authority, it is a separate agency established by & 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.

The Executive Office of Health and Human Services (EOHHS) is the single state agency for administration of the Medicaid program in Massachusetts. MassHealth, the medical assistance unit within EOHHS, oversees the administration and day-to-day operation of the TBI Waiver by the Massachusetts Rehabilitation Commission (MRC), a state agency within EOHHS. The State Medicaid Director has ultimate oversight authority over waiver operational activities.

(a) MassHealth and MRC have entered into an Interagency Service Agreement (ISA) that outlines the responsibilities of the parties. MRC's responsibilities include:
- all case management functions,
- Level of Care determinations and redeterminations,

- the service needs assessment process,
- service plan development and service authorization activities,
- contracting with and reimbursing waiver service providers,
- working with contractors to provide any necessary training,
- ongoing verification and monitoring of provider qualifications and performance, respectively,
- collecting, aggregating, and submitting to MassHealth waiver quality data related to the six Quality Assurance areas, as well as information on waiver enrollees' utilization of and satisfaction with waiver services.

(b) MassHealth and MRC have entered into an Interagency Services Agreement to document the responsibility for performing and reporting on waiver operational activities.

(c) MassHealth oversees MRC in its operation of and reporting on the TBI Waiver as follows:
- Regular oversight meetings. Staff of the MassHealth HCBS Waiver Unit meets with MRC staff on at least a monthly basis to review waiver operations, discuss quality goals and measurement, and identify needs for any policy or program changes to ensure appropriate operation of the waiver and alignment with both CMS's and the state's policies, rules, and regulations.
- Enrollment and expenditure reporting. The Commonwealth is required to report enrollment and expenditure data for the Waiver to CMS through the submission of CMS-372 reports. MassHealth coordinates this activity with MRC as well as with EOHHS staff from Information Technology/Data Warehouse, Budget and Revenue to ensure appropriate coding for claims and enrollee identification are used and reports are accurate. Reports are used for monitoring as well as federal reporting.
- Regulations and policy implementation. MassHealth regulations at 130 CMR 519.007(F) describe eligibility for the Waiver. The MassHealth Operations unit (MHO) ensures that the eligibility system (MA-21) has logic and coding to properly determine eligibility for the Waiver program as well as procedures for accepting clinical determinations and processing financial information for eligibility determinations.

The Medicaid Director reviews and signs off on 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) (s*elect 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.*

☑	**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:

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:

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:	AA3. MassHealth and MRC work collaboratively to improve quality of services through the submission and review of annual quality management (QM) reports: the Mortality Report, Residential Monitoring Report , participant survey results, Incident Report Summary, and LOC Re-Assessments Report. Numerator: Number of QM reports submitted timely to MassHealth for review. Denominator: Number of reports due.
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **MRC Management Reports**	

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

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	AA1. Participants are supported by competent and qualified Case Managers. Numerator: Number of Case Managers with a rating of "meets expectations" or "exceeds expectations" on their performance evaluations. Denominator: Number of Case Managers due for performance evaluation.
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify: **Case Manager Performance Evaluations**	

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

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

Performance Measure:	AA2. MassHealth and MRC work collaboratively to improve quality of services by, in part, ensuring that service provider oversight is conducted in accordance with policies and procedures. Numerator: Number of service provider reviews conducted in accordance with policies and procedures. Denominator: Number of service provider reviews due during the period.
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	***Frequency of data collection/generation:***	***Sampling Approach*** *(check each that applies)*

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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 (MRC) and MassHealth are responsible for ensuring effective oversight of the waiver program. As problems are discovered with management of the waiver program or waiver service providers, MRC and MassHealth 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 and MRC are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality- related issues.

ii Remediation Data Aggregation

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

c. Timelines

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

☑	**No**
○	**Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Select one Waiver Target Group		Target Group/Subgroup	Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
☐	**Aged or Disabled, or Both - General**				
	☐	Aged (age 65 and older)			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☑	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	☑	Brain Injury	18		☑
	☐	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			☐
	☐	Serious Emotional Disturbance			

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

When used anywhere in this waiver, traumatic brain injury or TBI refers to brain damage resulting from: a blunt blow to the head; a penetrating head injury; crush injury resulting in compression to the brain; severe whiplash causing internal damage to the brain; or head injury secondary to an explosion. Brain damage secondary to other neurological insults (e.g. infection of the brain, stroke, anoxia, brain tumor, Alzheimer's Disease and similar neuron-degenerative diseases) is not considered to be a traumatic brain injury.

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	100
Year 2	100
Year 3	100
Year 4 (only appears if applicable based on Item 1-C)	100
Year 5 (only appears if applicable based on Item 1-C)	100

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

Waiver Year	**Purpose** (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):
	Purpose (describe):	**Purpose** (describe):
	Describe how the amount of reserved capacity was determined:	**Describe how the amount of reserved capacity was determined:**
	Capacity Reserved	**Capacity Reserved**
Year 1		
Year 2		
Year 3		
Year 4 (only if applicable based on Item 1-C)		
Year 5 (only if applicable based on Item 1-C)		

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

Applicants for the TBI 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.

Applicants for the TBI waiver must be 18 years of age or older and have a traumatic brain injury as defined in B-1-b of the waiver application.

Applicants for the TBI waiver are assessed on a first-come first-served basis.

Any applicants who are denied entry to the waiver will be offered the opportunity to request a fair hearing as noted in Appendix F.

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

Waiver Phase-In/Phase Out Schedule

Based on Waiver Proposed Effective Date:

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

○	Phased-in
○	Phased-out

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

Beginning (base) number of Participants:

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

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

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

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

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

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

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

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

2. Miller Trust State.

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

☑	No
○	Yes

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

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

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*	
○	**No**. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
☑	**Yes**. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*
○	All individuals in the special home and community-based waiver group under 42 CFR §435.217
☑	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:
☑	A special income level equal to (select one):
☑	300% of the SSI Federal Benefit Rate (FBR)
○ %	A percentage of FBR, which is lower than 300% (42 CFR §435.236) Specify percentage:
○ $	A dollar amount which is lower than 300% Specify percentage:
☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
☐	Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)
☐	Aged and disabled individuals who have income at: *(select one)*
○	100% of FPL
○ %	of FPL, which is lower than 100%
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) *specify*:

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217.

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act. *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after 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. Allowance for the needs of the waiver participant (*select one*):				
☑	The following standard included under the state plan *(Select one):*			
	○	**SSI standard**		
	○	**Optional state supplement standard**		
	○	**Medically needy income standard**		
	☑	**The special income level for institutionalized persons** *(select one):*		
		☑	**300% of the SSI Federal Benefit Rate (FBR)**	
		○ %	**A percentage of the FBR, which is less than 300%** Specify the percentage:	
		○ $	**A dollar amount which is less than 300%.** Specify dollar amount:	
	○ %		A percentage of the Federal poverty level Specify percentage:	
	○	**Other standard included under the state Plan** Specify:		
○	**The following dollar amount** Specify dollar amount:	$	If this amount changes, this item will be revised.	
○	**The following formula is used to determine the needs allowance:** Specify:			
○	Other Specify:			

ii. Allowance for the spouse only (*select one*):			
☑	**Not Applicable**		
Specify the amount of the allowance (*select one*):			
○	**SSI standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.

○	**The amount is determined using the following formula:** *Specify:*

iii. Allowance for the family *(select one)*:

☑	**Not Applicable *(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*

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

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

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

Select one:

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

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

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. Allowance for the personal needs of the waiver participant

*(select one)***:**

○	**SSI Standard**		
○	**Optional state supplement standard**		
○	**Medically needy income standard**		
☑	**The special income level for institutionalized persons**		
○	%	Specify percentage:	
○	**The following dollar amount:**	$	If this amount changes, this item will be revised
○	**The following formula is used to determine the needs allowance:** *Specify formula:*		
○	**Other** *Specify***:**		

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

Select one:

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

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

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

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

Select one:

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

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

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.

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 participant does not receive scheduled services for longer than one month (for example when absent from the home due to hospitalization). Monitoring includes in-person, telephone, video-conferencing, text messaging, e-mail contacts, and/or other electronic modalities with the participant, guardian, or other family member designated by the participant and may also include collateral contact with service providers or informal supports. Guardians and other family members designated by the participant will be documented in their electronic record by the Case Manager. Contact requires a response from the participant, guardian or other specified family member in order to be considered monitoring.

The participant will receive, at a minimum, a quarterly visit by the case manager. These may occur in person, or via telephone or video-conference.

Every participant has an in-person visit by the case manager at least annually that must occur in the participant's home. Additional in-person visits could be conducted in a different location that accommodates the participant's needs.

Also, any time that any service provider is delivering services in the home, they are required to communicate to the case manager any changes to the home environment that would impact a participant's safety.

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*:
○	**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:

Neuropsychologists and Registered Nurses. A neuropsychologist is an MRC-qualified licensed psychologist, specializing in clinical neuropsychology, who meets professional training guidelines established by the American Psychological Association (Division 40) and International Neuropsychological Society.

Registered Nurses (RN) are graduates of an approved school for professional nursing and must possess a valid nursing license issued by the Massachusetts Board of Registration of Nursing and be in good standing.

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 clinically 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 level of care if the individual has a confirmed diagnosis of a traumatic brain injury, and he or she requires daily assistance to address at least three needs in the following areas: Instrumental Activities of Daily Living (IADL); Activities of Daily Living (ADL); Behavior Intervention; or Cognitive Abilities, as described below. Regardless of whether an individual exhibits one or more IADL needs, IADL needs will count as a maximum of one deficit for purposes of determining eligibility. Likewise, regardless of whether an individual exhibits one or more ADL needs, ADL needs will count as a maximum of one deficit for purposes of determining eligibility.

I. Instrumental Activities of Daily Living (IADL) – includes some help (help some of the time), full help (performed with help all of the time) or task done by others (performed by others), per MDS-HC definitions, for needs with the following activities:

1. Meal Preparation

2. Ordinary Housework (includes laundry)

3. Managing Finances

4. Managing Medications

5. Phone Use

6. Shopping

7. Transportation

II. Activities of Daily Living (ADL) – includes 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. Mobility/ambulation – 1:1 supervision, 1:1 stand-by guard, or physical assistance

6. Eating – does not include meal or tray preparation

III. Behavior Intervention – Staff intervention required for selected types of behaviors that are generally 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; or requiring a consistent staff one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental-health professional. Behaviors as described in the MDS-HC include:

1. Wandering

2. Verbally abusive

3. Physically abusive

4. Socially inappropriate

IV. Cognitive Abilities – includes deficits in any of the following areas:

1. Receptive language (comprehension) – ability to understand through any means such as verbal, written, sign language, Braille, or communication board;

2. Expressive language – ability to express needs through any means such as verbal, written, sign language, Braille, or communication board;

3. Learning – ability to learn, retain or retrieve information for purposes of habilitating day to day and generally managing within one's environment;

4. Capacity for independent living – ability to live alone related to safety issues, ability to exit building in case of fire or natural disaster, ability to call 911 in case of an emergency, ability to safely cross the street.

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 additional traumatic brain injury assessment questions, is used for evaluation and 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 to evaluate level of care of nursing facility residents to determine eligibility for payment. Chronic and rehabilitation hospitals assess for level of care utilizing the Medicare Adult Appropriateness Evaluation Protocol (AEP) utilized by the Peer Review Organization.

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:

A neuropsychologist and/or registered nurse conducts an evaluation of each TBI waiver participant. Information gathered for the evaluation of level of care is derived from interviews generally conducted in the participant's home, but which may be conducted in an alternative location, and includes a thorough evaluation of the participant's individual circumstances and medical records. While in-person is the default method for interviews, alternative modalities may be allowable in certain situations. The evaluator will obtain authorization from the clinical supervisor and document the reason for the utilization of an alternative modality in the participant's electronic record. The TBI diagnosis is confirmed as part of the initial evaluation. Once this diagnosis is confirmed it is considered a permanent condition. Otherwise, the reevaluation process is identical to the initial evaluation process.

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

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

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

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

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

MRC administrative staff maintain a database of waiver participants, the dates of LOC evaluations and dates for reevaluation, and are responsible for insuring that the re-evaluation is triggered 60 days prior to the date it is due. Participants will be notified, and MRC clinicians will be assigned to complete the process.

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:

Electronic records are maintained for each waiver participant at the MRC.

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:	LOCa1. A clinical Level of Care assessment will be initiated within 30 days of identified need. Numerator: Number of individuals who received an initial clinical LOC assessment within the established timeframe. Denominator: Number of individuals who received an initial clinical LOC assessment.

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

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 levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

i. Performance Measures

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

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

Performance Measure:	No longer needed in new QM system
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis	***Frequency of data aggregation and analysis:***

(check each that applies	*(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:	LOCc1. % of applicants whose initial clinical eligibility assessment is documented in accordance with waiver requirements. Numerator: Number of applicants whose initial clinical eligibility assessment was documented in accordance with waiver requirements. Denominator: Number of applicants whose initial clinical eligibility assessment was documented
Data Source *(Select one) (Several options are listed in the on-line application):* **Records reviews, on-site**	
If 'Other' is selected, specify:	

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

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The Massachusetts Rehabilitation Commission and MassHealth are responsible for ensuring effective oversight of the waiver program. As problems are discovered with management of the waiver program or waiver service providers, MRC and MassHealth 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 and MRC are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii Remediation Data Aggregation

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

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

c. Timelines

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

☑	**No**
○	**Yes**

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

Appendix B-7: Freedom of Choice

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

i. informed of any feasible alternatives under the waiver; and

ii. given the choice of either institutional or home and community-based services.

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

Once initial clinical eligibility has been determined, the MRC provides a Recipient Choice Form to the participant (or legal representative) either in person or by mail. This form offers the applicant the opportunity to choose between community-based or facility-based services. The participant indicates his/her preference on the Recipient Choice Form. The signed and dated form is maintained by the Case Manager in the client record.

If the participant chooses to receive community-based services, the Case Manager informs the participant of all services available under the waiver as part of the needs assessment and 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 client record at MRC for a minimum of three years.

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

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

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 has made MassHealth eligibility notices and information regarding appeal rights, 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.

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 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 cultural facilitators that may be accessed to assist in this process.

The MRC website offers the Google Translation feature, allowing the viewer to translate web content into 37 languages.

MRC attempts to ensure that employees are capable of communicating directly with participants in their primary language, including American Sign 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.

State:	
Effective Date	

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	**Homemaker**
Statutory Service	**Individual Support and Community Habilitation**
Statutory Service	**Residential Habilitation**
Statutory Service	**Respite**
Statutory Service	**Supported Employment**
Other Service	**Adult Companion**
Other Service	**Assistive Technology for Telehealth**
Other Service	**Day Services**
Other Service	**Home Accessibility Adaptations**
Other Service	**Shared Living – 24 Home Supports**
Other Service	**Specialized Medical Equipment**
Other Service	**Transitional Assistance**
Other Service	**Transportation**

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:							
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:			
				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 60-Hour Personal Care Training Certificate of Home Health Aide Training Certificate of Nurses Aide Training Certificate of 40-Hour Homemaker Training	Any not-for-profit or proprietary organization that becomes qualified through the MRC open procurement 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. 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. Provider must have the ability to meet all requirements for operating a high quality program, as specified by EHS or its designee and the 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 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 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 that have experience providing services to persons with disabilities will be preferred. 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.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Homemaker Agencies	Massachusetts Rehabilitation Commission	Every two years

Service Specification
Service Type:
Statutory Service
Service:
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 the acquisition, retention or improvement of skills related to personal finance, health, shopping, and use of community resources; locating appropriate housing; as well as community safety, and other social and adaptive skills required to live in the community. Individual Support and Community Habilitation services 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. These services may also include modeling, training and education in self-determination and self-advocacy to enable the individual to acquire skills necessary to exercise control and responsibility over the services and supports they receive and to become more independent, integrated, and productive in their communities. Individual Support and Community Habilitation is not available to waiver participants receiving Residential Habilitation. 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. 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.
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 Support Worker		ISCH Provider Agencies	

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

ISCH Provider Agencies			Any not-for-profit or proprietary organization that becomes qualified through the EOHHS open procurement 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. Provider must have the ability to meet all requirements for operating a high quality program, as specified by EHS 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 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 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 Individual Support and Community Habilitation services must meet requirements for individuals in such roles, including: having been 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; ability to handle emergency situations, set limits, and communicate effectively with participants, families, other providers and agencies; and have the ability to meet legal requirements in protecting confidential information. Specific competencies needed to meet the support needs of the participant will be delineated in the ISP. - Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well

			applicable state law, M.G.L. Ch. 6 Section 84, to protect the privacy and security of the participant's protected health information. MRC/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by MRC and EOHHS officials.
Individual Support Worker			Individuals who provide Individual Support and Community Habilitation services must have become qualified through the MRC open procurement process and must meet requirements for individuals working in such roles, including, but not limited to must: have been 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; ability to handle emergency situations, set limits, and communicate effectively with participants, families, other providers and agencies; and have the ability to meet legal requirements in protecting confidential information. Specific competencies needed to meet the support needs of the participant will be delineated in the ISP. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 6 Section 84, to protect the privacy and security of the participant's protected health information. MRC/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This

			methodology is accepted by MRC and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
ISCH Provider Agencies	Massachusetts Rehabilitation Commission	Monthly review of participant Progress Reports by Case Manager with any issues reported to supervisor for follow-up. The Case Manager Supervisor meets with the agency staff twice a year. The agency is reviewed every two years.
Individual Support Worker	Massachusetts Rehabilitation Commission	Case Manager will review participant Progress Reports on a monthly basis to identify any issues related to work of support worker. In addition, Case Manager Supervisor will conduct a review of all information that may be aggregated related to support worker performance to identify problems twice per year.

Service Specification
Service Type:
Statutory Service
Service:
Residential Habilitation
☑ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Residential Habilitation consists of ongoing services and supports by paid staff in a provider-operated residential setting that are designed to assist individuals to acquire, maintain or improve the skills necessary to live in a noninstitutional setting. Residential Habilitation provides individuals with daily staff intervention for care, supervision and skills training in activities of daily living, home management and community integration in a qualified provider operated residence with 24 hour staffing. Residential Habilitation includes individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports (such as safety sign recognition and money management), and social and leisure skill development, that assist the participant to reside in the most integrated

setting appropriate to their needs. Residential habilitation also includes personal care and protective oversight and supervision. This service may include the provision of medical and health care services that are integral to meeting the daily needs of participants. Transportation between the participant's place of residence and other service sites or places in the community may be provided as a component of residential habilitation services and included in the rate paid to providers of residential habilitation services.

Provider owned or leased facilities where residential habilitation services are furnished must be compliant with the Americans with Disabilities Act and must meet the applicable requirements of the Community Rule (42 CFR 441.301(c)(4)). Residential habilitation will be provided in settings with at least two and no more than four individuals receiving the service. Settings with more than four individuals require state approval.

Residential Habilitation is not available to individuals who live with their immediate family unless the immediate family member (grandparent, parent, sibling or spouse) is also eligible for residential Habilitation supports and had received prior authorization, as applicable, for Residential Habilitation. 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 for Residential Habilitation is specified in Appendix I-5. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as provided in Appendix C-2.

Participants receiving Residential Habilitation may not receive duplicative waiver services including: Homemaking, Adult Companion, Individual Supports and Community Habilitation, Respite, Home Accessibility Adaptations or Shared Living - 24 Hour 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:
				Residential Habilitation Service Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Residential Habilitation Service Agencies		Residential Habilitation Provider employees must have a High School diploma, GED or relevant equivalencies or competencies.	Any not-for-profit or proprietary organization that becomes qualified through the MRC open procurement process, and as such, has successfully demonstrated, at a minimum the following: Program and Physical Plant: Experience providing 24/7 services to persons with traumatic brain injuries. Demonstrated experience and/or willingness to work effectively with EHS or its designees 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 residential habilitation services, including: - Understanding and compliance with all required policies, procedures, and physical plant standards. - Experience and evidence of strong community linkages and referrals to medical, behavioral, psychiatric, substance abuse and crisis emergency providers and planning for accessing clinical services as needed. - Demonstrated understanding and provision of meaningful daytime activities and services as necessary. - Clear on-call procedures and identified staff in case of emergencies. - 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, accessibility standards and the ADA, as applicable. Staff and Training: Demonstrated staff development practices including specialized trainings regarding provision of 24/7 services to persons with acquired brain injuries. Demonstrated practices that support community integration, participant choice, recognition of individual abilities, person-centered service planning. Experience recruiting and maintaining qualified staff; assurance that all staff will be CORI checked; appropriate policies/procedures/practices; assurance that there is a team approach to service delivery. Quality: Ability to meet all requirements for operating a high quality program, as specified by EHS or its designee; ability

			to provide program and participant quality data and reports. Providers who have DDS/DMH licensure are considered to have met the above requirements.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Residential Habilitation Service Agencies	Massachusetts Rehabilitation Commission	Annually

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 enroll 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 an Assisted Living Residence provides personal care services by an entity certified by the Executive Office of Elder Affairs. - Respite care in DDS licensed respite facilities provides care and supervision in a setting licensed by the Department of Developmental Disabilities. - 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) 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				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Skilled Nursing Facility
				Adult Foster Care
				Hospital
				DDS License Respite Facilities
				Assisted Living Residence

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Skilled Nursing Facility	Licensed by the Department of Public Health in accordance with 105 CMR 153.00 (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).		
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.

Hospital	Licensed by the Department of Public Health in accordance with 105 CMR 130.00 (Department of Public Health Hospital Licensure regulations that describe the standards for the maintenance and operations of hospitals in Massachusetts).		
DDS License Respite Facilities	Licensed by the Department of Developmental Services in accordance with 115 CMR 7.00 and 8.00		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.
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)	
Verification of Provider Qualifications			

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Skilled Nursing Facility	Massachusetts Rehabilitation Commission	Every two years, or prior to utilization of service.
Adult Foster Care	Massachusetts Rehabilitation Commission	Every two years, or prior to utilization of service.
Hospital	Massachusetts Rehabilitation Commission	Every two years, or prior to utilization of service.
DDS License Respite Facilities	Massachusetts Rehabilitation Commission	Every two years, or prior to utilization of service.
Assisted Living Residence	Massachusetts Rehabilitation Commission	Every two years, or prior to utilization of service.

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 clarify the skills that participants will need to strengthen ahead of job placement, determine if any specific skill training will be needed for successful job placement and retention, and enable participants who need supports to perform in a regular work setting to achieve successful placement in a competitive work setting, with such supports. Supported Employment may include assisting the participant to locate a job or developing a job on behalf of the participant, as well as post-placement intermittent support. 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. This service may be delivered remotely via telehealth 100% of the time. Supported Employment includes activities needed to obtain and sustain paid work by participants, including assessment, education and skills training activities, job development and placement, support upon initial placement, and intermittent post-placement job supports. 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.

This service does not include continuous, long-term 1:1 support to enable an individual to complete work activities.

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-Based Employment Services Provider

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community-Based Employment Services Provider			Any not-for-profit or proprietary organization that becomes qualified through the open Integrated Employment Services procurement process and, as such, has demonstrated the experience and ability to successfully provide five components of supported employment programs, including Intake, Evaluation and Assessment, Job-Targeted Education and Skills Training Activities, Job Development and Placement, Initial Employment Supports and Ongoing and Interim Supports, as specified by the Executive Office of Health and Human Services (EOHHS) and to meet, at a minimum, the following requirements: Program: - Experience providing supported employment services to individuals with brain injuries. - Demonstrated experience and/or willingness to work effectively with EHS 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. 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 EHS and understand the principals of participant choice, as it relates to those with cognitive impairments.

			Quality: - Ability to meet all requirements for operating a high quality program, as specified by EHS or its designee; ability to provide program and participant quality data and reports, as 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 applicable state law, M.G.L. Ch. 6 Section 84, to protect the privacy and security of the participant's protected health information. MRC/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by MRC and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community-Based Employment Services Provider	Massachusetts Rehabilitation Commission	Every two years, or prior to utilization of service.

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 or ADL 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. This service may be delivered remotely via telehealth 100% of the time.

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		Adult Companion Provider Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Companion Provider Agencies			Any not-for-profit or proprietary organization that becomes qualified through the EOHHS open procurement 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 requirements for operating a high quality program, as specified by EHS 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. - Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 6 Section 84, to protect the privacy and security of the participant's protected health information. MRC/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by MRC and EOHHS officials. - 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 (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 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; ability to handle emergency situations, set limits, and communicate effectively with participants, families, other providers and agencies; and have the ability to meet legal requirements in protecting confidential information.
Individual Aide			Individuals who provide Adult Companion services must have become qualified through the MRC open procurement process and must meet requirements for individuals in such roles, including: having been CORI checked, have life or work experience providing services to individuals with disabilities; have the ability to handle emergency situations; set limits, and communicate effectively with participants, families, other providers and agencies; and have the ability to meet legal requirements in protecting confidential 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 applicable state law, M.G.L. Ch. 6 Section 84, to protect the privacy and security of the participant's protected health information. MRC/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by MRC and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Companion Provider Agencies	Massachusetts Rehabilitation Commission	Monthly review of participant progress reports by Case Manager with any issues reported to Case Manager Supervisor for follow-up. The Case Manager Supervisor meets with the agency staff twice a year. The agency will be reviewed every two years.
Individual Aide	Massachusetts Rehabilitation Commission	Case Manager will review participant Progress Reports on a monthly basis to identify any issues related to work of individual aide. In addition, Case Manager Supervisor will conduct a review of all information that may be aggregated related to individual aide performance to identify problems twice per year.

Service Specification
Service Type:
Other Service
Service:
Assistive Technology for Telehealth
☑ 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 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 participant to engage in telehealth. This service includes device installation and set up costs but excludes installation and set-up and ongoing provision fees related to internet service.

These devices are not intended for purely diversional/recreational purposes. When needed, this service includes technical assistance for the participant or where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and technical assistance for professionals or other individuals who provide services to or are otherwise substantially involved in the major life functions of participants. Assistive Technology for Telehealth must be authorized by the waiver Case Manager in the waiver Plan of Care. Only items not covered by the State Plan may be purchased through the Waiver.

Service only available if participant does not already have, or have access to, such a device.

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

$500 limit, every five years.

Participants may not receive devices through both the Transitional Assistance service and the Assistive Technology for Telehealth service. The Assistive Technology for Telehealth service evaluation includes identification of technology already available and assesses technology modifications or provision of a new device 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:
				Assistive Technology/Telehealth Provider Agencies
				Waiver Provider Agency

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Assistive Technology/Telehealth Provider Agencies			Any not-for-profit or proprietary organization that becomes qualified through the EOHHS open procurement process, and as such, has successfully demonstrated, at a minimum the following: Vendors must meet industry standards in the community. Providers shall ensure that individual workers employed by the agency who

			will have direct contact with waiver participants have been CORI checked, and are able to perform assigned duties and responsibilities. Providers of assistive technology for telehealth must ensure that all devices have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.
Waiver Provider Agency			Any qualified and enrolled Waiver Provider Agency may be authorized to purchase telehealth devices on behalf of a participant.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Assistive Technology/Telehealth Provider Agencies	MRC	Every two years, or prior to utilization of service
Waiver Provider Agency	MRC	Every two years, or prior to utilization of service

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 provide structured day activities tailored to the participant's specific personal goals and outcomes related to the acquisition, improvement, and/or retention of skills and abilities. 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 provide assistance to learn activities of daily living and functional skills; language and communication training; compensatory, cognitive and other strategies to compensate for functional limitations due to brain injury; interpersonal skills training; recreational/socialization skills training and skills training to negotiate and manage difficult or complex community relationships to prepare the individual to undertake various community inclusion activities. This service may reinforce, but not duplicate, 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/supports can be provided in a provider operated setting in the community, or, using a small group model, as individualized supports through a flexible array of community activities that promote socialization,

peer interaction, and community integration. This service is primarily delivered in person; telehealth may be used to supplement the scheduled in-person services 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.
Day Services do not duplicate any services under the State Plan.

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:
				Brain Injury Community Center
				Human Service Agency
				Rehabilitation Agency

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Brain Injury Community Center			Providers must be qualified under the Brain Injury Community Center RFR. Providers must demonstrate experience providing functional, community-based services and living skills training to persons with brain injuries, and understanding of the philosophy of maximizing independence, participant participation, community integration and a comprehensive blend of services for this population. Providers are required to have adequate organizational structure to support the establishment and delivery of day services, including: • Demonstrated ability to plan and deliver services in the day 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;

			• A staffing and training plan that demonstrates a team approach to service delivery including the ability to establish services that meet participant goals and objectives. Providers must have the ability to access relevant clinical support as needed. The provider will demonstrate experience recruiting and maintaining qualified staff; assurance that all staff will be CORI checked. Providers must meet all the requirements of the MRC Provider Manual. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 6 Section 84, to protect the privacy and security of the participant's protected health information. MRC/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by MRC and EOHHS officials.
Human Service Agency			Any not-for-profit or proprietary organization that becomes qualified through the EOHHS open procurement process, and as such, has successfully demonstrated, at a minimum the following: 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 to persons with traumatic brain injuries and understanding of the philosophy of maximizing independence, participant participation, community

			integration and a comprehensive blend of services for this population. - Demonstrated experience and/or willingness to work effectively with EHS 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: - Demonstrated 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. 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: - There is a team approach to service delivery - Program management and staff meet the minimum qualifications established by EHS and understand the principles of participant choice as it relates to those with cognitive impairments Quality: - Ability to meet all requirements for operating a high quality program, as specified by EHS or its designee; ability

			to provide program and participant quality data and reports. - Compliance with the licensure and certification standards of another Executive Office of Health and Human Services agency (or example Department of Development Services requirements at 115 CMR 7.00 & 8.00 or Department of Mental Health requirements at 104 CMR 28.00 Subpart B) may be substituted for the above qualifications. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 6 Section 84, to protect the privacy and security of the participant's protected health information. MRC/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by MRC and EOHHS officials.
Rehabilitation Agency			Any not-for-profit or proprietary organization that becomes qualified through the EOHHS open procurement process, and as such, has successfully demonstrated, at a minimum the following: 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 to persons with traumatic brain injuries and understanding of the philosophy of maximizing independence, participant participation, community integration and a comprehensive blend of services for this population.

			- Demonstrated experience and/or willingness to work effectively with EHS 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: - Demonstrated 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. 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: - There is a team approach to service delivery. - Program management and staff meet the minimum qualifications established by EHS and understand the principles of participant choice as it relates to those with cognitive impairments. Quality: - Ability to meet all requirements for operating a high quality program, as specified by EHS or its designee; ability to provide program and participant quality data and reports.

			- Compliance with the licensure and certification standards of another Executive Office of Health and Human Services (EOHHS) agency (or example Department of Developmental Services requirements at 115 CMR 7.00 & 8.00 or Department of Mental Health requirements at 104 CMR 28.00 Subpart B) may be substituted for the above qualifications. Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 6 Section 84, to protect the privacy and security of the participant's protected health information. MRC/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by MRC and EOHHS officials.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Brain Injury Community Center	Massachusetts Rehabilitation Commission	Annually
Human Service Agency	Massachusetts Rehabilitation Commission or other EOHHS agency. For providers licensed and/or certified by another EOHHS agency, MRC will verify the status of licensure annually.	Annually
Rehabilitation Agency	Massachusetts Rehabilitation Commission or other EOHHS agency. For providers licensed and/or certified by another EOHHS agency, MRC will verify the status of licensure annually.	Annually

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 participant's 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.

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:
	Architect/Designer		Architect/Design Agencies	
	Home Accessibility Adaptations Prover (Self-Employed)		Home Accessibility Adaptation Agencies	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
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 checked, and are able to perform assigned duties and responsibilities. Staff responsible for architectural drawings must be: Licensed architects, certified designers or draftsmen.
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 check, and must be able to perform assigned duties and responsibilities.
Home Accessibility Adaptations Prover (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, Plumbers license, etc.)
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		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

	(e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc.)		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.)

Verification of Provider Qualifications

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

Service Specification

Service Type:

Other Service

Service:

Shared Living - 24 Hour 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 Living - 24 Hour Supports is a residential option that matches a participant with a Shared Living caregiver. This arrangement is overseen by a Residential Support Agency. The match between participant and caregiver is the cornerstone to the success of this model. Shared Living is an individually tailored 24 hour/7 day per week, supportive service.

Shared Living is available to participants who need daily structure and supervision. Shared Living 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, protective oversight and supervision.

Shared Living integrates the participant into the usual activities of the caregiver's family life. In addition, there will be opportunities for learning, developing and maintaining skills including in such areas as ADL's, IADL's, social and recreational 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 Living agencies recruit caregivers, assess their abilities, coordinate placement of participant or caregiver, train and provide guidance, supervision and oversight for caregivers and provide 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 Living services. Participants may only receive one residential support service at a time.

Shared Living 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 living 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 Living 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	Residential Support Agency Provider employees must have a High School diploma, GED or relevant equivalencies or competencies.	Residential Support Agency Provider employees must possess appropriate qualifications as evidenced by interview(s), two personal or professional references and a Criminal Offender Records Inquiry (CORI), be age 18 years or older, be knowledgeable about what to do in an emergency; be knowledgeable about how to report abuse and neglect, have the ability to communicate effectively in the language and communication style of the participant, maintain confidentiality and privacy of the consumer, respect and accept different values, nationalities, races, religions, cultures and standards of living.

	governing Licensing and Operational Standards for Community Programs).		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Residential Support Agencies	Massachusetts Rehabilitation Commission	Annually, or prior to utilization of service.

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 (SME) 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 he/she lives; (c) items necessary for life support or to address physical conditions, including ancillary supplies and equipment necessary for 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 or home accessibility adaptations.
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 Assistive Technology Provider		Pharmacy	
			Assistive Technology Agencies	
			Qualified Business	
			Medical Equipment Suppliers	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Pharmacy			- Assessment, evaluation, training, and consultation on functional capacities and rehabilitation technology needs shall be performed by personnel trained and skilled in the application of rehabilitation technology and meeting applicable licensing or certification requirements of the Commonwealth of Massachusetts - 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 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			Assessment, evaluation, training, and consultation on functional capacities and rehabilitation technology needs shall be performed by personnel trained and skilled in the application of rehabilitation technology and meeting applicable licensing or certification requirements of the Commonwealth of Massachusetts. Individuals who provide Assistive Technology 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 whom provide services to or are otherwise substantially involved in

			the major life functions of individuals with disabilities.
Assistive Technology Agencies			- Assessment, evaluation, training, and consultation on functional capacities and rehabilitation technology needs shall be performed by personnel trained and skilled in the application of rehabilitation technology and meeting applicable licensing or certification requirements of the Commonwealth of Massachusetts - 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 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 whom provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.
Qualified Business			Meet applicable State regulations and industry standards for type of goods/services provided.
Medical Equipment Suppliers			- Assessment, evaluation, training, and consultation on functional capacities and rehabilitation technology needs shall be performed by personnel trained and skilled in the application of rehabilitation technology and meeting applicable licensing or certification requirements of the Commonwealth of Massachusetts - 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 specialized medical equipment and supplies must ensure that all devices and supplies have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Pharmacy	Massachusetts Rehabilitation Commission	Every two years, or prior to utilization of service.
Individual Assistive Technology Provider	Massachusetts Rehabilitation Commission	Every two years, or prior to utilization of service.
Assistive Technology Agencies	Massachusetts Rehabilitation Commission	Every two years, or prior to utilization of service.
Qualified Business	Massachusetts Rehabilitation Commission	Every two years, or prior to utilization of service
Medical Equipment Suppliers	Massachusetts Rehabilitation Commission	Every two years, or prior to utilization of service.

Service Specification
Service Type:
Other Service
Service:
Transitional Assistance
☑ Service is included in approved waiver. There is no change in service specifications. ☐ Service is included in approved waiver. The service specifications have been modified. ☐Service is not included in approved waiver.
Service Definition (Scope)**:**
Transitional Assistance services are non-recurring personal household set-up expenses for individuals who are transitioning from a nursing facility or hospital or other provider-operated living arrangement to a community living arrangement, where the participant is directly responsible for his or her own set-up expenses. Allowable expenses for Transitional Assistance services 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; (i) activities to assess the need for, arrange for and procure needed resources related to personal household expenses, specialized medical equipment, or community services; and (j) cell phones, tablets, computers, and ancillary equipment necessary for the operation of the devices that enable the individual to participate in telehealth. Transitional Assistance services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, are clearly identified in the service plan, and when the participant is unable to meet such expense or the services cannot be obtained from other sources. Transitional Assistance services do not include monthly rental or mortgage expenses; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. 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.

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. This service may be delivered remotely via telehealth 100% of the time.

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 his or her living arrangement. Home accessibility adaptations are limited to those which are initiated during the 180 days prior to discharge. FFP may not be claimed for this service until the participant is enrolled in the waiver.

Participants may not receive devices through both the Transitional Assistance service and the Assistive Technology for Telehealth service. The Assistive Technology for Telehealth service evaluation includes identification of technology already available and assesses technology modifications or provision of a new device 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:
				Qualified Business

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Qualified 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 applicable state law, M.G.L. Ch. 6 Section 84, to protect the privacy and security of the participant's protected health information. MRC/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by MRC and EOHHS officials.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Qualified Business	Massachusetts Rehabilitation Commission	Every two years.

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 Agency

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Transportation Provider Agency			Any not-for-profit or proprietary organization that becomes qualified through the Human Services Transportation Brokerage System, 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. Provider must have the ability to meet all requirements for operating a high quality program, as specified by EHS 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; 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 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
Transportation Provider Agency	EOHHS Transportation Office	Annually

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 172 and 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 contract review process. All providers of homemaking services to TBI waiver participants are contracted by MRC through the standard Executive Office of Elder Affairs Provider Agreement/Notice of Intent to Contract through which they agree to operate in compliance with specific terms and conditions including distinct requirements to comply with both criminal offender registry and patient abuse registry requirements. MRC will require all providers to certify annually that they have submitted CORI checks on all staff. MRC conducts provider monitoring and reviews documentation to ensure that agencies have completed criminal background checks as required.
○	**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 155.00 (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. Provider agency compliance with 105 CMR 155.000 is verified as part of the contract review process, as applicable. All providers of homemaking services to TBI waiver participants are contracted by MRC through the standard Executive Office of Elder Affairs Provider Agreement/Notice of Intent to

	Contract through which they agree to operate in compliance with specific terms and conditions including distinct requirements to comply with both criminal offender registry and patient abuse registry requirements. The MRC will ensure that the provisions of the regulation at 101 CMR 15.00, Executive Office of Health and Human Services, Criminal Offender Record Checks, are fully met by all entities to which the provisions are applicable. MRC will ensure that all other mandatory screenings are also performed by entities providing waiver services under contract to the Commission. MRC provider monitoring and reviews documentation that agencies have completed Abuse Registry Screening as required.
○	**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 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. The Commonwealth's Executive Office of Health and Human Services has a prequalification process (808 CMR 1.04) to determine the fiscal health of the provider. All providers must complete this process in order to qualify as a provider of waiver services. Providers must also be deemed qualified by MRC in order to provide services, by submitting an application that answers specific questions. Prospective providers find information regarding required qualifications, the provider application process, and other information related to the process of responding to open procurements online through the Massachusetts contracting system, CommBuys. As part of each open procurement, MRC provides information in response to any questions from prospective providers about qualification requirements and the application process.

MRC's standards ensure that waiver providers possess the requisite skills and competencies to meet the needs of the waiver target population. Any participant may choose from among qualified providers who meet both the state's prequalification and MRC service standards.

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:	QPa1. % of contracted waiver service providers required to maintain licensure/certification, in accordance with waiver specifications, that meet these specifications. Numerator: # of waiver service providers required to maintain licensure/certification that adhered to these specifications. Denom: # of licensed/certified waiver service providers scheduled for review during the reporting period.

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:*

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:	QPb1. % of non-licensed/non-certified waiver service providers that meet all provider qualification requirements specified in the waiver application. Num: # of contracted non-licensed/non-certified providers scheduled for review during the reporting period that demonstrate 100% compliance. Denom: # of contracted nonlicensed/non-certified providers scheduled for review during the reporting period.
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:*	
		Providers are reviewed on the schedule	☐ *Other Specify:*

		specified in Appendix C.		

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:*

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:	QPc1. % of providers of waiver services that conduct and/or participate in training in accordance with the State requirements. Numerator: The number of contracted waiver providers with documentation that staff attended required training. Denominator: The number of contracted waiver providers scheduled for review during the reporting period.
Data Source *(Select one) (Several options are listed in the on-line application):* **Training verification records**	
If 'Other' is selected, specify:	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

Prospective providers must submit documentation supporting their qualification for any service they are applying to provide. MRC's contracts department reviews and verifies the documentation along with the application to ensure that providers in fact meet all qualification standards as a requisite of contracting and prior to providing services.

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 (MRC) and MassHealth are responsible for ensuring effective oversight of the waiver program. As problems are discovered with management of the waiver program or waiver service providers, MRC and MassHealth 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 and MRC are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii Remediation Data Aggregation

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

c. *Timelines*

When the state does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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, Adult Companion, and Individual Support and Community Habilitation. The basis of the limit is to promote use of appropriate sets of services in this waiver—including, for example, that waiver participants who require services on a 24 hour basis appropriately access Residential Habilitation or Shared Living 24 Hour Supports. 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 from a facility setting or from a provider-operated community setting to the participant's own home, 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 habilitation setting. 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 residential services in the waiver, or to non-waiver community-based alternatives such as Adult Foster Care or Assisted Living Residences.

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 Rehabilitation Commission (MRC), an agency within EOHHS that has primary responsibility for day-to-day operation of the TBI waiver, completed systemic and site-specific assessment to ensure compliance of all waiver service settings with all applicable HCBS Community Rule requirements.

The MRC review and assessment process included: a thorough review of regulations, policies and procedures, waiver service definitions, provider qualifications and quality management and oversight systems to determine whether the systemic infrastructure was consistent with the principles of community integration; development of an assessment tool that borrowed substantially from the exploratory questions that CMS published; and review of existing residential and non-residential settings to determine if those settings met standards consistent with the federal HCB settings requirements.

Based upon the MRC review and assessment, all the 24-hour residential settings serving participants in the TBI waiver were determined to be in compliance with federal HCB settings requirements with the exception of having legally enforceable leases and entrance doors lockable by the resident of the unit, which have now been put into place.

MRC continues to monitor all residential settings through use of state agency staff who do not provide direct services to participants. This creates a conflict-free monitoring system. In addition, MRC staff conduct annual on-site compliance evaluations on an on-going basis and will work with providers as needed to maintain compliance.

All participants receive ongoing monitoring for all applicable settings rule requirements as part of the existing case management monitoring practices.

The case manager will maintain regular contact with the participant through a variety of means (e.g., in person, telephone, video-conferencing, text messaging, e-mail contacts, and/or other electronic modalities) as needed or requested by the participant, between meetings. Every participant has an in-person meeting at least annually which must take place in the participant's home.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Plan of Care

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

☐	**Registered nurse, licensed to practice in the state**
☐	**Licensed practical or vocational nurse, acting within the scope of practice under state law**
☐	**Licensed physician (M.D. or D.O)**
☐	**Case Manager** (qualifications specified in Appendix C-1/C-3)
☑	**Case Manager** (qualifications not specified in Appendix C-1/C-3). *Specify qualifications*:
	Case Managers 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; experience working with individuals with brain injuries is strongly preferred.
☐	**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 participant and facilitated by a 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. 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. Case Managers must be aware of all services available through the waiver, 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, in addition to the participant, 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 document.

The Case Manager has a discussion with the participant 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);
- The participant's desired role in the service planning meeting, including whether the participant wishes to lead the meeting;
- What resources the participant requires to lead or participate as the participant desires in the service planning meeting;
- Identification of the person's goals, strengths, and preferences regarding services and 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 his or her 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 he or she wishes to be part of the service planning process. The Case Manager is responsible for arranging any resources that the participant may require to lead or otherwise meaningfully participate in the service planning meeting. 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 his (or her) 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.

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 follow standard procedures and time frames in performing the intake, assessment, case conferencing, service planning and review processes 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 POC development processes. Through the person-centered planning process and using a state-approved tool, the service needs assessment will gather 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. This includes the opportunity to seek employment, engage in community life and control personal resources. The service needs assessment reflects the living 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 assessment and person-centered planning process address functional domains that reflect the participant's current status and goals/objectives, including the following:

- General Health and Medical management, including medications
- Activities of daily living and personal care supports needs
- Assistive technology and adaptive equipment needs
- Personal goals
- Community living and integration skills
- Day services/programming
- Leisure/Recreational activities

- Vocational/Avocational activities
- Behavior management needs, as appropriate
- Social/Family activities

The service needs assessment process may, as appropriate, include an initial neuropsychological assessment to evaluate cognitive function, neurobehavioral status and other cognitively-based functional needs. Other assessments may include medical/skilled nursing, rehabilitation and/or a psychopharmacology review.

The initial 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 neuropsychologist, registered nurse, psychiatrist or therapist, for further assessment and identification of needs.

Linked to the participant's vision, goals and needs, the Case Manager facilitates development of the Plan of Care with the participant. The Participant, his/her guardian and other formal and informal supports identified by the participant are part of the Team. This may include providers with knowledge and history of serving the participant. The Case Manager is responsible for providing information and referral to non-waiver services and supports to address identified needs, coordinating and communicating service plans and changes to appropriate community agencies and ensuring that waiver participants have access, as eligible, to other public benefits and other community services.

The Case Manager's responsibilities include: facilitating the service planning process with the participant and his/her guardian, as appropriate, ensuring the final plan is agreed to and signed by the participant and addresses his or her expressed and assessed needs. The Case Manager is also responsible for monitoring the participant's satisfaction with the plan and assisting to ensure the participant receives the services in the plan. Additionally, the Case Manager ensures notification to participants/guardians, facilitates subsequent monitoring meetings, and meets routinely with the participant to assess the participant's progress towards identified goals. As needed or as requested by the participant, the Case Manager makes changes to the POC. The Case Manager ensures that the participant receives a copy of the signed POC.

During the service planning process and development of the POC, the Case Manager utilizes the state-approved person-centered needs-assessment tool to elicit the participant's goals and service preferences, and to help the participant identify team members. The Case Manager explains programs and services to the participant/guardian and assists him or her in selecting an array of services which address the participant's needs and expressed goals. These services will include waiver services and may include Medicaid state plan services and other supports, both formal and informal. 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 participant, or his/her legal guardian, is not English, the information in service plans must be translated into his/her primary language, including ASL, and explained with the assistance of an interpreter. If the participant is unable to read or exhibits other cognitive deficits (e.g., memory disorder) which may compromise his/her response to the service plan, and he or she does not

have a guardian, alternative methods (e.g. audio-taping) shall be utilized in order to ensure that the information is cognitively accessible.

A POC that has been signed by the participant/guardian is required in order for the Case Manager to initiate authorization of waiver services. The Case Manager is responsible for maintaining the Plan of Care in the client record, and for periodically reviewing it with the participant and making modifications as needed. The participant will receive, at a minimum, a quarterly visit by the Case Manager. These may occur in person, or via telephone or video-conference. The Case Manager may determine that more frequent visits would be beneficial and visit the participant more frequently if he/she agrees. In addition, if the Case Manager becomes aware of changes in the participant's health condition or living circumstances, he or she 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 (e.g., in person, telephone, video-conferencing, text messaging, e-mail contacts, and/or other electronic modalities) with the participant between the quarterly visits. The POC may be revised at any point by the Case Manager with 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 to ensure the provision of any reasonable accommodations needed for the participant's and, as appropriate, the family's involvement in the service planning meetings. Accommodations may include personal care assistants, interpreters, translators, physical accessibility, assistive devices, and transportation. These needs may be coordinated and accessed through a waiver service provider involved with the participant.

Positive Behavioral Supports

Behavioral assessment and the development of a positive behavioral support plan may be necessary to address the neurobehavioral/neuropsychiatric consequences of brain injury, which are related to the etiology, localization and severity of the injury. For certain individuals, neurobehavioral symptoms may be complicated by a history of substance abuse, pre-morbid psychiatric disorder, seizure disorder, and/or post-traumatic stress disorder (PTSD).

Those participants who have identified behavioral health needs should undergo an initial behavioral assessment and periodic reviews. Should a positive behavioral 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, his or her guardian.

Positive behavioral support plans must always be cognitively accessible and must be reviewed with and signed by the participant.

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 annual service planning process. The assessment and planning process informs the development of plans to address participants' daily needs, medical or behavioral health emergencies, as well as public disaster situations (e.g., flooding, severe weather, etc.). Case managers work with participants to identify services or other supports to mitigate potential risk areas identified through the assessment process. This information is documented in a formal back-up plan that is agreed to by the participant, included in the individual's service plan, and reviewed and updated annually. Case managers work with the participant's service providers to ensure that the identified risks are appropriately managed consistent with the service plan.

In addition to the development of the formal back-up plan as part of each participant's annual service planning process, providers of residential supports are required to have policies and procedures in place to address their:
- Risk assessment processes
- Emergency response and management protocols
- Emergency evacuation safety plans
- Participant elopement from the program

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 care planning 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 provider best able to meet the requirements and preferences of the waiver participant. The participant ultimately chooses which providers from among those available in his/her geographic area will deliver his/her 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 seek assistance from the Case Manager, should the participant seek the Case Manager's assistance with a provider issue, and how to raise issues with the Case Manager Supervisor if he/she wishes to change Case Managers or has 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 Plan of Care 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):

Case Managers will maintain electronic records for all participants. These files are subject to sample reviews by MRC. A random sampling method will be utilized to identify waiver participants for review. The sample size is intended to meet requirements of a 95% confidence interval and a +/-5% confidence level. Case Manager Supervisors at MRC will conduct retrospective reviews of assessment data and service plans for the participant's Plan of Care annually to ensure that plans are developed in accordance with applicable policies and procedures and that plans ensure the health and welfare of waiver participants. This monitoring and oversight activity ensures that service plans for waiver participants are consistent with all

applicable safeguards and standards of care. Summary findings from these reviews are reported by MRC to MassHealth on an annual basis.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

○	**Every three months or more frequently when necessary**
○	**Every six months or more frequently when necessary**
☑	**Every twelve months or more frequently when necessary**
○	**Other schedule** *Specify the other schedule*:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies)*:

☑	**Medicaid agency**
☐	**Operating agency**
☑	**Case manager**
☐	**Other** *Specify:*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The 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 service plan, 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, his/her Care Plan Team, and other service providers as appropriate.

The participant will, at a minimum, meet quarterly with the case manager. The case manager may determine that more frequent meetings would be beneficial and meet with 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 meet with the participant. In addition, the case manager will maintain regular contact with the participant through a variety of means (e.g., in person, telephone, video-conferencing, text messaging, e-mail contacts, and/or other electronic modalities) as needed or requested by the participant, between meetings. The frequency and method used to engage with participants based on their preferences will be documented in the participants' electronic records. Contact requires a response from the participant, guardian or other specified family member in order to be considered monitoring. Every participant has an in-person meeting at least annually which must take place in the participant's home. The service plan may be revised at any point by the case manager with the participant, based on changes in the participant's needs or circumstances.

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 identification of community supports and strategies as preferred by the participant to minimize these risks while ensuring maximum opportunities for self-sufficiency. One outcome of the risk assessment is the development of a back-up plan. Back-up plans vary by person to reflect their unique circumstances and supports. Individuals and families are provided with this information, in an accessible format, to ensure they know who to contact in an emergency situation.

As described in Appendix G, Case Managers are notified by providers, family, participants, and the informal supports of an individual of incidents that occur for individuals on their caseload. Pursuant to MRC's Incident Reporting requirements, Case Managers or supervisors are required to review and approve action steps taken by the

reporting provider to address such incidents. Reported incidents may not be closed until such time as action steps have been approved.

As part of ongoing case management supports, utilization of back-up plans is reviewed quarterly with each participant to ensure that they continue to be current as well as effective and accessible. In addition, through the review of service plans, the Case Manager Supervisor reviews back-up plans and corresponding case log notes and/or incident data to further assess the effectiveness of back-up plans.

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.

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 meeting and contact, the Case Manager will inquire as to the participant's satisfaction with both the services included in their service plan and the service providers. The participant has free choice of service providers and may, at any time, request a change of service providers.

b. Monitoring Safeguards. *Select one:*

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

Quality Improvement: Service Plan

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

a. **Methods for Discovery: Service Plan Assurance**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-assurances:

a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

i. Performance Measures

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

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

Performance Measure:	SPa2. Service plans are individualized and reflect participants' goals. Numerator: The number of waiver participants' files reviewed indicating that a service plan is individualized and reflects their goals. Denominator: The total number of waiver participants.
Data Source *(Select one) (Several options are listed in the on-line application):* **Record review, on-site**	
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:	SPa1. The Case Manager completes an approved needs assessment tool for all waiver participants. Numerator: The number of waiver participants with approved needs assessment completed. Denominator: Total number of waiver participants.
Data Source *(Select one) (Several options are listed in the on-line application):* **Records reviews, on-site**	
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:	SPa3. Service plans are individualized and reflect participants' identified needs, as outlined in the needs assessment tool, either through waiver or non-waiver services. Numerator: The number of waiver participants' files reviewed indicating that a service plan is individualized and reflects their identified needs. Denominator: The total number of waiver participants.
Data Source *(Select one) (Several options are listed in the on-line application):* **Records reviews, on-site**	
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 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. Remove QM System if no longer needed.
Data Source *(Select one) (Several options are listed in the on-line application):*	
If 'Other' is selected, specify:	

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
☐ *State Medicaid Agency*	☐ *Weekly*
☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
☑ *Other Specify:*	☐ *Annually*
No longer needed	☐ *Continuously and Ongoing*
	☑ *Other Specify:*
	No longer needed

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

c. Sub-assurance: 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:	SPc1. % of service plans that are completed and/or updated annually. Numerator: Number of waiver participants with documented review/update of service plan within past year. Denominator: Total number of waiver participants.
Data Source *(Select one) (Several options are listed in the on-line application):* **Record reviews, on-site**	
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:	SPc2. % of service plans updated when warranted by changes in participants' needs. Numerator: Number of service plans updated when needs change. Denominator: Number of participants reviewed with changing needs.
Data Source *(Select one) (Several options are listed in the on-line application):* **Record reviews, on-site**	
If 'Other' is selected, specify:	

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

	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☑ *Representative Sample; Confidence Interval =*
	☐ *Other Specify:*	☑ *Annually*	95%, +-5 & 50/50
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

i. Performance Measures

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

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

Performance Measure:	SPd1. % of participants who are receiving services according to the type, amount, frequency, duration and scope identified in their plan of care. Numerator: Number of participants who are receiving services according to the type, amount, frequency, duration and scope in their plan of care. Denominator: Total number of waiver participants.
Data Source *(Select one) (Several options are listed in the on-line application):* **Record reviews, on-site**	
If 'Other' is selected, specify: **Service plan data in participant record and service delivery data submitted by waiver service providers**	

	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)

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:	SPe1. Waiver participants are aware of all services available through the waiver and receive a listing of the available providers as indicated by their signature on TBI Service Listing acknowledgement form. Numerator: The number of waiver participants' records that contain a signed acknowledgement form. Denominator: Total number of waiver participants.
Data Source *(Select one) (Several options are listed in the on-line application):* **Record reviews, on-site**	
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.

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 (MRC) and MassHealth are responsible for ensuring effective oversight of the waiver program. As problems are discovered with management of the waiver program or waiver service providers, MassHealth/MRC 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 and MRC are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii. Remediation Data Aggregation

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

c. Timelines

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

☑	**No**
○	**Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

○	**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
☑	**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○	**Yes. The state requests that this waiver be considered for Independence Plus designation.**
○	**No. Independence Plus designation is not requested.**

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

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:

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*

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.

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:

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	Budget

	Authority	Authority
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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:	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
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:*

	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:*
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.	

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:*	
☐	**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:*	

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:

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.

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		
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**)**		

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 TBI 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 TBI Waiver; (3) there is a denial, suspension, reduction or termination of services, including a substantial failure to implement the services contained in their Plan of Care, within the terms and conditions of the TBI 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 a 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 TBI 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).

State:	
Effective Date	

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 policy requires that a formal Incident Report must be filed in response to any significant injury, medical, medication, or behavioral/psychiatric event involving an individual participating in any service and/or program providing TBI Waiver services. Through the provider qualification process, MRC ensures that all providers are aware of and responsive to this policy.

In addition to sending the completed Incident Report to MRC, provider staff must immediately contact MRC by phone or by email (with a written Incident Report to follow within 24 hours) in the event of any of the following types of incidents:

a. Unresolved elopement from a program
b. Events which result in the necessity to report alleged abuse/neglect—including any use of restraints or seclusion, or any unauthorized use of restrictive interventions—of a waiver participant or others
c. Event involving law enforcement
d. Hospitalization (psychiatric or medical) of a participant
e. Death of a participant
f. Relocation or evacuation of residents

For b) and e) above, providers are also mandated to contact either the Disabled Persons Protection Commission (DPPC) or the Executive Office of Elder Affairs Elder Protective Services program and report the incident.

Upon receipt of an Incident Report related to any of the types of incidents identified above, MRC staff, i.e. staff designated to receive such reports or Case Managers, must respond as follows:

- Notify supervisor or designee by the next business day following receipt of the Incident Report.
- Review and respond to the provider within three business days.
- Supervisors will review and approve or require revisions of the Incident Report, including the Case Manager's recommendations on the provider's follow-up action/safety plans, within three business days following notice of a report ready for supervisory review.
- The Case Manager will work with the provider to ensure that action/safety plans address and resolve all needed follow up.

Providers must report all other incidents to MRC via completed incident report form within five days of the occurrence of the incident, including weekends and holidays. Upon receipt of Incident Reports for such other types of incidents, MRC Case Managers or other staff designated to receive such reports must respond as follows:

- Review and respond to the provider within five business days of receipt of the report.
- Notify Supervisor of receipt of Incident Report within three business days after the report is received.
- The Case Manager will work with the provider to ensure that action/safety plans address and resolve all needed follow up.

In addition to MRC's incident reporting requirements, all instances of suspected or substantiated abuse, neglect, or exploitation of waiver participants are referred to the respective investigative body as appropriate based on the participant's age. Any instances of suspected or documented abuse for participants under age 60 or any individuals living in group settings are referred to the Disabled Persons Protection Commission (DPPC). Instances of suspected or documented abuse or neglect by a paid or unpaid caretaker of participants age 60 and over who are living independently or with family are referred the Executive Office of Elder Affairs (EOEA) Elder Protective Services program. In addition, local law enforcement authorities are contacted as needed based on the nature of the incident, for example a participant's unresolved elopement from a waiver residential habilitation program, or episodes of threatened or actual significant aggression to or by a waiver participant directed at staff or others participating in the program.

MRC is responsible for monitoring trends and patterns in incident reports and, as appropriate, conducting administrative review processes of providers related to incidents involving waiver participants.

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 exploitation as well as the appropriate agency to whom they should report allegations of abuse, neglect and exploitation. Individuals and their families are given this information both verbally and in writing, in a form and format accessible by the participant.

In addition, as part of their role, MRC Case Managers also inform individuals about how to report alleged cases of abuse, neglect and exploitation. Hotline phone numbers are given to all waiver participants and are posted in all residential programs for the participant or family member/guardian to use to report abuse, neglect and exploitation. Discussion and training on reporting abuse, neglect and exploitation with the participant/guardian is part of the annual care planning process. The Plan of Care document includes a section for the individual/guardian to sign, documenting that they have been informed about and understand how to report abuse, neglect and exploitation. The TBI training manual includes information regarding reporting abuse, neglect and exploitation, and instructions for staff on how to provide annual education to waiver participants/guardians. This includes:

- Discussion with participants/guardians regarding abuse,neglect and exploitation in clear, accessible language.
- Reviewing with waiver participants/guardians what sorts of actions could be considered physical, emotional or financial abuse.
  - Examples are provided of abuse, neglect and exploitation.
  - Participants/guardians are encouraged to ask questions, and to discuss concerns.
- Discussion with waiver participants/guardians what actions may be considered neglectful, including examples of neglectful behaviors and, for example, an explanation of the term omission.

Participants/guardians are provided with phone numbers to report suspected abuse, neglect and exploitation.

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 the review of incidents and for managing the appropriate response of the various providers.

When an incident report is sent into MRC, the Case Manager reviews the report as does the Case Manager's supervisor. Depending on the nature of the incident it may also be reviewed by a neuropsychologist. The report is entered into the MRC Incident Reporting System by the Case Manager. It is the responsibility of the Case Manager, and the Case Manager's supervisor, to review the Incident Report to ensure that immediate actions have been taken to protect the participant. In addition, any incident of the following type is escalated to the Statewide Head Injury Program (SHIP) Director for review and to ensure referral to the appropriate investigative bodies, as described in G-1-b:

a. Unresolved elopement from a program
b. Events which result in the necessity to report alleged abuse/neglect of a waiver participant or others
c. Event involving law enforcement
d. Hospitalization (psychiatric or medical) of a participant
e. Death of a participant
f. Relocation or evacuation of residents

Case Managers are to inform their supervisor immediately upon receipt of an incident report; supervisors will check the MRC Incident Reporting System weekly to ensure that all incident

reports have been reviewed and all necessary actions taken to ensure participant safety. The SHIP Director will review the MRC Incident Reporting System to ensure that supervisory review has occurred. Incident Reports are considered closed only after all necessary action steps are taken and all required reviews and approvals are completed.

For those participants between the ages of 18 and 59, incidents that must be reported to the Disabled Persons Protection Commission (DPPC), i.e. allegation of abuse or neglect, potentially subject to investigation, are reported to 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 may then refer the case to the appropriate agency for investigation. DPPC can decide the incident does not warrant investigation, or to conduct the investigation itself, refer the case to the MRC or another EOHHS agency for investigation, or refer the case to law enforcement entities as the circumstances require. If a report 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 or neglect are processed by trained, experienced staff at DPPC. When deemed necessary, immediate protective services are put into place 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 with DPPC. 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 supervisor and SHIP Director will conduct 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.

Within EOHHS, MRC is responsible for the oversight of the reporting of and response to all incidents or events that affect waiver participants. Incidents are addressed and reported as they occur by MRC to EOHHS in accordance with EOHHS policies and procedures for such reporting. As noted in Appendix A Section 2, staff within EOHHS, from MassHealth and MRC, meet at least monthly. MRC will monitor and exercise ongoing supervision of Case Managers and oversight of waiver service providers, in relation to all incidents and events. Oversight of the incidents occurs on three levels: the individual, the provider and the system. 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 will oversee incident reports in order to discern and track patterns and trends by location and provider. MRC will undertake such review on a quarterly basis. On a systems level, MRC will track patterns and trends in order to make service, as well as policy and procedural improvements and to update provider requirements. Incident report data is aggregated and trends information is used to identify systemic issues requiring remediation. Remediation actions are addressed immediately, as appropriate, and incorporated into the annual standard contract review with providers and performance based objectives.

Quality management standards will incorporate quality improvement measures related to the oversight, monitoring, and remediation of critical incident patterns.

The MRC Community Living Division has a Mortality Review Team (MRT) which screens all deaths to determine if further review or investigation is warranted. The MRC MRT will aggregate and systemically review data to identify commonalities among participant deaths, identify changes that may reduce the risk of mortality in the future and enhance the quality of care/support for the population as a whole; and, take statewide actions based on mortality information to improve care. All deaths of TBI Waiver participants must be reported to the MRT.

An MRC Death Report is completed by MRC Community Living (CL) program staff and submitted to the Mortality Review Team Coordinator and to MRC Legal Counsel. MRT meetings will be held quarterly.

For deaths of all TBI waiver participants, the Mortality Review Team will review the entire case record including case notes, medical documents, service plans/plans of care, any and all Incident Reports if applicable, and any other pertinent information specific to the individual and their life and death. The MRC Director of Protective Services will contact DPPC to determine if there is an ongoing investigation and/or prior history. If DPPC determines an incident does not warrant investigation, i.e. screens it out, and MRC discovers any relevant information during its review that may require further investigation,, MRC will send that information to DPPC for their consideration. All of this information will be used to inform the MRC review process and help to formulate any recommendations for systems improvement if trends are noted. The Mortality Review Team will consider whether there are any unanswered questions related to the death and request additional information if necessary. They will determine whether to close the case or recommend further action, e.g. Corrective Action Plan (CAP). However, when there is an open DPPC investigation, MRC will keep the case in pending status awaiting any additional information that may guide its final conclusions and actions. The mortality review process will be documented including any findings or recommendations, and a final report will be completed.

Trend Analysis:
The MRT will review the tracking data by cause of death and by provider on a quarterly basis. Analysis of data may identify trends such as deaths due to potentially preventable causes, etc. This review may result in systems improvements and actions such as revisions of training practices or additional training for direct care staff, the development and dissemination of clinical guidelines, and/or the development of an action plan to reduce or eliminate the likelihood of such issue reoccurring. MRC submits to MassHealth an annual Mortality Report to support identification and tracking of trends.

MRC oversees and tracks the reporting of all medication occurrences for each residential program, aggregates the data and identifies trends on a monthly, semi-annual and annual basis. If specific and/or systemic issues are identified, MRC staff intervenes to clarify procedures and require adjustments in operations. If necessary, MRC develops and monitors adherence to corrective action plans on an individual provider and program basis. MRC has instituted a provider self-monitoring process and requires that providers conduct periodic audits to review their internal operations, methods, and systems of medication administration. MRC submits an annual report on medication occurrences to MassHealth.

MRC will track incident reports in order to discern patterns and trends by location and provider. MRC will undertake such review on a quarterly basis. On a systems level, MRC will track

patterns and trends in incident report data to make improvements to service provision, agency policy and procedures and provider requirements.

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 is allowed in the TBI waiver, thus, all such use is unauthorized. While extremely rare, the unauthorized use of a restraint must be reported by providers pursuant to MRC's Incident Reporting requirements. Providers must also report these incidents to DPPC or Elder Protective Services, as appropriate depending on the age of the participant involved. Regulations requiring investigation of all reports of abuse and neglect and mistreatment, 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), 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements) and 651 CMR 5.00 et seq (Elder Abuse Reporting and Protective Services Program). In addition, as noted above, MRC's Incident Reporting requirements are utilized to identify systemic as well as isolated issues, which would include unauthorized use of restraint, within the service system serving TBI Waiver participants. Review of data reported on incidents provides Case Managers and supervisors with information that is used to detect unauthorized use of restraints.
○	**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 Residential Habilitation, Shared Living and Day Programs. MRC requires that any interventions designed to modify behavior in these 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.

As an example, when a participant is prone to wandering and there are concerns for the participant's safety, MRC would review the idea of placing an alarm on a door to alert staff when that specific participant, who has been given a wander alert bracelet, leaves the residence.

MRC has important safeguards pertaining to restrictive interventions. In those cases where a restrictive intervention is included in a participant's plan of care, a positive behavioral support plan will be developed and overseen by a licensed clinician with expertise in behavioral supports and management. Positive behavioral support 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 that may be employed, 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 participant's positive behavioral support 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 three waiver services, the Massachusetts Rehabilitation Commission has the primary responsibility for the monitoring and oversight of policy compliance and restrictive interventions. In addition to the previously mentioned reviews by the treating clinician, the care plan team, and the provider's 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 any restrictive interventions and/or any behavior plans are being appropriately implemented by the provider, documented 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 any restrictive interventions and/or any behavior plans must be reported.

3. An individual's need for, and type of, restrictive interventions are reassessed at least annually or more often if the need arises or if requested by the individual or guardian. DPPC receives, through protective service reports or provider complaints, reports of unauthorized use of restrictive interventions for participants served through the TBI Waiver. Regulations requiring investigation of all reports of abuse and neglect and mistreatment, 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 is utilized to identify systemic as well as isolated issues, which would include unauthorized use of restrictive interventions, within the service system serving TBI Waiver participants. Review of data reported on incidents provides Case Managers and supervisors 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 seclusion is allowed in the TBI waiver, thus, all such use is unauthorized. While extremely rare, the unauthorized use of seclusion must be reported by providers pursuant to MRC's Incident Reporting requirements. Providers must also report these incidents to DPPC or Elder Protective Services, as appropriate depending on the age of the participant involved. Regulations requiring investigation of all reports of abuse and neglect and mistreatment, which would include the unauthorized use of seclusion may be found at 118 CMR 5.00 (Regulations for the state's Disabled Persons Protection Commission [the Commission] that define the requirements for abuse investigations conducted by the Commission and the review and oversight standards to be used by the Commission), 105 CMR 155 et seq (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements) and 651 CMR 5.00 et seq (Elder Abuse Reporting and Protective Services Program). In addition, as noted above, MRC's Incident Reporting requirements are utilized to identify systemic as well as isolated issues, which would include unauthorized use of seclusion, within the service system serving TBI Waiver clients. Review of data reported on incidents provides Case Managers and supervisors with information that is used to detect unauthorized use of seclusion.
○	**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix 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 waiver participants in Residential Habilitation settings the responsibility for monitoring medication regimens is a joint one between providers and MRC staff (specifically, case managers, Medication Administration Program (MAP) coordinators and the MAP Director).

MAP is a DPH (Department of Public Health) program that ensures standardized and safe medication administration in community programs. MAP requirements are outlined in 105 CMR 7.00 (Implementation of M.G.L. c. 94C). As outlined in 105 CMR 700.003 (E). each location, or home must be a Massachusetts Controlled Substances Registered (MCSR) site. This registration is issued by the MA DPH.

MRC requires staff of Residential Habilitation providers to be trained in medication administration through the Medication Administration Program (MAP). All non-licensed provider agency staff who administer medications must be MAP trained and certified. MAP is a comprehensive program After completion of the training by an Approved MAP Trainer, Provider staff are given a knowledge test and a skills test by a third-party tester to evaluate their competency to administer medications. Once they pass all components of the test, they are certified and authorized to administer medications in MAP registered sites for 2 years. After 2 years they are retested and recertified. Proof of MAP certification for all staff that administer medication is maintained at the program by provider management.

Provider agency staff monitor the use of medication and side effects on an on-going basis. MRC nurses are available for consultation and support to MRC Case Managers and /or providers when there are questions or concerns about prescribed medications. Provider agency nurses are also available to the care team. Direct support professionals are educated about the purpose and side effects of the specific medications individuals they are supporting are taking and report any issues to the appropriate supervisory and consultant personnel.

As part of the MAP administration and oversight process, MRC provides ongoing oversight and quality management for each residential habilitation provider, including the review of medication records and documentation of physician orders, the dispensing of medications and the assessments of the relative independence of each resident in self-administration. MRC oversight includes monitoring of the physical management of medications, including locking and storage of all medications. MRC oversees and tracks the reporting of all medication occurrences for each residential program, aggregates the data and identifies trends by residential programs as well as system-wide on a quarterly basis or more frequently

if needed. If specific issues are identified, staff intervenes to clarify procedures and requires adjustments in operations. If necessary, MRC develops and monitors adherence to corrective action plans on an individual provider and program basis. MRC instituted a provider self-monitoring process and ensures that providers conduct periodic audits utilizing professional/nursing staff from elsewhere within the provider organization, if available, to review their internal operations, methods, and systems of medication administration. MRC MAP Coordinators conduct annual audits at each home, and are also available to assist providers with compliance issues as needs arise.

MRC requires Shared Living Placement Agencies to have a system in place for oversight of medication administration in each shared living home. The Shared Living Placement Agencies must demonstrate that it has an effective mechanism to monitor and oversee medication administration for Shared Living provider homes. MAP training is strongly encouraged. Shared Living providers must be able to demonstrate that they have a system in their home to assure that there are current health care provider orders, side effect information, labeled pharmacy containers, safe storage of medications, and a process to track and document administration of medications.

Shared Living Provider Agencies do monthly site visits of shared living homes to monitor compliance with regulatory requirements and review medication administration. As a part of the MRC case manager visits to the homes, they review both the system that the Shared Living Provider Agency has in place to monitor medication administration as well as reviewing the individual shared living home to assure that medication is being correctly administered and monitored. Nurses at MRC are available to case managers and providers for consultation if any concerns arise .

When receiving Respite services waiver participant medication management is overseen by the entity that certifies or licenses the respite care setting. Medication management responsibilities fall under the Department of Public Health for Hospitals and Skilled Nursing Facilities. Adult Foster Care providers are overseen by MassHealth. Assisted Living Residences are certified by the Executive Office of Elder Affairs and DDS Respite Facilities are licensed by the Department of Developmental Services. 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), 130 CMR 404.000 (MassHealth Adult Day Health 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), 115 CMR 7.00 and 8.00 (Department of Developmental Services regulations that describe the requirements for all DDS supports and services provided by public and private providers 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), MGL c. 94C (the Massachusetts Controlled Substances Act) and MGL c. 112 s. 74 and 74A (which address the regulation of certain professions).

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.

MRC is the state agency responsible for the oversight, monitoring, identification of issues/concerns, and follow up to ensure correction of such issues related to medication management and administration in residential habilitation and shared living services. MRC staff maintains regular contact with provider residential habilitation and shared living programs to review medication procedures, operations, records, documentation of administration if relevant, and of client assessments, and the storage and security of the medications. The MRC Incident Reporting process and requirements capture all information related to medication errors and occurrences; and MRC routinely reviews all incidents, tracks the reporting of all medication occurrences for each residential habilitation and shared living program, aggregates data captured on medication incidents, and identifies any adverse trends on a provider-by-provider basis. Specific issues are identified and corrective action enforcement is undertaken, as necessary.

MRC employs a MAP administrator and MAP coordinators to oversee the specialized program. MRC MAP Coordinators conduct yearly and as needed MAP Audits for all MRC MAP registered residential sites. Oversight and follow up in MAP registered settings are conducted in accordance with DPH MAP Policy.

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), 130 CMR 404.000 (MassHealth Adult Day Health 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), 115 CMR 7.00 and 8.00 (Department of Developmental Services regulations that describe the requirements for all DDS supports and services provided by public and private providers 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), 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 is allowed in Residential Habilitation, Shared Living and Respite settings that are funded and supported by MRC.

In Residential Habilitation settings, the state medication administration program (MAP) is implemented by MRC and overseen by the Department of Public Health as outlined in 105 CMR 7.00 (Implementation of M.G.L. c. 94C). The MAP program provides for the registration of locations where medication is administered by non-licensed certified staff, identifies the requirements about storage and security of medications, defines the specific training and certification requirements for non-licensed staff, and specifies documentation and record keeping requirements.

Residential Habilitation sites are required to obtain a site registration from DPH for the purpose of permitting medication administration by MAP certified staff and the storage of medications on site.

Direct support professionals, including licensed nurses working in positions that do not require a nursing license, must be MAP certified in order to administer medications. MAP certification is valid for two years. Staff must be re-certified every two years. In order to be certified, staff must be trained by an Approved MAP Training using the approved training curriculum of a duration not less than 16 hours, including classroom/online hybrid instruction, testing and a practicum. Trainers must be a registered nurse, nurse practitioner, physician assistant, registered pharmacist or licensed physician who meets applicable requirements as a trainer. Individuals must pass a test consisting of three distinct components (written knowledge, transcription and medication administration) in order to be certified to administer medications.

Re-certifications must be done by an approved MAP trainer. MAP certified staff and providers must maintain proof of current MAP certification at the program. An individual's certification may be revoked for cause, after an informal hearing process.

Providers are required to adhere to a strict set of standards with respect to storage of medications, documentation of medication counts at the start and end of each shift, labeling of medications and documentation of medication administration for each individual.

Oversight of the medication administration program is conducted by nurses within provider programs as well as the MRC MAP Director, MRC MAP Coordinators, who are registered nurses, consistent with the Department of Public Health clinical review process.

Shared Living Provider Agencies must be able to demonstrate that they have a system in their home to assure that there are current health care provider orders, side effect information, labeled pharmacy containers, safe storage of medications, and a process to track and document administration of medications.

Shared Living Provider Agencies do monthly site visits of shared living homes to monitor compliance with regulatory requirements and review medication administration. As a part of the MRC case manager quarterly visits to the homes, they review both the system that the Shared Living Provider Agencies has in place to monitor medication administration as well as reviewing the individual shared living home to assure that medication is being correctly

administered and monitored. Nurses at MRC are available to case managers and providers for consultation if any concerns arise .

Self-administration: An individual is determined to be self-administering when the medication is under the complete control of the individual with no more than minimal assistance from program staff. The ability to self-administer medication is determined in conjunction with the individual's care plan team as part of an assessment process. If the individual is determined to be capable of learning to self-administer medication, a teaching plan is developed and documented as part of the service planning process. Once an individual is determined to be self-administering, an oversight system is developed with built in review periods of at least every 3 months. An individual's ability to continue to self-administer medication is reviewed in conjunction with the annual service planning process. Self-administration is applicable to individuals in both Residential Habilitation and Shared Living.

State oversight and follow-up of medication administration in respite settings 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), 130 CMR 408.000 (MassHealth Adult Foster Care regulations that define provider eligibility requirements and program rules), 130 CMR 404.000 (MassHealth Adult Day Health 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), 115 CMR 7.00 and 8.00 (Department of Developmental Services regulations that describe the requirements for all DDS supports and services provided by public and private providers 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), 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:
	Residential Habilitation Providers are required to file medication occurrence reports to MRC via the Incident Reporting System within 24 hours. A DPH MOR (Medication Occurrence Report) is required in follow up within 7 days. All incident reports and MORS are reviewed and approved by MAP Coordinators (registered nurses). All MORs that involve any intervention by a health care provider are also reported to the State Department of Public Health. Shared Living Provider Agencies are required to file reports of any medication occurrence as an Incident Report to the Massachusetts Rehabilitation Commission. MRC ensures that medication errors are reported to DPPC when the error results in illness, injury or death. Medication errors in DPH licensed facilities are reported to the Massachusetts Department of Public Health. Medication errors in Assisted Living Residences are reported to the Executive Office of Elder Affairs. Pharmacy errors are reported to the Board of Registration in Pharmacy.
	(b) Specify the types of medication errors that providers are required to *record:*
	Providers are required to record in all of the following circumstances: anytime a medication is given to the wrong person, anytime the wrong medication is given, anytime a medication is given at the wrong time, anytime a wrong dose is given, anytime a medication is administered through the wrong route, or anytime the medication is omitted.
	(c) Specify the types of medication errors that providers must *report* to the state:
	Residential Habilitation and Shared Living Placement Agencies are required to report in all of the following circumstances: anytime a medication is given to the wrong person, anytime the wrong medication is given, anytime a medication is given at the wrong time, anytime a wrong dose is given, anytime a medication is administered through the wrong route, or when the medication is omitted. 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.**

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

The Massachusetts Rehabilitation Commission (MRC) has primary responsibility for oversight of the management and administration of medications within residential settings for participants in the TBI Waiver.

The Massachusetts Rehabilitation Commission has primary responsibility of oversight of the Medication Administration Program for programs funded or supported by MRC. The Department of Public Health (DPH) also participates in the oversight responsibility for sites participating in the MAP program. Providers are required to report all medication occurrences within 24 hours of discovery through the MRC Incident Reporting System. The MOR report details the person involved, the type of error, the medications involved, the consultant contacted, any medical interventions that were involved, what followed from the intervention and supervisory follow up action taken. Any MOR that involves medical intervention is also reported to the DPH and is defined as a "hotline" call. All MORs get reviewed and approved by the assigned MAP Coordinators who are registered nurses. Follow-up occurs with providers on all hotline MORs. This may be accomplished through a phone conversation or a direct site visit, utilizing a Technical Assistance Tool.

On an individual level, MORs are reviewed by case managers and supervisors and are part of an integrated review of all incidents that pertain to the individual.

Finally, on a systems level, all information regarding medication occurrences is aggregated and reports are generated quarterly. These reports detailing the number of medication occurrences including the type and follow up action are reviewed and analyzed to identify trends and patterns. Information is then shared through training, communicating data and advisories aimed at steps providers can take to reduce the number of medication occurrences. Data is also aggregated on an annual basis, analyzed for trends and reported and reviewed with MassHealth.

MRC is responsible for monitoring the performance of Shared Living Provider Agencies in implementation of their medication administration policies. Shared Living Provider Agencies are required to submit medication errors following incident reporting requirements consistent with MAP. As a part of the MRC case manager quarterly visits to the homes, they review both the system that the Shared Living Provider Agencies has in place to monitor medication administration as well as reviewing the individual shared living home to assure that medication is being correctly administered and monitored. Nurses at MRC are available to case managers and providers for consultation if any concerns arise.

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:	HWa4. % of waiver service providers that conduct Criminal Offender Record Information (CORI) checks of prospective employees and take appropriate action when necessary. Numerator: Number of waiver service providers that conduct CORIs of prospective employees and take required action. Denominator: 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*	
		☐ *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:	HWa3. Provider performance monitoring exists to ensure providers are trained in mandated reporting of abuse, neglect, exploitation, and unexplained death. Numerator: Number of service providers with documentation of training for staff on abuse, neglect, exploitation, unexplained death, and mandated reporter requirements. Denominator: 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*	
		☐ *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:	HWa1. Every waiver participant has been assessed to identify concerns regarding abuse and neglect. Numerator: Number of waiver participants with a documented assessment of abuse and neglect issues. Denominator: Total number of waiver participants.

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

If 'Other' is selected, specify: **ASAP and SCO quality 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*	
		☐ *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:	HWa2. Case Management staff receive training on their responsibilities as mandated reporters of abuse, neglect, exploitation, and unexplained death. Numerator: Number of CM staff with documentation of training on abuse, neglect, exploitation, unexplained death, and mandated reporter requirements. Denominator: Total number of CM staff.
Data Source *(Select one) (Several options are listed in the on-line application):* **Training verification records**	
If 'Other' is selected, specify: **ASAP and SCO quality 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*	
		☐ *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:	HWa5. % of participants who received information about how to report abuse, neglect and exploitation. Numerator: Number of participants who received information about how to report abuse, neglect and exploitation. Denominator: Number of participants.
Data Source *(Select one) (Several options are listed in the on-line application):* **Record reviews, on-site**	
If 'Other' is selected, specify: **ASAP and SCO quality 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*	
		☐ *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:	HWb1. % of deaths that are required to have a clinical review that received a clinical review. Numerator: Number of deaths that have a clinical review. Denominator: Number of deaths required to have a clinical review.
Data Source *(Select one) (Several options are listed in the on-line application):* **Mortality reviews**	
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	***Frequency of data aggregation and analysis:***

(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:	HWb2. Allegations of abuse, neglect, exploitation and unexplained death (ANE) affecting waiver participants are reported to the appropriate investigative entity. Numerator: Number of allegations of ANE affecting waiver participants reported to the appropriate investigative entity Denominator: Number of allegations of ANE affecting waiver participants.
Data Source *(Select one) (Several options are listed in the on-line application):* **Record reviews, on-site**	
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	***Frequency of data aggregation and analysis:***

(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:	HWb3. Case Management staff receive training on their incident reporting responsibilities Numerator: Number of case management staff with documentation of training on incident reporting requirements. Denominator: Total number of case management staff.
Data Source *(Select one) (Several options are listed in the on-line application):* **Training verification records**	
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	***Frequency of data aggregation and analysis:***

(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:	HWb4. Risk mitigation & prevention measures are implemented in response to allegations of abuse, neglect, exploitation and unexplained death (ANE). Numerator: # of allegations of ANE death affecting waiver participants for which risk mitigation and prevention measures are implemented Denom: # of allegations of ANE affecting waiver participants with recommendations for risk mitigation & prevention.
Data Source *(Select one) (Several options are listed in the on-line application):* **Record reviews, on-site**	
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)

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:	HWc1. % of Behavior Intervention Plans (BIPs) including restrictive interventions that demonstrate compliance with state policies. Num: # of BIPs including restrictive interventions that are compliant with state policies and approved by the MRC Behavior Intervention Plan Review Committee. Denom: total # of BIPs including restrictive interventions that are submitted for review by the MRC Behavior Intervention Plan Review Committee.
Data Source *(Select one) (Several options are listed in the on-line application):* **Other**	
If 'Other' is selected, specify: MRC Behavior Intervention Plan Review Committee Data	

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

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

Add another Data Source for this performance measure

Data Aggregation and Analysis

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

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

d. Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

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

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

Performance Measure:	HWd2. % of waiver participants who have identified a primary care provider. Numerator: Number of waiver participants not receiving Residential Habilitation or Shared Living with a documented primary care provider. Denominator: Number of waiver participants not receiving Residential Habilitation or Shared Living.
Data Source *(Select one) (Several options are listed in the on-line application):* **Record reviews, on-site**	
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:	HWd1. % of participants who receive Residential Habilitation or Shared Living who have had an annual visit with their identified primary care provider in the last 15 months. Num: # of participants who receive Residential Habilitation/Shared Living with a documented visit with their identified PCP in the past 15 months. Denom: # of participants who receive Residential Habilitation/Shared Living

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:*

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 (MRC) and MassHealth are responsible for ensuring effective oversight of the waiver program. As problems are discovered with management of the waiver program or waiver service providers MassHealth and MRC 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 and MRC are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii. **Remediation Data Aggregation**

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

		☐ **Other** Specify:

c. **Timelines**

When the state does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

State:	
Effective Date	

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.

MRC and MassHealth's quality management strategy is designed to assure that essential safeguards are met with respect to health, safety and quality of life for waiver participants. The overarching quality management approach is designed to utilize and build on the CMS Quality Assurance and Sub-assurance areas to ensure quality outcomes in the following areas:
- Individuals have access to flexible community-based supports in their communities.
- Supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences, and decisions concerning his or her life in the community.
- Providers possess and demonstrate the capability to effectively serve participants.
- Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
- Participants receive support to exercise their rights and accept personal responsibilities.
- Participants are satisfied with their supports and achieve desired outcomes.
- The system supports participants efficiently and effectively, and constantly strives to improve quality.
- The system will ensure quality in service delivery for individuals who choose 1915(c) Waiver services.

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. A goal of the waiver quality management system is to obtain concrete discovery data that, when aggregated and analyzed, allows for prioritization of any assurance areas that need immediate quality improvement strategies to remedy the findings, as well as identification of trends that indicate need for systemic change and improvement. MassHealth will also identify current processes that may be considered a best practice and should be recommended to MRC for implementation across the waiver service network to promote uniformity and assure that applicable standards are being met.

The quality management strategy is based on the following key operational principles:
1. The system is designed to create a continuous loop of quality assessment and 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, policies and procedures, 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, participant satisfaction and participant involvement in care planning.

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) has oversight responsibility for waiver quality management for this 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 and MRC, as the case management entity, are in compliance with MRC and MassHealth policies and procedures. Waiver service providers and Case Managers will be responsible for the collection, maintenance and reporting of specific data that will allow discovery of issues. MRC will aggregate data from Case Managers and waiver service providers and make available system-wide data, analysis of such data, identification of trends and reports to MassHealth in order to facilitate our discovery, remediation planning and overall system quality improvement strategies.

The MRC Community Living (CL) Division oversees operation of the TBI Waiver. TBI Waiver staff are housed at MRC's central office and operate on a statewide basis. The TBI Waiver team can draw from staffing and expertise available from other units within the CL Division, as well as resources from the larger agency, including the Evaluation, Research and Development department. The Director of Community Supports and Operations in the CL Division is a member of the agency's senior leadership team and reports directly to the MRC Commissioner. It is ultimately the Director of the Statewide Head Injury Program (SHIP), who reports directly to the Director of Community Supports and Operations in the CL Division, who is accountable for assuring that identified service improvement efforts are implemented and reviewed. The responsibility for determination of areas that would benefit from measures designed to more accurately gather qualitative data rests ultimately with the MRC / MassHealth Quality Oversight Team. The responsibility for implementing recommendations from this team lies with the MRC Analytics and Quality Assurance Team. This team consists of:

- The Director of Community Living
- The Director for SHIP
- The Director of Community Supports and Operations • The Director of Analytics and Quality Assurance• Assigned Analytics and Quality Assurance staff

The components of the three tiers of quality review are described briefly below.

Tier I- The Individual Level

On the individual level, MRC utilizes data and reports they develop and will draw on information a) gleaned directly from the consumers through survey monitoring, b) from Case Managers, through their documentation of prescribed activities and incidents noted during an individual's period of waiver enrollment, c) from virtual and in-person site visits, and d) from information reported directly to MRC by the participating waiver service providers. Quality management activities relating to the individual's experience in the waiver include measurements and analysis of performance regarding:

1. Appropriate level of care determinations and re-determinations and whether they are conducted using approved tools, by the appropriate assessors and in a timely manner;
2. The development, through a person-centered process, of waiver enrollees' service plans, including their timeliness, degree of responsiveness to the individual participant's identified needs, and how the process ensures participant involvement;
3. Case Manager's activities on behalf of the waiver participant, and documentation of same;
4. Documentation of home visits and telephone contact with waiver enrollees to determine how well Case Managers monitor the participant's well-being in the waiver program;
5. Community Online Critical Incident and mandatory abuse/neglect reporting, per MRC requirements and Massachusetts laws, and an abuse investigation and resolution process which protects individuals from harm and incorporates corrective action plans; and
6. Results of provider site reviews.

Tier II-The Provider Level

MRC is responsible for provider qualification and performance monitoring and oversight. All waiver service providers will be required to go through the following quality assurance processes:
1. All residential habilitation and day service providers receive initial on-site reviews prior to opening, at least once during the first six months after the first services are provided, and annually after that. Where a provider review indicates that a waiver service provider is not meeting standards as set forth in the waiver application and MRC's CL Provider Manual, MRC will investigate the matter further and, if necessary, take steps to institute quality improvement measures and development of a corrective action plan with the provider.
2. MRC Case Managers inquire about participants' experiences and satisfaction with services and service providers as part of routine quarterly check-ins with the participants in their caseloads. Where responses indicate that a particular provider is performing in a substandard manner in terms of participant satisfaction and/or direct service quality, Case Managers report such concerns to their supervisor for follow-up. MRC will investigate the matter further and if necessary, take steps to institute quality improvement measures and development of a corrective action plan with the provider.

Tier III- The System Level

Quality oversight of the overall TBI Waiver Program is the responsibility of MassHealth and MRC. With the current complement of HCBS waivers in Massachusetts, processes have been and continue to be established to support and enhance quality oversight. MassHealth and MRC collaborate on an on-going basis 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 and MRC review and evaluate measures related to provider capability; provider qualifications, performance and compliance with applicable standards and requirements; safeguards and incident management; client satisfaction; and system performance and wherever appropriate align applicable performance measures with those in other waivers.

In addition to provider and individual level reports and analysis, and identification of trends effecting systemic performance, MassHealth and MRC work collaboratively to improve quality of services through the review of aggregate data in management reports. Specifically, MRC produces reports that support system level findings about overall waiver program performance. These include the Annual Mortality Report, Annual Residential Monitoring Report, participant survey results, and Incident Reporting data. MassHealth will review MRC's reports and Quality Management practices and will work with MRC to develop and prioritize quality improvement strategies for identified areas in need of improvement.

As an important component to its commitment to stakeholder and participant input, MRC collaborates with the Department of Developmental Services (DDS) in facilitating an ABI/MFP/TBI Waiver Stakeholder Advisory Committee to obtain valuable input from constituents. A program staff person from the MRC TBI waiver team and a member from the Analytics and Quality Assurance department will participate in these meetings. The Committee plays an advisory role and assists in evaluating and improving waiver program performance. Specifically, this committee reviews data reports and other waiver program materials, and provides valuable qualitative feedback about waiver initiatives, proposed changes, prioritization of issues and overall program performance.

MRC is responsible for implementing system improvement activities identified as needed through the evaluation process. MassHealth collaborates with MRC to monitor the effectiveness of system improvement activities.

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 and MRC have a strong commitment to a quality management system which continuously evaluates the processes in place to monitor waiver activities, participant outcomes, and system design changes.

The cornerstone of the process for monitoring and analyzing the effectiveness of system design changes is MRC's administrative case management function for waiver participants through which MRC obtains continuous and on-going feedback on all aspects of system performance related to waiver participants' experiences, including participant satisfaction, provider performance, and incident occurrence and follow-up. Through regular Case Manager supervision and performance evaluation as well as regular review of case management records and annual performance reviews, in order to identify any issues with an individual case manager or system-wide, MRC monitors and assesses the impact and effectiveness of system design changes.

In addition, MRC and MassHealth collaborate in reviewing quality of services and overall system performance captured in quality management reports including the Annual Mortality Report, Annual Residential Monitoring Report, participant feedback from participant satisfaction survey results, Incident Reporting data, and Level of Care Re-assessments Report. Through longitudinal analysis of these reports, MRC and MassHealth monitor and assess the impact and effectiveness of system design changes in these areas.

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 on a quarterly basis and reviews performance, system design changes and assessments. This Committee supports MassHealth, DDS and MRC in assessing and ensuring the highest quality services, on-going monitoring of implemented improvements, and promoting consistency across waivers where appropriate. 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 is committed to evaluating the processes and systems in place that comprise the quality management strategy. MRC holds regular internal quarterly meetings with the Analytics and Quality Assurance Department and Waiver program staff. Additionally, MassHealth and MRC meet on an annual basis to review and evaluate the quality improvement strategy, and in on-going collaboration with other EOHHS agencies, consider quality improvement systems-related best practices. In addition, to ensure consumer involvement and stakeholder feedback related to the quality management strategy, MRC will work with DDS to obtain input from the ABI/MFP/TBI Stakeholder Advisory Committee on an on-going basis.

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report has not been finalized for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been finalized. Upon expiration of the Appendix K amendment, Massachusetts will gather and submit any outstanding 372 reports as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 report(s) within a timeframe between 90 days and up to 6-months (to be negotiated with the state) of receiving the final quality review report and 372 report acceptance decision.

H.2 Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one):*

- o No
- • Yes *(Complete item H.2b)*

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

- o HCBS CAHPS Survey;
- o NCI Survey;
- o NCI AD Survey;
- • Other *(Please provide a description of the survey tool used)*:

The Massachusetts Rehabilitation Commission (MRC) conducts an annual waiver participant satisfaction survey, administered to TBI Waiver participants enrolled during the waiver year. The survey tool was developed by MRC's Community Living Division and is administered in-person and via mail to TBI Waiver participants. The purpose of the satisfaction survey is to assist the Commonwealth in measuring TBI performance standards and to assess overall participant satisfaction. Survey domains include case management, waiver provider services, and participants' satisfaction with their own progress within the program.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) 808 CMR 1.00: Compliance, Reporting and Auditing for Human and Social Services, requires organizations entering into a contract with the Commonwealth to perform an independent audit and annually submit a Uniform Financial Statement and Independent Auditor's Report to the Executive Office of Administration and Finance's Operational Services Division. For existing/current providers for which MRC is the Principal Purchasing Agency (PPA), these records are reviewed by the MRC Contracts Office annually; new providers must submit financial statements for review by MRC before a contract can be executed. For providers for which another state agency is the PPA, the MRC Contracts Office confirms on an annual basis that the PPA has completed this review process.

(b) The integrity of provider billing data for Medicaid payment of waiver services is managed by the Massachusetts Medicaid Management Information System (MMIS). MRC confirms the delivery of services and that such delivery is consistent with the set of services authorized by the Case Manager in each individual participant's Plan of Care, the units of services and the cost of all services through contract and invoice management prior to submitting claims to Medicaid. MRC and EOHHS establish rates for each waiver service. All ineligible expenses are excluded from waiver service rates. 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 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:	FAa1. % of submitted service claims that were coded and paid for in accordance with the reimbursement methodology specified in the waiver application. Numerator: Approved and paid MMIS claims. Denominator: 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:*

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:	FAb1. Services are coded and paid for in accordance with the rate methodology specified in the waiver application. Numerator: Number of services with rates derived from and consistent with rate regulations Denominator: Number of services for which claims were submitted.
Data Source *(Select one) (Several options are listed in the on-line application):* **Financial records (including expenditures)**	
If 'Other' is selected, specify: **Reports from SIMS and MMIS data**	

	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.*

MRC is responsible for ensuring that provider billing is in accordance with the services authorized in the service plan. MRC ensures that expenditures for which no electronic invoice/payment voucher is provided or for which expenditures do not match the electronic invoice/payment voucher will be identified and reconciled by the Case Manager and reported to either supervisory staff or the director. If any discrepancy is noted, the discrepancy will be reviewed on an individual basis with the service provider and the services will only be claimed upon reconciliation of the discrepancy. Claims that cannot be reconciled with electronic invoices/payment vouchers or other service documentation 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 a public hearing to provide an opportunity for the public to provide oral comment. See MGL Chapter 118E Section 13D; see also MGL Chapter 30A Section 2. The purpose of this public process is to ensure that the public (and in particular, providers) are given advance notice of proposed rates and the opportunity to provide feedback, both orally and in writing, to ensure that proposed rates meet the statutory rate adequacy requirements noted above.

All rates established in regulation by EOHHS are required by statute to be reviewed biennially and updated as applicable, to ensure that they continue to meet the statutory rate adequacy requirements. See MGL Chapter 118E Section 13D. In updating rates to ensure continued compliance with statutory rate adequacy requirements, a cost adjustment factor (CAF) or other updates to the rate models may be applied. The cost adjustment factor for all rates using such a factor is from the Massachusetts Consumer Price Index optimistic forecast provided by Global Insight, based on an average for the prospective two-year period during which the rate will apply.

Additional information on the rate development for waiver services follows.

1. For waiver services in which there is a comparable Medicaid state plan service and 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:

-Specialized Medical Equipment (set in accordance with 101 CMR 322.00 (formerly 114.3 CMR 22.00): Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment). These

regulations establish a process for determining the price of equipment. This same process is used to determine the cost of the specific item being purchased as Specialized Medical Equipment. The rate is determined at the time of purchasing.

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

2. Transportation services: Massachusetts has a coordinated statewide Human Service Transportation (HST) brokerage system with six Regional Transit Authorities currently brokering and managing consumer trips throughout the state. Brokers arrange transportation services by subcontracting with local qualified transportation providers. Work volume for transportation providers can be as limited as occasional trips for mid-day medical appointments to long-term, multiple days a week, route-structured program services. For Demand-response trips, contracted providers will be awarded trips on a daily basis based on lowest price, availability and prior performance. Program-Based trips for a specific destination, frequency and time, usually operating on a daily or regularly scheduled basis were procured for a five year period beginning July 1, 2015. Additional routes are added as needed. Contracts are awarded based on lowest price, availability and prior performance.

3. For waiver services where there is a comparable EOHHS Purchase of Service (POS) rate, the waiver service rate was established in POS regulation after public hearing pursuant to MGL Chapter 118E, Section 13D. All POS rates were established in regulation pursuant to this statutory requirement. In accordance with Massachusetts General Laws (MGL) Chapter 118E, Section 13D Duties of ratemaking authority; criteria for establishing rates, the rates are reviewed every two years. 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, which requires providers to submit UFRs on an annual basis. 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. EOHHS uses the most recent complete state fiscal year UFR available to determine the average across providers of that service for each line item, which are then used to build each rate. When analyzing a variable that is relatively normally distributed, EOHHS considers an outlier as data that falls two or more standard deviations from its mean. In general, outliers belong to one of two categories: a mistake in the data or a true outlier. Depending on the data set being analyzed, an outlier would generally be handled by either excluding the outlier data or capping the outlier data so that the outlier data would not adversely affect the ability of EOHHS to develop rates applicable to providers of a particular service.

The waiver service rate is set at the comparable EOHHS POS rate for the following waiver services:

-Adult Companion (set in accordance with 101 CMR 423.00: Rates for Certain In-Home Basic Living Supports)

- Individual Support and Community Habilitation (set in accordance with 101 CMR 422.00: General Programs – Disability Services and 101 CMR 423.00: Rates for Certain In-Home Basic Living Supports)
-Day Services (set in accordance with 101 CMR 415.00: Rates for Community-Based Day Supports and 101 CMR 422.00: General Programs – Disability Services)
- Homemaker Services (set in accordance with 101 CMR 422.00: General Programs – Disability Services)
-Residential Habilitation (set in accordance with 101 CMR 420.00 Rates for Adult Long-Term Residential Services) -Shared Living – 24 Hour Supports (set in accordance with 101 CMR 411.00 Rates for Certain Placement and Support Services)
-Rates for Supported Employment Services (set in accordance with 101 CMR 419: Rates for Supported Employment Services, and 101 CMR 410: Rates for Competitive Integrated Employment Services)
No productivity expectations and administrative ceiling calculations have been used in establishing these rates.
4. Home Accessibility Adaptations, Respite, Transitional Assistance and Assistive Technology for Telehealth 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:
(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.
The State does not establish a limit or maximum allowable rate for home accessibility adaptations, respite or transitional assistance services.

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 informs participants of the availability of information about waiver services payment rates during service planning meetings.

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:

Claims for waiver services are adjudicated through the state's approved MMIS system.
The Massachusetts Rehabilitation Commission's billing intermediary Public Sector Partners (PSP), which is a unit within the University of Massachusetts Medical School (UMMS) Public Provider Reimbursement (PPR) Unit, bills Traumatic Brain Injury (TBI) waiver services using an approved claims transaction system in the Standard Format as required by HIPAA. Direct service providers 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 via the Electronic Invoice Management System (EIM) or the Massachusetts Management Accounting and Reporting System (MMARS). Waiver expenditure reports are then generated and processed through a claims transaction system and submitted to MMIS to determine Federal Financial Participation (FFP) amounts.

Once the claims have been 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.

On a monthly basis, MRC verifies services rendered through contract and invoice management. Service documentation data includes client identifier, procedure codes, quantity of service units and service costs. Upon review and approval of documentation of services, the UMass Revenue Unit will submit claims to the MMIS which will process and pay claims as appropriate. Claims will be electronically submitted to MMIS on a routine basis, at a minimum quarterly, for claim editing and processing for eligible clients and expenditures.

MRC monitors the Electronic Invoice/payment voucher and Service Delivery practices and procedures of their TBI waiver service providers, which are received by PPR approximately 60 days after services are rendered. PPR, which serves as the liaison between PSP and MRC, ensures the following:
- Submission of claims data in accordance with existing requirements and regulations;
and
- Review, research and ensuring the resubmission of denied claims as appropriate.

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 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.*)
		MRC certifies public expenditures for TBI waiver services. Expenditures are certified annually utilizing cost report data. Staff from the Public Provider Reimbursement Unit at the University of Massachusetts Medical School Center for Health Care Financing review cost reports and identify allowable and disallowable costs (such as room and board) to ensure that rates used for claiming never include room and board or any other disallowable costs. Payments are made to waiver providers contracted through MRC. These providers retain 100% of the payment. Expenditures for waiver services are funded from annual legislative appropriations to EOHHS and MRC. Claims for waiver services are adjudicated at approved rates through the state's approved MMIS system. Once the claims have adjudicated through the CMS approved MMIS system, which validates that the claims are eligible for Federal Financial participation, the expenditures for waiver services are reported on the CMS 64 report.
	☐	**Certified Public Expenditures (CPE) of Local Government Agencies**. Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

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

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. MRC confirms the delivery of services and that such delivery is consistent with the approved service plan through contract and invoice management prior to submitting claims to MMIS. This validation results in the removal of inappropriate billing prior to the calculation of FFP. MMIS also maintains eligibility data to ensure that a participant is enrolled in a Medicaid waiver program prior to payment of claims. Post- payment billing validation is overseen by the MassHealth Program Integrity Unit, as outlined in Appendix I-1.

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:
	MRC makes payments directly to waiver service providers. MRC payments are validated through a claims transaction system and adjudicated in the state's approved MMIS system through which units of service, rates and member eligibility are processed and verified. Payment for waiver services is made through the state accounting system MMARS. The basis for the draw of federal funds and the claiming of these expenditures on the CMS-64 is payments to vendors and claims validated through MMIS.
○	**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.** Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☑	**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
☐	**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
☐	**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.** Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐	**Providers 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:
	Annual legislative appropriation to MRC provides the non-federal share which is expended directly by MRC as CPEs. The Department directly makes expenditures from its appropriation and Federal Financial Participation (FFP) is returned to the State General Fund.
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select one:*

☑	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
○	**Applicable** *Check each that applies:*
☐	**Appropriation of Local Government Revenues.** Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:
☐	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds . *Select one:*

☑	**None of the specified sources of funds contribute to the non-federal share of computable waiver costs.**	
○	**The following source(s) are used.** *Check each that applies.*	
	☐	**Health care-related taxes or fees**
	☐	**Provider-related donations**
	☐	**Federal funds**
	For each source of funds indicated above, describe the source of the funds in detail:	

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○	**No services under this waiver are furnished in residential settings other than the private residence of the individual.**
☑	**As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

The Executive Office of Health and Human Services (EOHHS) has developed rates that are used to pay for the services delivered in residential habilitation and shared living settings for participants in this waiver.

EOHHS developed the service rates by examining the Uniform Financial Reports (UFRs) and other financial data for current providers of these services. The UFR data detail costs incurred by the providers for particular activities, and clearly separate activity costs that are part of the residential habilitation and shared living service from activity costs that related to providing room and board to residents in these settings. All room and board costs are excluded from the service rate computation and are never included in claims for FFP.

For residential habilitation EOHHS developed a separate schedule of rates reflecting the cost of room and board for participants; the Commonwealth makes room and board payments separately from the service rate payments. The Commonwealth makes payments for room and board directly to the providers of residential habilitation service through the state's MMARS accounting system. These payments are not submitted to the MMIS system. The Commonwealth's payments to providers for the cost of room and board will not be submitted for Medicaid claims.

Participants receiving Shared Living - 24 Hour Supports are responsible for payment of their own room and board. When the Shared Living -24 Hour Supports Participant lives in the caregiver's home, he or she is 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

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:

State:	
Effective Date	

State:	
Effective Date	

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)*:	Hospital, Nursing Facility						
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	$144,579.90	$31,083.38	$175,663.28	$294,254.45	$32,316.12	$326,570.57	$150,907.29
2	$148,178.86	$31,857.36	$180,036.22	$301,581.39	$33,120.79	$334,702.18	$154,665.96
3	$151,870.34	$32,650.61	$184,520.95	$309,090.77	$33,945.50	$343,036.27	$158,515.32
4	$155,653.07	$33,463.61	$189,116.68	$316,787.13	$34,790.74	$351,577.87	$162,461.19
5	$159,526.62	$34,296.85	$193,823.47	$324,675.13	$35,657.03	$360,332.16	$166,508.69

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	Nursing Facility
Year 1	100	42	58
Year 2	100	42	58
Year 3	100	42	58
Year 4 (only appears if applicable based on Item 1-C)	100	42	58
Year 5 (only appears if applicable based on Item 1-C)	100	42	58

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-a.

The Average Length of Stay (ALOS) of 352 is based on the actual ALOS reported on the WY21 CMS-372 report for the TBI Waiver (MA.0359).

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 each Traumatic Brain Injury (TBI) Waiver service, except those noted below, is based on the average actual utilization as reflected in data reported on the Waiver Year (WY) 2019-2021 CMS-372 reports and WY 2022 claims data for this waiver.
For Homemaker, Respite, Supported Employment (all component types), Assistive Technology for Telehealth, Home Accessibility Adaptations, and Transitional Assistance which has no utilization the number of users was estimated at one user per waiver year.

Average Units per User:

The average units per user for all waiver services except those noted below are based on the average actual utilization for the TBI Waiver, as reflected on the WY 2019 - 2021 CMS-372 reports and WY 2022 claims data. For services of which there was no utilization, average units per user is estimated as follows:
- Assistive Technology for Telehealth - this service is primarily a single-time purchase of an item, each user of this service would typically require only one unit of service.
- Homemaker – Estimated based on utilization in the state funded Statewide Head Injury Program (SHIP).
- Home Accessibility Adaptations – This estimate is based on one unit per user.
- Respite - The estimate is based on utilization from the Frail Elder Waiver.
- Supported Employment (15-min unit) – Estimated based on utilization in the state funded Statewide Head Injury Program (SHIP).
- Supported Employment (Episode units) – The state utilizes four component types for this service As payment is made for these services upon completion of each component activity, the average units per user of each component is one episode.
- Shared Living 24-Hour Supports – Estimated based on one unit per day adjusted for the average length of stay for the waiver.
- Transitional Assistance – This service is claimed on a per episode basis, and based on experience in this and other MA HCBS waivers, waiver participants typically make only one transition between settings in a given year. Therefore, the estimated units per user is one episode.

Average Cost per Unit:
Except as noted below, the average cost per unit for all waiver services is based on claims data from Waiver Year 2023. For waiver services for which there were no waiver service claims during that period, average cost per unit is estimated as follows:
- Assistive Technology for Telehealth - The average cost per unit is based on claims data for this service in the Frail Elder Waiver in Waiver Year 2022.
- Homemaker – The average of the five regional rates established in 101 CMR 422.00 (General Programs - Disability Services).
- Home Accessibility Adaptations - The average cost per unit is based on spending for this service in the state funded Statewide Head Injury Program (SHIP).
- Respite - The average cost per unit is based on claims data for this service in the Frail Elder Waiver in Waiver Year 2022.
-Shared Living 24-Hour Supports – The average cost per unit is based on Waiver Year 2021, trended forward by the cost adjustment factor.
- Supported Employment (15-min unit) – The average cost per unit is based on the rate established in 101 CMR 419.00 (Rates for Supported Employment Services).
- Supported Employment (Episode units) – The average cost per unit is based on the rate established in 101 CMR 410.00 (Rates for Competitive Integrated Employment Services).
- Transitional Assistance – The average cost per unit is based on claims data for this service in the Frail Elder Waiver in Waiver Year 2022.

Trend:
The rates described above were trended forward annually to WY1, as well as for subsequent waiver years, by 2.49%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 24-months October 2021 through September 2023).

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' costs are based on WY 2021 utilization of all other Medicaid services (D') by MA.0359 Waiver participants as reported on the WY 2021 CMS-372. The annualized value of Factor D' is adjusted by the average length of stay used for Factor D to make the period of comparison comparable as follows: the annualized value of Factor D' was multiplied by the average length of stay and divided by 365.

In addition, WY 2021 costs were trended forward annually 2.49%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 24-months October 2021 through September 2023) to estimate Factor D' for WY1 (Waiver Year 2025), as well as for subsequent waiver years.

The calculation for Factor D' in WY1 is as follows:
WY1 D' = WY 2021 Factor D' x 1.0249^4

As Factor D' costs are based on WY 2021 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.

As noted in Appendix J-2-c-ii, the annualized value of Factor D' is adjusted by the average length of stay used for Factor D, and then was trended forward annually by 2.49% to estimate Factor D' for WY1 (WY2025).

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was derived using the average statewide MassHealth Nursing Facility per diem rate for FY24 and the average statewide MassHealth Chronic Disease and Rehabilitation Hospital (excluding pediatric facilities) per diem rate for FY24. The annualized value of Factor G is adjusted by the average length of stay used for Factor D to make the period of comparison comparable as follows: the annualized value of Factor G was multiplied by the Factor D average length of stay and divided by 365.

WY 2024 rates were trended forward annually by 2.49%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 24-month October 2021 ended September 2023) to estimate Factor G for WY1 (Waiver Year 2025), as well as for subsequent waiver years.

The calculation for Factor G in WY1 is as follows:
WY1 G = WY 2025 Factor G x 2.49^1

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' costs are based on the utilization of all Medicaid services (G') in WY 2021 for MassHealth members with traumatic brain injuries who resided in a nursing facility or chronic rehabilitation hospital in WY 2021 in a long-stay, as reported on the WY 2021 CMS-372 for the Traumatic Brain Injury as described above. The annualized value of Factor G' is adjusted by the average length of stay used for Factor D to make the period of comparison comparable as follows: the annualized value of Factor G' was multiplied by the Factor D average length of stay and divided by 365.

WY 2021 costs were trended forward annually by 2.49%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 24-month October 2021 ended September 2023) to estimate Factor G' for WY1 (Waiver Year 2025), as well as for subsequent waiver years.

The calculation for Factor G' in WY1 is as follows:
WY1 G' = WY 2021 Factor G' x 4.49^4

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
Homemaker
Individual Support and Community Habilitation
Residential Habilitation
Respite
Supported Employment
Adult Companion
Assistive Technology for Telehealth
Day Services
Home Accessibility Adaptations
Shared Living – 24 Hour Supports
Specialized Medical Equipment
Transitional Assistance
Transportation

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**
Homemaker	15 min	1	208	$6.78	$ 1,410.24
Individual Support and Community Habilitation	15 min	20	447	$14.96	$ 133,742.40
Residential Habilitation	Per Diem	74	343	$537.04	$ 13,631,149.28
Respite	Per Diem	1	13	$362.12	$ 4,707.56
Supported Employment Total:					$16,174.23
Supported Employment – Ongoing and Interim Supports	15 min	1	208	$17.20	$ 3,577.60
Supported Employment – Intake, Evaluation, and Assessment	Episode	1	1	$1,126.05	$ 1,126.05
Supported Employment – Job – targeted Educational and Skills Training Activities	Episode	1	1	$3,072.48	$ 3,072.48
Supported Employment – Job Development and Placement	Episode	1	1	$6,189.07	$ 6,189.07
Supported Employment – Initial Employment Supports	Episode	1	1	$2,209.03	$ 2,209.03
Adult Companion	15 min	18	1,617	$7.22	$ 210,145.32
Assistive Technology for Telehealth	Item	1	1	$242.12	$ 242.12
Day Services	15 min	18	2,338	$7.26	$ 305,529.84
Home Accessibility Adaptations	Item	1	1	$15,519.42	$ 15,519.42
Shared Living – 24 Hour Supports	Per Diem	1	352	$291.800	$ 102,713.60
Specialized Medical Equipment	Item	1	2	$1,756.41	$ 3,512.82
Transitional Assistance	Episode	1	1	$ 1,266.82	$ 1,266.82

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Transportation	One-Way trip	3	187	$56.82	$ 31,876.02
GRAND TOTAL:					**$ 14,457,989.67**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					100
FACTOR D (Divide grand total by number of participants)					**$ 144,579.90**
AVERAGE LENGTH OF STAY ON THE WAIVER					**352.00**

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**
Homemaker	15 min	1	208	$6.95	$1,445.60
Individual Support and Community Habilitation	15 min	20	447	$15.33	$137,050.20
Residential Habilitation	Per Diem	74	343	$550.41	$13,970,506.62
Respite	Per Diem	1	13	$371.14	$4,824.82
Supported Employment Total:					$16,577.32
Supported Employment – Ongoing and Interim Supports	15 min	1	208	$17.63	$3,667.04
Supported Employment – Intake, Evaluation, and Assessment	Episode	1	1	$1,154.09	$1,154.09
Supported Employment – Job – targeted Educational and Skills Training Activities	Episode	1	1	$3,148.98	$3,148.98
Supported Employment – Job Development and Placement	Episode	1	1	$6,343.18	$6,343.18
Supported Employment – Initial Employment Supports	Episode	1	1	$2,264.03	$2,264.03
Adult Companion	15 min	18	1,617	$7.40	$215,384.40
Assistive Technology for Telehealth	Item	1	1	$248.15	$248.15

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**
Day Services	15 min	18	2,338	$7.44	$313,104.96
Home Accessibility Adaptations	Item	1	1	$15,905.85	$15,905.85
Shared Living – 24 Hour Supports	Per Diem	1	352	$299.07	$105,272.64
Specialized Medical Equipment	Item	1	2	$1,800.14	$3,600.28
Transitional Assistance	Episode	1	1	$1,298.36	$1,298.36
Transportation	One-Way trip	3	187	$58.23	$32,667.03
GRAND TOTAL:					$14,817,886.23
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					100
FACTOR D (Divide grand total by number of participants)					$148,178.86
AVERAGE LENGTH OF STAY ON THE WAIVER					352.00

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Homemaker	15 min	1	208	$7.12	$1,480.96
Individual Support and Community Habilitation	15 min	20	447	$15.71	$140,447.40
Residential Habilitation	Per Diem	74	343	$564.12	$14,318,493.84
Respite	Per Diem	1	13	$380.38	$4,944.94
Supported Employment Total:					$16,990.31
Supported Employment – Ongoing and Interim Supports	15 min	1	208	$18.07	$3,758.56
Supported Employment – Intake, Evaluation, and Assessment	Episode	1	1	$1,182.83	$1,182.83
Supported Employment – Job – targeted Educational and Skills Training Activities	Episode	1	1	$3,227.39	$3,227.39
Supported Employment – Job Development and Placement	Episode	1	1	$6,501.13	$6,501.13
Supported Employment – Initial Employment Supports	Episode	1	1	$2,320.40	$2,320.40

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**
Adult Companion	15 min	18	1,617	$7.58	$220,623.48
Assistive Technology for Telehealth	Item	1	1	$254.33	$254.33
Day Services	15 min	18	2,338	$7.63	$321,100.92
Home Accessibility Adaptations	Item	1	1	$16,301.91	$16,301.91
Shared Living – 24 Hour Supports	Per Diem	1	352	$306.52	$107,895.04
Specialized Medical Equipment	Item	1	2	$1,844.96	$3,689.92
Transitional Assistance	Episode	1	1	$1,330.69	$1,330.69
Transportation	One-Way trip	3	187	$59.68	$33,480.48
GRAND TOTAL:					$15,187,034.22
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					100
FACTOR D (Divide grand total by number of participants)					$151,870.34
AVERAGE LENGTH OF STAY ON THE WAIVER					352.00

Waiver Year: Year 4					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Homemaker	15 min	1	208	$7.30	$1,518.40
Individual Support and Community Habilitation	15 min	20	447	$16.10	$143,934.00
Residential Habilitation	Per Diem	74	343	$578.17	$14,675,110.94
Respite	Per Diem	1	13	$389.85	$5,068.05
Supported Employment Total:					$17,413.38
Supported Employment – Ongoing and Interim Supports	15 min	1	208	$18.52	$3,852.16
Supported Employment – Intake, Evaluation, and Assessment	Episode	1	1	$1,212.28	$1,212.28
Supported Employment – Job – targeted Educational and Skills Training Activities	Episode	1	1	$3,307.75	$3,307.75

Waiver Year: Year 4					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Supported Employment – Job Development and Placement	Episode	1	1	$6,663.01	$6,663.01
Supported Employment – Initial Employment Supports	Episode	1	1	$2,378.18	$2,378.18
Adult Companion	15 min	18	1,617	$7.77	$226,153.62
Assistive Technology for Telehealth	Item	1	1	$260.66	$260.66
Day Services	15 min	18	2,338	$7.82	$329,096.88
Home Accessibility Adaptations	Item	1	1	$16,707.83	$16,707.83
Shared Living – 24 Hour Supports	Per Diem	1	352	$314.15	$110,580.80
Specialized Medical Equipment	Item	1	2	$1,890.90	$3,781.80
Transitional Assistance	Episode	1	1	$1,363.82	$1,363.82
Transportation	One-Way trip	3	187	$61.17	$34,316.37
GRAND TOTAL:					$15,565,306.55
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					100
FACTOR D (Divide grand total by number of participants)					$155,653.07
AVERAGE LENGTH OF STAY ON THE WAIVER					352.00

Waiver Year: Year 5					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Homemaker	15 min	1	208	$7.48	$1,555.84
Individual Support and Community Habilitation	15 min	20	447	$16.50	$147,510.00
Residential Habilitation	Per Diem	74	343	$592.57	$15,040,611.74
Respite	Per Diem	1	13	$399.56	$5,194.28
Supported Employment Total:					$17,846.74
Supported Employment – Ongoing and Interim Supports	15 min	1	208	$18.98	$3,947.84
Supported Employment – Intake, Evaluation, and Assessment	Episode	1	1	$1,242.47	$1,242.47

Waiver Year: Year 5					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Supported Employment – Job – targeted Educational and Skills Training Activities	Episode	1	1	$3,390.11	$3,390.11
Supported Employment – Job Development and Placement	Episode	1	1	$6,828.92	$6,828.92
Supported Employment – Initial Employment Supports	Episode	1	1	$2,437.40	$2,437.40
Adult Companion	15 min	18	1,617	$7.96	$231,683.76
Assistive Technology for Telehealth	Item	1	1	$267.15	$267.15
Day Services	15 min	18	2,338	$8.01	$337,092.84
Home Accessibility Adaptations	Item	1	1	$17,123.85	$17,123.85
Shared Living – 24 Hour Supports	Per Diem	1	352	$321.97	$113,333.44
Specialized Medical Equipment	Item	1	2	$1,937.98	$3,875.96
Transitional Assistance	Episode	1	1	$1,397.78	$1,397.78
Transportation	One-Way trip	3	187	$62.69	$35,169.09
GRAND TOTAL:					$15,952,662.47
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					100
FACTOR D (Divide grand total by number of participants)					$159,526.62
AVERAGE LENGTH OF STAY ON THE WAIVER					352.00