Application for

RENEWAL

of a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Includes Changes Implemented through November 2014

Submitted by:

Submission Date:	

CMS Receipt Date *(CMS Use)*	

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

PURPOSE OF THE

HCBS WAIVER PROGRAM

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

1. Major Changes

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

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

1. Added the following new services to support greater self-sufficiency for participants: Cellular PERS, Goal Engagement Program, Evidence Based Education Program, Orientation and Mobility Services, and Peer Support.
2. Updated the service descriptions and re-named the following services: Home Safety/Independence Evaluations (formerly Occupational Therapy) and Complex Care Oversight and Training (formerly Skilled Nursing).

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*): Frail Elder Waiver

C. **Type of Request: 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**

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

○	**Model Waiver**
●	**Regular Waiver**

E. **Proposed Effective Date:** 1/1/2019

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

☐	**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)** If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID facility level of care:

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

Select one:

○	**Not applicable**			
●	**Applicable**			
	Check the applicable authority or authorities:			
	☑	**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**		
	☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*		
		Specify the §1915(b) authorities under which this program operates (*check each that applies*):		
		☐ §1915(b)(1) (mandated enrollment to managed care)	☐ §1915(b)(3) (employ cost savings to furnish additional services)	
		☐ §1915(b)(2) (central broker)	☐ §1915(b)(4) (selective contracting/limit number of providers)	
	☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*		
	☐	**A program authorized under §1915(i) of the Act.**		
	☐	**A program authorized under §1915(j) of the Act.**		
	☐	**A program authorized under §1115 of the Act.** Specify the program:		

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

PURPOSE:
Many elders who are nursing facility eligible prefer to remain in their homes in the community when sufficient supports can be put into place to maintain them safely in this setting. The purpose of the Frail Elder Waiver is to make such supports available to frail elders, aged 60 and older who have been determined through an assessment process to meet a nursing facility level of care and require supports to reside successfully in the community. Included in this waiver are individuals with a variety of needs that can be met through supports that range from basic to intensive levels.

GOAL:
The goals of the Frail Elder Waiver include: maintaining eligible elders in a home setting, avoiding, delaying or shortening nursing facility stays, meeting the wishes of elders who prefer to stay in their homes, and providing cost effective, high quality alternatives to support elders' home and community based service needs.

ORGANIZATIONAL STRUCTURE:
The Executive Office of Elder Affairs (EOEA or Elder Affairs) is an agency under the umbrella of the Executive Office of Health and Human Services (EOHHS), the single state agency. As such EOEA is under the administrative authority of EOHHS. EOEA is responsible for providing supports to elders, and is directly responsible for the oversight of the day-to-day operation of the Frail Elder Waiver on behalf of EOHHS. The EOHHS MassHealth Office of Long Term Services and Supports (LTSS) oversees the provision to eligible members of long term services and supports including through the Senior Care Options program, a Massachusetts integrated managed care program for eligible elders. EOEA and MassHealth meet regularly and collaborate on organizational matters, waiver management, quality reporting and other aspects of waiver administration.

Elder Affairs contracts with and oversees the on-going responsibilities of 26 non-profit agencies called Aging Services Access Points (ASAPs), most of which are also Area Agencies on Aging. Waiver participants age 65 and older may choose to voluntarily enroll in a Senior Care Organization (SCO) which is a Medicaid managed care plan that manages all covered State Plan and Frail Elder Waiver services for enrolled members who are waiver participants. ASAPs and SCOs are responsible for assessing clinical level of care (LOC) for FEW participants (initial LOC for all waiver participants is done through an ASAP), conducting needs assessments, developing and monitoring services plans, conducting administrative case management functions and reporting client and quality-related data to Elder Affairs. Case management is provided to waiver participants as an administrative activity. Elder Affairs conducts oversight of all ASAP activities and the MassHealth Office of Long Term Services and Supports (LTSS) conducts oversight of all SCOs. Elder Affairs leads efforts and reviews quality jointly with LTSS.

SERVICE DELIVERY:
Through development of a person-centered service plan, waiver services are planned, authorized, arranged for and monitored by the case manager. Waiver participants who choose to enroll in a SCO will receive all waiver services through the SCO as well as work with an ASAP-employed Case Manager (the Geriatric Services Supports Coordinator, GSSC) under a contract between an ASAP and the SCO. Waiver services delivered through traditional service ASAP service delivery model use a

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network of contracted direct care providers. As noted, waiver services are coordinated and authorized through, and service delivery is arranged and monitored by, the Case Manager.

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3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

○	**Not Applicable**
○	**No**
●	**Yes**

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

●	**No**
○	**Yes**

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services.

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

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

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the

services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are:

(1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

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

This section will be populated after the public comment period, prior to submission to CMS.

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, Community Based Waivers				
Agency:	MassHealth				
Address :	One Ashburton Place				
Address 2:	5th Floor				
City:	Boston				
State:	MA				
Zip:	02108				
Phone:	(617) 573-1751	**Ext:**		☐	**TTY**
Fax:	(617) 573-1894				
E-mail:					

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

Last Name:	Vidler				
First Name:	Lynn				
Title:	Director of Home and Community Programs				
Agency:	Executive Office of Elder Affairs				
Address:	One Ashburton Place				
Address 2:	5th floor				
City:	Boston				
State:	MA				
Zip :	02108				
Phone:	(617) 222-7589	**Ext:**		☐	**TTY**
Fax:	(617) 727-9368				
E-mail:					

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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:	Tsai				
First Name:	Daniel				
Title:	Assistant Secretary and Director of MassHealth				
Agency:	Executive Office of Health and Human Services				
Address:	One Ashburton Place				
Address 2:	11th Floor				
City:	Boston				
State:	MA				
Zip:	02108				
Phone:	(617) 573-1600	**Ext:**		☐	**TTY**
Fax:	(617) 573-1894				
E-mail:					

Attachment #1: Transition Plan

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

☐ Replacing an approved waiver with this waiver.

☐ Combining waivers.

☐ Splitting one waiver into two waivers.

☐ Eliminating a service.

☐ Adding or decreasing an individual cost limit pertaining to eligibility.

☐ Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

☐ Reducing the unduplicated count of participants (Factor C).

☐ Adding new, or decreasing, a limitation on the number of participants served at any point in time.

☐ Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

☐ Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

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.

Completed.

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 Executive Office of Elder Affairs-While EOEA is organized under EOHHS & subject to its oversight authority, it is a separate state 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 Frail Elder Waiver ("FEW" or "Waiver") by the Executive Office of Elder Affairs (EOEA), a state agency within and subject to the oversight authority of EOHHS. The State Medicaid Director has ultimate oversight authority over waiver operational activities.

MassHealth and EOEA developed an Interagency Service Agreement that specifies the functions of MassHealth and EOEA related to operation of the Waiver. Using several management functions, the Medicaid Director, MassHealth staff and Executive Office of Elder Affairs staff collaborate in the operation of the waiver program. Some of these oversight activities include:

-Regular Secretariat-level meetings related to Long Term Services and Supports oversight are typically monthly meetings convened by the Secretary of Health and Human services and including the Secretary of Elder Affairs, the Assistant Secretary for MassHealth, and senior leadership staff for the purpose of overseeing the governance of the Office of Long Term Services and Supports, including the SCO program, and coordination between long term services and supports delivered under the Medicaid State Plan and the waiver.

-Regular Waiver Oversight meetings. Staff of the MassHealth Community Waiver Unit and the EOEA staff operating the waiver meet at least monthly, and on an ad hoc basis to review waiver operations, discuss quality goals and measurement, and identify needs for any changes to the waiver.

-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's Director of Community Based Waivers coordinates this activity with EOHHS staff from Elder Affairs, Information Technology/Data Warehouse, the MassHealth Office of Long Term Services and Supports Coordinated Care Unit, 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 for federal reporting.

-Regulations and policy implementation. MassHealth regulations at 130 CMR 519.007(B) describe eligibility for the Waiver. The MassHealth Operations (MHO) unit 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.

-Systems validation reports. The Evaluation unit of MHO performs random reviews of all MA-21 results to determine accuracy and examine supporting financial documentation. Error rates are determined and inaccuracies are referred to MHO eligibility staff for resolution.

-Staff of the MassHealth Community Waiver Unit participate, as appropriate, in EOEA workgroup activities associated with establishing quality indicators, policy and programmatic change contemplated to ensure appropriate waiver operation and alignment with CMS policies, rules and regulations.

- EOEA and the MassHealth Office of Long Term Services and Supports Coordinated Care Unit meet regularly to discuss operation of the waiver. Topics discussed include Senior Care Options (SCO), operational performance, contract management, quality reporting, and changes to be made in waiver policy.

- Executive Office of Elder Affairs Leadership Team Meetings – The Executive Office of Elder Affairs regular leadership team meetings include participation from the MassHealth Office of Long Term Services and Supports, the EOEA Home and Community Programs staff, and EOEA programmatic and finance leadership. This meeting includes key issues related to the operation of the ASAP network and the SCO organizations.

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Deleted: -MassHealth Leadership Team meetings lead by the Medicaid Director. These are bi-weekly meetings comprised of executive and senior management staff from all areas of the Medicaid program. These meetings provide oversight to the Medicaid program overall including a specific emphasis on community long term services and supports that includes activities and issues related to the Frail Elder Waiver as a key Medicaid program for meeting the needs of elders in need of on-going community based services.¶

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Deleted: In the near future, these functions will be subsumed within the state's Health Insurance Exchange (HIX) system.

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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:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

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

●	**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).** Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	Frail Elder Waiver participants aged 65 and older may choose to enroll in Senior Care Options, a managed care delivery system, to receive their Waiver services through a MassHealth-contracted managed care organization known as a Senior Care Organization ("SCO"). MassHealth contracts with SCOs for certain waiver operational and administrative functions, as indicated in Appendix A-7. SCO organizations are responsible for continuously monitoring clinical status, redetermination of level of care, conducting needs assessments, developing and monitoring person-centered service plans, providing interdisciplinary care management, and reporting participant data to MassHealth. In addition SCO organizations deliver qualified provider enrollment and quality assurance and improvement activities. SCOs have contractual relationships with ASAPs for case management of community based long term services and supports of SCO-enrolled individuals receiving Waiver services. These contracted case managers participate on the SCO's interdisciplinary care team.
○	**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

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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*:

The Executive Office of Elder Affairs contracts with 26 nonprofit agencies called Aging Services Access Points (ASAPs) in the operation of the Waiver. As EOEA's agents, the ASAPs are responsible for assessing clinical eligibility, determining level of care, conducting needs assessments, developing and monitoring person-centered service plans, providing interdisciplinary care management, and reporting participant data to EOEA. Aging Services Access Points (ASAPs), which are frequently also the local Area Agency On Aging, are designated by and under contract to the Executive Office of Elder Affairs. Massachusetts General Laws c.19a § 4b describes the functions of ASAPs. ASAPs contract with Elder Affairs to: purchase community-based long term services and supports for participants, and provide Adult Protective Services, nutrition services, Information and Referral, and Case Management, as well as coordinate and authorize the delivery of Home Care Program Services, and provide clinical screening for: nursing facility care, HCBS waiver eligibility, and community-based long term services and supports. Each agency is organized to plan, develop, and implement the coordination and delivery of community-based long term services and supports.

Deleted: Aging Services Access Points (ASAPs) conduct certain waiver operational and administrative functions at the local level at the direction of the Executive Office of Elder Affairs

Deleted: The Medicaid agency contracts with Senior Care Organizations (SCO's) for certain waiver operational and administrative functions. These SCO's have contractual relationships with ASAPs for case management of SCO-enrolled individuals receiving waiver services.

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

The Executive Office of Elder Affairs is responsible for oversight of all ASAP activities, including identifying and analyzing trends related to the operation of the Waiver and determining strategies to address quality-related issues. EOEA is responsible for ensuring that remediation strategies are implemented within appropriate timelines if/when any issues are discovered related to ASAPs' operation of the waiver program.

The MassHealth Office of Long Term Services and Supports (LTSS) oversees the Senior Care Options program, and is responsible for ensuring that remediation strategies are implemented within appropriate timelines if/when any issues are discovered related to SCOs' contracted waiver operational and administrative functions. LTSS, in conjunction with EOEA, provides guidance and direction to SCOs. If areas of noncompliance are identified, LTSS requires SCOs to submit corrective action plans (CAPs) as appropriate, and monitors the SCOs' implementation of CAPs to ensure their effectiveness.

Deleted: and the MassHealth Office of Long Term Services and Supports.

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

The Executive Office of Elder Affairs conducts ongoing on-site reviews and desk audits of each ASAP.

These audits include a review of all waiver functions the ASAPs perform on behalf of EOHHS. As part of the audit process, a random sample of waiver participants is selected and both paper and electronic records are reviewed for adherence to identified compliance measures and quality indicators. In addition, annual reporting by the ASAP to EOEA ensures they are meeting the measures for all waiver participants. EOEA conducts key informant interviews to learn about agency practices and procedures. Summary findings of any review conducted by EOEA are made available to MassHealth on an as-needed basis.

The MassHealth Office of Long Term Services and Supports (LTSS) conducts audits of each SCO annually, which includes review of Level of Care re-evaluations, qualified provider enrollment, and quality assurance/quality improvement activities as they relate to waiver participants. As part of the audit process, a random sample of waiver participants is selected and reviewed for adherence to identified compliance measures and quality indicators. In addition, SCOs are required to report waiver quality indicator data no less than twice a year to LTSS. LTSS staff works in tandem with EOEA to analyze quality indicators to determine if the SCOs are meeting the measures for all SCO-enrolled waiver participants. If areas of noncompliance are identified, LTSS will institute corrective action plans for a SCO.

Deleted: the Medicaid agency

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Deleted: The Medicaid agency requires a monthly report from each SCO ensuring they are meeting their contractual requirements. These reports include data on Financial, Marketing and Quality management activities. If needed, the Medicaid agency

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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	☑	☐	☐	☐

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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	☑	☐	☑	☑

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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: *#1*	EOEA and MassHealth oversaw, through annual data analysis, ASAP and SCO performance of waiver functions, as described in the waiver application. Numerator: Number of performance measures for which EOEA analyzed data Denominator: Number of performance measures in the waiver application
Data Source *(Select one) (Several options are listed in the on-line application):* Other	
If 'Other' is selected, specify:	
EOEA annual quality reporting on performance measures	

	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:*

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*

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	☐ *Other Specify:*

Performance Measure: *#3*	Participants were supported by competent and qualified case managers, in accordance with state requirements. Numerator: Number of Case Managers that met qualification standards Denominator: Number of Case Managers
Data Source *(Select one) (Several options are listed in the on-line application):* Reports to State Medicaid Agency on delegated Administrative functions	
If 'Other' is selected, specify:	
ASAP quality reporting to EOEA and SCO reporting to LTSS SCO Unit	

	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*	
	ASAPs and SCOs	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

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*
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	☐ *Continuously and Ongoing*

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	☐ *Other* *Specify:*

Performance Measure: #2	EOEA and MassHealth worked collaboratively with ASAPs and SCOs to ensure systematic and continuous data collection and analysis of the ASAP and SCO functions, as evidenced by timely and accurate submission of quality data reports. Numerator: Number of ASAP and SCO quality reports that were accurate, on time, and in the correct format Denominator: Number of ASAP and SCO reports due
Data Source *(Select one) (Several options are listed in the on-line application):* Reports to State Medicaid Agency on delegated Administrative functions	
If 'Other' is selected, specify:	
ASAP quality reporting to EOEA and SCO reporting to LTSS SCO Unit	

	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*	
	ASAPs and SCOs	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other* *Specify:*	
			☐ *Other Specify:*

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*

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	☐ Other Specify:

Performance Measure: 4	*An annual reevaluation of level of care was completed on a timely basis for each waiver participant.* *Numerator: Number of waiver participants whose level of care evaluation was conducted in the past year* *Denominator: Number of waiver participants who were due for a level of care redetermination*

Data Source *(Select one) (Several options are listed in the on-line application): Reports to State Medicaid Agency on delegated Administrative functions*

If 'Other' is selected, specify:

SIMS data 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:

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

If 'Other' is selected, specify:

Analysis of SCO MDS submissions

	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:*

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 Executive Office of Elder Affairs (EOEA), MassHealth and LTSS are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Aging Services Access Points (ASAPs) and Senior Care Organizations (SCOs). In the event problems are discovered with the management of the waiver program, ASAPs/SCOs, or waiver service providers, EOEA/MassHealth/LTSS 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, EOEA, MassHealth and LTSS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

Deleted: The Medicaid agency is responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Aging Services Access Point. As problems are discovered with the management of the waiver program at individual ASAPs/SCOs, the Executive Office of Elder Affairs and MassHealth's Office of Long Term Support Services are responsible for ensuring that a corrective action plan is created, approved, and implemented within appropriate timelines.

ii Remediation Data Aggregation

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

c. Timelines

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

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

Appendix B: Participant Access and Eligibility

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

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

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
☐	**Aged or Disabled, or Both - General**				
	☑	Aged (age 65 and older)	65		☑
	☑	Disabled (Physical)	60	64	
	☐	Disabled (Other)			
☐	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐	**Intellectual Disability or Developmental Disability, or Both**				
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
☐	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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:

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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*):

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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	19,200
Year 2	19,400
Year 3	19,600
Year 4	19,800
Year 5	20,000

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.**

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:

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:

The waiver provides for the entrance of all eligible persons.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

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.*

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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*):

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- ● 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.*

Deleted: ○

- ○ 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.*

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NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

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

b. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

ii. <u>Allowance for the spouse only</u> (*select one*):			
●	**Not Applicable**		
Specify the amount of the allowance (*select one*):			
○	**SSI standard**		
○	**Optional State supplement standard**		
○	**Medically needy income standard**		
○	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*		

iii. Allowance for the family *(select one)*:	
●	**Not Applicable** ***(see instructions)***
○	**AFDC need standard**
○	**Medically needy income standard**
○	**The following dollar amount:** $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	**The amount is determined using the following formula:** *Specify:*
○	**Other** *Specify:*
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. Select one:	
●	**Not applicable** ***(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The State does not establish reasonable limits.**
○	**The State establishes the following reasonable limits** *Specify*:

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

c. Regular Post-Eligibility Treatment of Income: 209(B) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

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).

Deleted: *Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.*

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**
○	**A percentage of the Federal Poverty level**
○	% Specify percentage:
○	**The following dollar amount:** $
○	**The following formula is used to determine the needs allowance:** *Specify formula:*
○	**Other** *Specify*:

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

Select one:

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

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

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

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

Select one:

●	**Not applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
○	**The State does not establish reasonable limits.**
○	**The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

NOTE: Items B-5-e, B-5-f and B-5-g only apply for the five-year period beginning January 1, 2014. If the waiver is effective during the five-year period beginning January 1, 2014, and if the state indicated in B-5-a that it uses spousal post-eligibility rules under §1924 of the Act before January 1, 2014 or after December 31, 2018, then Items B-5-e, B-5-f and/or B-5-g are not necessary. The state's entries in B-5-b-2, B-5-c-2, and B-5-d, respectively, will apply.

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state – 2014 through 2018. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e

Deleted: Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.¶

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility: 209(b) State – 2014 through 2018. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Deleted: Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.¶

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – 2014 through 2018

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

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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 may include face-to-face or telephone contact with the participant and may also include collateral contact with formal or informal supports. These contacts will be documented in the participant's case record.

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

○ **Directly by the Medicaid agency**

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

● **By an entity under contract with the Medicaid agency.**
Specify the entity:

Aging Services Access Point (ASAP) Registered Nurses are responsible for performing initial level of care evaluations for all waiver participants and for performing annual level of care reevaluations for waiver participants served by the ASAP. For waiver participants enrolled in Senior Care Options, Senior Care Organizations (SCOs) Registered Nurses are responsible for

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	performing annual level of care reevaluations only.
○	**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:

Registered Nurses (RN) licensed in Massachusetts

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.

Participants must meet the clinical eligibility criteria for nursing facility services as outlined in 130 CMR 456.409 (MassHealth Nursing Facility regulations that describe the requirements for medical eligibility for nursing facility services). Functional impairment level and need criteria are assessed in accordance with Home Care Program regulations found at 651 CMR 3.03 (Department of Elder Affairs Home Care Program regulations that describe home care program eligibility). MassHealth Provider Bulletins and Elder Affairs Program Instructions or Information Memoranda may be issued from time to time to further clarify regulatory requirements.

Registered nurses employed by the ASAPs perform the clinical evaluations of potential participants with an in-person assessment utilizing a standard assessment tool, the Comprehensive Data Set (CDS), which includes, in its entirety, the Minimum Data Set-Home Care (MDS-HC) or successor tool in use by the state. The CDS assessment is automated in the Senior Information Management System (SIMS).

The participant's annual redetermination will utilize the core elements of same tool (i.e. MDS-HC).

For waiver participants enrolled in Senior Care Options, Senior Care Organizations (SCOs) Registered Nurses are responsible for performing level of care reevaluations. Participants are assessed using the Minimum Data Set-Home Care (MDS-HC).

Clinical eligibility for all participants is determined using the current clinical criteria for nursing facility services.

Deleted: A Center for Medicare and Medicaid Services (CMS) 485 Form, or an MDS-HC completed by another RN, such as an Adult Day Health provider nurse may be used to supplement information gathered by the ASAP RN. . In addition to completion of the CDS, the ASAP RN must obtain a completed Physician Summary Form or a CMS 485 Form that includes the physician's signature. ¶
¶
The same tools and criteria are used for reevaluation of level of care.

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

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

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

The ASAP RN conducts an in-person assessment of the applicant/participant for both initial as well as annual reevaluation of level of care, and completes the CDS assessment tool. The in-person assessment is generally conducted in the elder's home, but may be conducted in an alternative location such as a nursing facility. Additional information may be obtained from other sources including any case manager or other providers.

The ASAP RN enters these clinical determinations and supporting information into the participant's record in SIMS.

For participants enrolled in a Senior Care Organization (SCO), the SCO RN conducts an in-person reevaluation of the participant and completes the MDS-HC assessment tool. The in-person assessment is generally conducted in the participant's home, but may be conducted in an alternative location. Additional information may be obtained from other sources including the case manager or other provider. The MDS-HC is submitted electronically to MassHealth and reviewed by nurses employed by LTSS for confirmation that the participant continues to meet level of care requirements.

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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)*:

Timely reevaluation of level of care completed by the appropriate ASAP or SCO nurse is ensured by the use of an automated information system. The automated information system tracks the date of the individual's level of care evaluation and the due date for the next re-evaluation. Through the use of management reports ASAP and SCO staff are provided with the data needed to ensure timely completion of reevaluation. State monitoring is conducted on all records to ensure that re-evaluations have been conducted in accordance with all requirements.

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

Determinations of level of care are maintained in electronic records as part of the Senior Information Management System (SIMS). Reevaluations of level of care are maintained in a consistent manner either by the ASAP or a SCO, depending on the service delivery system chosen by the Participant. Paper records are maintained for each waiver participant by the relevant ASAP or SCO, in accordance with 808 CMR 1.00 (The State's Division of Purchased Services regulations that describe the contract compliance, financial reporting and auditing requirements applicable to state procurements of human and social services.) and EOEA-PI-04-08.

For SCO enrolled participants, reevaluation assessments are uploaded electronically through the EOHHS Virtual Gateway. Once level of care is confirmed the data transfers to the EOHHS data warehouse. The reevaluation assessments uploaded by the SCO plans are maintained electronically in the MassHealth data warehouse indefinitely and the data is retrievable.

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Deleted: SCO providers must maintain a single, centralized, comprehensive record that documents the particpants medical, functional, and social status.

Deleted: The SCO ensures that the PCP and all members of the interdisciplinary team as well as any other appropriate Providers, including subcontracted Providers, make appropriate and timely entries describing the care provided, diagnoses determined, medications prescribed, and treatment plans developed. The organization and documentation included in the Centralized Enrollee Record must meet all applicable professional requirements. The centralized record is available and accessible 24 hours per day, seven days per week, either in its entirety or in a current summary of key clinical information, to triage and acute care Providers for Emergency Conditions and Urgent Care.

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:5	*Applicants' initial clinical eligibility was assessed by an RN within 10 business days of identifying their need for the waiver program.* *Numerator: Number of waiver applicants whose initial clinical eligibility was assessed within 10 business days of identifying their need for the waiver program.* *Denominator: Number of waiver applicants,*
Data Source *(Select one) (Several options are listed in the on-line application):Reports to State Medicaid Agency on delegated Administrative functions*	
If 'Other' is selected, specify:	
SIMS data 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*

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

i. Performance Measures

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

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

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Deleted: *Annual reevaluation of the level of care was completed on a timely basis for each waiver participant. Numerator: The number of waiver participants in the reporting period with a timely re-evaluation of level of care; Denominator: The number of waiver participants in the reporting period.*

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	(check each that applies)	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.

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

Performance Measure:8	The reevaluation of level of care was completed using an approved assessment tool. Numerator: Number of waiver participants whose level of care was determined using an approved assessment tool Denominator: The number of waiver participants who had an annual level of care redetermination completed
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	

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SIMS data 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:*

Analysis of SCO MDS submissions			
	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:*

Data Aggregation and Analysis

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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:6	*Applicants' initial level of care evaluation was completed by an RN, as evidenced by a signature and credentials on the approved evaluation tool.* *Numerator: Number of applicants whose initial level of care evaluation was completed by an RN, as evidenced by a signature and credentials on the approved evaluation tool* *Denominator: Number of assessed applicants*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
SIMS data 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:*

Data Aggregation and Analysis

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

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(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:7	*RNs cited the regulatory requirements on the approved tool to support applicants' initial level of care determinations.* *Numerator: Number of applicants with appropriate regulatory requirements cited in support of initial level of care determinations* *Denominator: Number of assessed applicants*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
SIMS data 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:*

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*

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☐ *Operating Agency*	☐ *Monthly*
☐ *Sub-State Entity*	☐ *Quarterly*
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	☐ *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.*

Deleted: ASAPs/SCOs will be responsible to perform 100% review of each of these areas and will report the results to EOEA on an annual basis. In addition, as part of the quality oversight responsibility of EOEA and OLTSS will include conducting retrospective reviews to validate the results of ASAP/SCO data reporting. A statistically significant sample of waiver participant records will be randomly selected from ASAPs and SCOs and will be reviewed by EOEA and OLTSS staff to validate data reporting elements.¶

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 Executive Office of Elder Affairs (EOEA), MassHealth and LTSS are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Aging Services Access Points (ASAPs) and Senior Care Organizations (SCOs). In the event problems are discovered with the management of the waiver program, ASAPs/SCOs, or waiver service providers, EOEA/MassHealth/LTSS 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, EOEA, MassHealth and LTSS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

Deleted: Annual Waiver Quality data reports for individual ASAPs and SCO's are reviewed by Medicaid Agency staff and all areas that reflect less than 100% are required to be addressed by a corrective action plan. ASAP staff will be responsible for remediation and/or necessary corrective action.. Timelines for remediation will be reflective of the nature and severity of the issue to be addressed.¶

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 case manager delivers a Recipient Choice Form to the elder (or legal representative) either in person or by mail. This form includes written notification that the elder has been determined eligible for nursing facility services and offers the elder the opportunity to choose between community-based or nursing facility services. The participant indicates his/her preference on the Recipient Choice Form. The signed and dated form is maintained by the ASAP, for all waiver participants, in the participant record.

If the elder chooses to receive community-based services, the case manager informs the elder of the services available under the waiver as part of the needs assessment and service plan development process.

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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 the ASAP office.

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

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

The Executive Office of Elder Affairs (EOEA) and its contractors have developed multiple approaches to promote and ensure access to the waiver by Limited English Proficient persons. EOEA has made waiver documents, such as eligibility notices and information regarding appeal rights, available in a number of languages. ASAPs and SCOs 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. ASAPs conduct outreach in their communities with brochures and other materials in languages appropriate to their geographic service area. ASAPs also work collaboratively with multicultural community organizations that provide social services to identify individuals and families who may be eligible for services from EOEA, including waiver program services. SCOs conduct outreach, as allowed by CMS and EOHHS, in a manner that ensures accessibility.

ASAPs/SCOs must ensure that ASAP/SCO employees are capable of speaking directly with participants in their primary language. When this is not possible, they must arrange for interpreting services by either a paid interpreting service or through an individual, such as a family member, designated by the participant. These entities are further required to assess the linguistic and cultural profile of the communities in which they provide services and identify populations not currently being served by linguistically or culturally appropriate staff of either the entity or waiver service providers. In addition, each ASAP and SCO must ensure access to TTY services or Telecommunications Relay Services.

EOEA promotes access to waiver services by working to build capacity among service providers to become more culturally responsive in the delivery of services. Contracting entities use information gathered in the linguistic and cultural profile of their communities to evaluate waiver service providers and to inform them of gaps in linguistic competence. In turn, service providers address identified gaps in multiple ways, including outreach efforts, hiring of bilingual and bicultural staff, providing information in the primary languages of the participants and families receiving services, and developing working relationships with other multicultural community organizations in their communities.

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Appendix C: Participant Services

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

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

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

Other Services *(select one)*	
○	Not applicable
●	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:

a.	Chore
b.	Companion
c.	Enhanced Technology/Cellular PERS
d.	Environmental Accessibility Adaptation
e.	Evidence Based Education Program
f.	Goal Engagement Program
e.	Grocery Shopping and Delivery
f.	Home Based Wandering Response Systems
g.	Home Delivered Meals
h.	Home Delivery of Pre-packaged Medication
i.	Laundry
j.	Medication Dispensing System
k.	Orientation & Mobility
l.	Home Safety/Independence Evaluation (formerly Occupational Therapy)
m.	Peer Support
n.	Senior Care Options (SCO)
o.	Complex Care Training and Oversight (formerly Skilled Nursing)
p.	Supportive Day Program
q.	Supportive Home Care Aide
r.	Transitional Assistance
s.	Transportation
Extended State Plan Services *(select one)*	
●	Not applicable
○	The following extended State plan services are provided *(list each extended State plan service by service title)*:
Supports for Participant Direction *(check each that applies))*	
☐	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
☐	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.
●	Not applicable

Deleted: Occupational Therapy

Deleted: Skilled Nursing

C-1/C-3: Service Specification

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

Service Specification						
Service Type: ☒ Statutory ☐ Extended State Plan ☐ Other						
Service Name: Habilitation						
Alternative Service Title (if any): Alzheimer's/Dementia Coaching						
☑ 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)**:**						
Alzheimer's/Dementia Coaching (Habilitation Therapy) is a service designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Alzheimer's/Dementia Coaching creates and maintains a positive experience for a person experiencing the effects of a dementia related illness. The objective is to provide education and support to the consumer and caregiver and to provide suggestions to modify elements of the environment that may exacerbate the symptoms of the disease. Habilitation Coaches provide knowledge and expertise to caregivers (and the person with the disease when appropriate) in understanding the disease process and pitfalls to avoid, as well as techniques of communication, behavior management, structuring the environment, creating therapeutic activities and planning for future care needs.						
Specify applicable (if any) limits on the amount, frequency, or duration of this service:						
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E			☑	Provider managed
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☑	Individual. List types:	☑	Agency. List the types of agencies:
	Qualified individual providers of Alzheimer's/Dementia Coaching		Alzheimer's/Dementia Coaching agencies	
			Homemaker/Personal Care Agencies	
			Home Health Agencies	

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Qualified individual providers of	In addition to the certification	Services must be performed by an	Adherence to Continuous QI Practices:

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Alzheimer's/Dementia Coaching	requirements listed below, Alzheimer's Dementia Coaching must be performed by a professional with a valid Massachusetts license for any of the following: - Registered Nurse - Licensed Independent Clinical Social Worker - Licensed Certified Social Worker w/one year of experience working with person with dementia/related illness - Occupational Therapist - or other similar professional licensure.	individual trained in Habilitation Therapy by the Alzheimer's Association	Providers Qualified individuals must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Individual Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).
Alzheimer's/Dementia Coaching agencies	In addition to the certification requirements listed below, Alzheimer's Dementia Coaching must be performed by a professional with a valid Massachusetts license for any of the following: - Registered Nurse - Licensed Independent Clinical Social	Services must be performed by an individual trained in Habilitation Therapy by the Alzheimer's Association. Agencies may apply to EOEA for a waiver in order to have an individual who has been trained in Habilitation Therapy by the Alzheimer's Association conduct training for additional staff.	Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability:

	Worker - Licensed Certified Social Worker w/one year of experience working with person with dementia/related illness - Occupational Therapist - or other similar professional licensure.		Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).
Homemaker/Personal Care Agencies	In addition to the certification requirements listed below, Alzheimer's Dementia Coaching must be performed by a professional with a valid Massachusetts license for any of the following: - Registered Nurse - Licensed Independent Clinical Social Worker - Licensed Certified Social	Services must be performed by an individual trained in Habilitation Therapy by the Alzheimer's Association. Agencies may apply to EOEA for a waiver in order to have an individual who has been trained in Habilitation Therapy by the Alzheimer's Association conduct training for additional staff.	Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical

	Worker w/one year of experience working with person with dementia/related illness - Occupational Therapist - or other similar professional licensure.		areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).
Home Health Agencies	In addition to the certification requirements listed below, Alzheimer's Dementia Coaching must be performed by a professional with a valid Massachusetts license for any of the following: - Registered Nurse - Licensed Independent Clinical Social Worker - Licensed Certified Social Worker w/one year of experience	Services must be performed by an individual trained in Habilitation Therapy by the Alzheimer's Association. Agencies may apply to EOEA for a waiver in order to have an individual who has been trained in Habilitation Therapy by the Alzheimer's Association conduct training for additional staff.	Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate.

	working with person with dementia/related illness - Occupational Therapist - or other similar professional licensure.		Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Qualified individual providers of Alzheimer's/Dementia Coaching	**ASAPs**	**Every 3 years**
Alzheimer's/Dementia Coaching agencies	**ASAPs**	**Every 3 years**
Homemaker/Personal Care Agencies	**ASAPs**	**Every 3 years**
Home Health Agencies	**ASAPs**	**Every 3 years**

Service Specification						
Service Type: ☒ Statutory ☐ Extended State Plan ☐ Other						
Service Name: Home Health Aide						
Alternate Service Title (if any):						
☐ Service is included in approved waiver. There is no change in service specifications.						
☑ Service is included in approved waiver. The service specifications have been modified.						
☐ Service is not included in approved waiver.						
Service Definition (Scope)**:**						
Home Health Aides provide healthcare assistance and help with personal care for participants whose care needs exceed the scope of Personal Care worker expertise and training as specified in Elder Affairs Personal Care Guidelines. Participants appropriate for Home Health Aide services have specialized care needs that waiver Personal Care service workers are not qualified to provide, which may include but are not limited to: inability to transfer more than 50% of their body weight, have extensive mobility limitations, require the use of a mechanical lift, require special skin care, require ostomy care or have other unstable medical conditions. Services are provided under the supervision of an RN and include: personal care, including incontinence care; assistance with ambulation and transfers; medication cueing and reminders; activities that support the participant's person-centered goals; and routine care of prosthetic and orthotic devices. Services defined in 42 CFR §440.70 that are provided in addition to home health aide services furnished under the approved State Plan. Home health aide services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from home health aide services in the State Plan. The difference from the State Plan is as follows: Agencies that provide Home Health Aide services under the waiver do not need to meet the requirements for participation in Medicare, as provided in 42 CFR §489.28. In addition, unlike State Plan Home Health benefits, waiver Home Health Aide services may be provided when the waiver participant is not receiving other skilled nursing or therapy 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:
				Home Health Agencies
				Homemaker/Personal Care Agencies

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agencies	Supervision of Home Health Aides must be provided by a	Individuals employed by the agency providing homemaker	Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their jobs, including handling emergency situations

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	Registered Nurse with a valid Massachusetts license.	services must have one of the following: -Certificate of Home Health Aide Training; or -Certificate of Certified Nurse's Aide Training	and 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements). In addition, providers shall ensure that individual home health aides employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing;

			accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.
Homemaker/Personal Care Agencies	Supervision of Home Health Aides must be provided by a Registered Nurse with a valid Massachusetts license.	Individuals employed by the agency providing homemaker services must have one of the following: -Certificate of Home Health Aide Training; or -Certificate of Certified Nurse's Aide Training	Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their jobs, including handling emergency situations and 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public

			Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements). In addition, providers shall ensure that individual home health aides employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agencies	**ASAPs**	**Every 2 years**
Homemaker/Personal Care Agencies	**ASAPs**	**Every 2 years**

Service Specification

Service Type: ☒ Statutory ☐ Extended State Plan ☐ Other

Service Name: Homemaker

Alternate Service Title (if any):

☑ 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)**:**

Homemaker service includes assistance with: shopping, menu planning, laundry, and 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/Personal Care Agencies
				Home Health Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Homemaker/Personal Care Agencies		Individuals employed by the agency providing homemaker services must have one of the following: -Certificate of Home Health Aide Training -Certificate of Nurse's Aide Training -Certificate of 40-Hour Homemaker Training	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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the

			Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements). In addition, providers shall ensure that individual homemakers employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.
Home Health Agencies		Individuals employed by the agency providing homemaker services must have one of the following: -Certificate of Home Health Aide Training -Certificate of Nurse's Aide Training -Certificate of 40-Hour Homemaker Training	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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair

			Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements). In addition, providers shall ensure that individual homemakers employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Homemaker/Personal Care Agencies	**ASAPs**	**Every 2 years**
Home Health Agencies	**ASAPs**	**Every 2 years**

Service Specification

Service Type: ☒ Statutory ☐ Extended State Plan ☐ Other

Service Name: Personal Care

Alternative Service Title (if any):

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

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

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually

performing a task for the person) or cuing and supervision to prompt the participant to perform a task. Such assistance may include assistance in bathing, dressing, personal hygiene and other activities of daily living, and medication reminders in accordance with Elder Affairs' Personal Care Guidelines. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the care plan, this service may also include such housekeeping chores as bed-making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health or welfare of the individual, rather than the individual's family. Personal care services may be provided on an episodic or on a continuing basis.

Personal care under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from personal care services in the State Plan. Personal care under the waiver may include supervision and cueing of participants. The waiver service is an agency model of care.

Deleted: p

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

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

Provider Specifications

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agencies		Individuals employed by the agency providing personal care services must have one of the following: -Certificate of Home Health Aide Training -Certificate of Nurse's Aide Training -Certificate of 60-Hour Personal Care Training	Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate.

			Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements). In addition, providers shall ensure that individual personal care workers employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.
Homemaker/Personal Care Agencies		Individuals employed by the agency providing personal care services must have one of the following: -Certificate of Home Health Aide Training -Certificate of Nurse's Aide	Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists. Adherence to Continuous QI Practices: Providers must have established strategies

		Training -Certificate of 60-Hour Personal Care Training	to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements). In addition, providers shall ensure that individual personal care workers employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agencies	**ASAPs**	**Every 2 years**
Homemaker/Personal Care Agencies	**ASAPs**	**Every 2 years**

Service Specification	
Service Type: ☒ Statutory ☐ Extended State Plan ☐ Other	
Service Name: Respite	
Alternative Service Title (if any):	
	☐ 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. Federal Financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

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. In addition to respite care provided in the participant's home or private place of residence, Respite Care services may be provided in the following locations:

-Respite Care in an Adult Foster Care Program provides personal care services in a family-like setting. A provider must meet the requirements set forth by MassHealth and must contract with MassHealth as an AFC provider.
-Respite Care in a Hospital is provided in licensed acute care medical/surgical hospital beds that have been approved by the Department of Public Health.
-Respite Care in a Rest Home provides residential care for clients in a supervised, supportive and protective environment. A Rest Home must be licensed 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 an Adult Day Health program provides an organized program of health care and supervision, restorative services, and socialization for elders who require skilled services or physical assistance with activities of daily living. Nutrition and personal care services are also provided to participants. Adult Day Health programs must be approved for operation by MassHealth.

Respite services provided in an Adult Foster Care Program, Hospital, Rest Home, Skilled Nursing Facility or Assisted Living Residence may include the costs of room and board.

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:
				Rest Home
				Skilled Nursing Facility
				Assisted Living Residence
				Adult Day Health
				Adult Foster Care

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Rest Home	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 in Massachusetts)		
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 in Massachusetts)		

Assisted Living Residence		Certified by EOEA in accordance with 651 CMR 12.00 (EOEA regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts)	
Adult Day Health	Licensed by the Department of Public Health in accordance with 105 CMR 158.000 (Department of Public Health Licensure of Adult Day Health Programs)		An organization that meets the requirements of 105 CMR 158.00 (Department of Public Health Licensure of Adult Day Health Programs) and that contracts with MassHealth as a provider of Adult Day Health services.
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 operation of hospitals in Massachusetts)		

Deleted: 130 CMR 404.00 (MassHealth Adult Day Health Regulations)

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Rest Home	DPH	Every 2 years
Skilled Nursing Facility	DPH	Every 2 years
Assisted Living	EOEA	Every 2 years

Residence		
Adult Day Health	DPH	Every 2 years
Adult Foster Care	MassHealth	Every 2 years
Hospital	DPH	Annually

Deleted: MassHealth

Service Specification
Service Type: ☐ Statutory ☐ Extended State Plan ☑ Other
Service Name: Goal Engagement Program
Alternate Service Title (if any):
☐ Service is included in approved waiver. There is no change in service specifications.
☐ Service is included in approved waiver. The service specifications have been modified.
☑ Service is not included in approved waiver.
Service Definition (Scope)**:**
The Goal Engagement program is a set of highly individualized, person-centered services that use the strengths of the waiver participant to improve her/his safety and independence. Goal Engagement Program services engage participants to identify and address their goals related to increasing functional independence, improving safety, decreasing depression and improving motivation, including addressing barriers to achieve and maintain maximum functional independence in their daily lives. Participants receive a structured set of home visits conducted by a multidisciplinary team consisting of an Occupational Therapist (OT), a Registered Nurse (RN), and a home repair specialist. The participant and OT work together to identify areas of concern using a standardized assessment tool. Areas evaluated include ADLs, IADLs, maintaining health and community engagement. Based on the assessment, the OT may recommend strategies that can be implemented by the home repair specialist to increase home safety and mitigate conditions that pose a risk or barrier to safe, independent daily functioning, such as changes necessary for fall prevention. Using a motivational interviewing approach, the OT engages the participant to develop goals based on difficulties found in the self-report, observations during the assessment, and what the participant identifies is meaningful activity for them in order to preserve their independence and prevent institutionalization. The participant and OT develop an action plan for addressing these goals. At each visit, the participant reviews their goals, refines them as desired, and practices the action plan with the assessor. Each visit includes training the participant to harness their motivation to work toward their goals. Complementing the OT work on functional goals, the RN addresses medical issues that inhibit daily function, such as pain, mood, medication adherence and side effects, strength and balance, and communication with healthcare providers. RN visits focus on goals set by the participant rather than on adherence to medical regimens unless this is the participant's goal. Each member of the multidisciplinary Goal Engagement Program team focuses on the participant's identified goals to customize the service according to the action plan. Accordingly, this service includes coordination between the OT, RN and home repair specialist to ensure services are targeted to meet the goals identified by

the participant.

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

Goal Engagement Program services include up to 10 in-home visits by the OT or RN. Purchases related to home safety, minor home repairs, and related items and services are limited to $1,800 per participant, per year, when reimbursed on a fee-for-service basis. Participants are limited to one set of Goal Engagement services per calendar year.

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

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

Provider Specifications

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Goal Engagement Program agencies	Occupational Therapy elements of the service must be performed by an Occupational Therapist with a valid Massachusetts license or by either a certified occupational therapy assistant or an occupational therapy student under the direct supervision of a licensed Occupational Therapist. Skilled nursing elements of the service must be performed by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license. If the scope of work involves minor home repairs, agencies and individuals employed by the agencies must	Staff providing OT and nursing must be CAPABLE certified.	Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay.

		possess any licenses/ certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc)		Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements). In addition, providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Goal Engagement Program agencies	ASAPs	Every 2 years

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

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes minor home repairs, maintenance, and heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Chore Provider Agencies			Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate.

			Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy and Client Emergency in the Home Policy. In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Chore Provider Agencies	ASAPs	Every 3 years

Service Specification	
Service Type: ☐ Statutory ☐ Extended State Plan ☒Other	
Service Name: 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. This service may	

include transportation for the participant when authorized through the care plan. 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.

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:
				Companion Provider Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Companion Provider Agencies	If the worker will be providing transportation they must have a valid Driver's License		Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay.

			Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: -Client Not at Home Policy and Client Emergency in the Home Policy. When transportation is provided: Providers must have policies and procedures that include: -Vehicle safety and maintenance -Assisting passengers on/off vehicles and from door to door -Ensuring drivers have current licenses as required and current Auto Insurance In addition, providers shall ensure that individuals employed by the agency to provide companion service are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Companion Provider Agencies	**ASAPs**	**Every 3 years**

Service Specification
Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other
Service Name: Enhanced Technology/Cellular Personal Emergency Response System (PERS)
☐ 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):

Enhanced Technology/Cellular Personal Emergency Response System (PERS) provides personal emergency response service to consumers who do not have a traditional landline telephone. Cellular PERS functionality includes:

- Cellular capacity that is built into the PERS unit, allowing emergency calls to go to the monitoring center by converting the signal to cellular.
- The consumer presses the help button and there is immediate response 24/7 via 2-way voice connection through the PERS device.

Agencies that provide Enhanced Technology/Cellular PERS under the waiver are not required to meet the requirements for participation in Medicaid, as provided in 130 CMR 409.00 (MassHealth Durable Medical Equipment regulations that describe the provider eligibility requirements and program rules). This service does not duplicate services available through the State Plan. Participants with an available landline telephone may not receive Enhanced Technology/Cellular Personal Emergency Response System (PERS).

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:
				Personal Emergency Response Providers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Emergency Response Providers			Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient

			services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: - Maintenance of 24-hour monitoring station, including communication protocols for the hearing impaired and access to interpreter services in emergencies; and - Equipment testing. In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Emergency Response Providers	ASAPs	Every 3 years For those agencies unable to be monitored via on-site visit due to geographical distance, the

			ASAP will conduct periodic random testing; at a minimum of every 6 months for waiver participants.

Service Specification							
Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other							
Service Name: Environmental Accessibility Adaptation							
☐ 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 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. 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 approved adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).							
Specify applicable (if any) limits on the amount, frequency, or duration of this service:							
Service Delivery Method	☐	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:
				Environmental Accessibility Adaptation Agencies

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Environmental Accessibility Adaptation	If the scope of work involves home modifications,		Any not-for-profit or proprietary organization that contracts with the ASAP as such and successfully demonstrates, at a

Agencies	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.)		minimum, the following: Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Deleted: 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
Environmental Accessibility Adaptation Agencies	**ASAPs**	**Every 3 years**

Service Specification

Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other

Service Name: Evidence Based Education Programs

Alternative Service Title (if any):

☐ 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)**:**

Evidence Based Education Programs provide participants with education and tools to help them better manage chronic conditions such as diabetes, heart disease, arthritis, HIV/AIDS and depression, to better manage/prevent falls, or to appropriately manage/assist their caregivers in provision of their care (eg., for individuals with dementia). All Evidence Based Education Programs are provided either as peer-facilitated self-management workshops that meet weekly for six or eight weeks or as 1:1 interventions with a trained coach. They promote participant's active engagement to undertake self-management of chronic conditions by teaching behavior management and personal goal-setting. Topics include diet, exercise, medication management, cognitive and physical symptom management, problem solving, relaxation, communication with healthcare providers and dealing with difficult emotions. Each course requires trained facilitators who adhere to prescribed, evidence-

based and validated modules for each workshop. Workshops are broken down to include training in: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) optimal nutrition, 6) decision making, and 7) how to evaluate new treatments. Classes and/or 1:1 trainings are highly interactive, where mutual support and success build the participants' confidence in their ability to manage their health and maintain active and fulfilling lives.

Evidence Based programs may include but are not limited to: Chronic Disease Self-Management Program (CDSMP), *Tomando Control de su Salud* (Spanish CDSMP), Arthritis Self-Management Program (English and Spanish), Chronic Pain Self-Management program, Diabetes Self-Management Program (English and Spanish), Positive Self-Management Program (HIV/AIDS), A Matter of Balance falls prevention, Healthy Ideas (identifying depression empowering activities for seniors), Healthy Eating for Successful Living, Savvy Caregiver, Powerful Tools for Caregivers, Enhanced Wellness, and Fit for Your Life.

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

Participants may enroll in no more than two courses per calendar year.

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

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

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Evidence Based Education Program provider agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Evidence Based Education Program provider agencies	Must be under license maintained by the Healthy Living Center of Excellence or Self-Management Resource Center (formally known as the Stanford Patient Education Research Center)	Certificate of good standing from the Healthy Living Center of Excellence	Agency provider must employ staff who have been trained and certified by the Healthy Living Center of Excellence or by the Self-Management Resource Center, and must demonstrate: 1. Leadership 2. Delivery infrastructure 3. Partnerships 4. Centralized and coordinated logistical processes

				5. Business planning and financial sustainability 6. Quality assurance and fidelity to the model of licensure and quality standards set forth by the evidence-based program developer. Education, Training, Supervision: Providers must ensure training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists. Individual staff who implement Evidence Based Education Program workshops and 1:1 trainings must complete 2 hours of continuing education (in person or webinar) annually with the Healthy Living Center for Excellence or the Self-Management Resource Center. 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L.c.66A. (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and

				Confidentiality Policies).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Evidence Based Education Program provider agencies	ASAPs	Every 2 years

Service Specification

Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other

Service Name: Grocery Shopping and Delivery

☑ 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)**:**

Grocery Shopping and Delivery includes obtaining the grocery order, shopping, delivering the groceries, and assisting with storage as needed.

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:
				Grocery Shopping and Delivery Provider Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Grocery Shopping and Delivery Provider Agencies			Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy and Client Emergency in the Home Policy. In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Grocery Shopping and Delivery Provider Agencies	**ASAPs**	**Every 3 years**

Service Specification							
Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other							
Service Name: Home Based Wandering Response Systems							
☐ Service is included in approved waiver. There is no change in service specifications.							
☑ Service is included in approved waiver. The service specifications have been modified.							
☐ Service is not included in approved waiver.							
Service Definition (Scope)**:**							
Home Based Wandering Response Systems are communication alert systems for participants at risk for wandering. Participants are outfitted with a device that transmits signals using technology such as GPS or radio frequency. The service includes 24/7 emergency response and location assistance in the event the participant wanders.							
Specify applicable (if any) limits on the amount, frequency, or duration of this service:							
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E			☑	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:
				Home Based Wandering Response Provider Agencies

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Based Wandering Response Provider Agencies			Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: -Maintenance of 24 hour monitoring station, including communication protocols for the hearing-impaired and access to interpreter services in emergencies; and -Equipment testing. In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

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Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Based Wandering Response Provider Agencies	ASAPs	Every 3 years. For those agencies unable to be monitored via on site visit due to geographical distance, the ASAP will conduct periodic random testing, at a minimum of every 6 months for waiver participants.

Service Specification						
Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other						
Service Name: Home Delivered Meals						
☑ Service is included in approved waiver. There is no change in service specifications.						
☐ Service is included in approved waiver. The service specifications have been modified.						
☐ Service is not included in approved waiver.						
Service Definition (Scope)**:**						
Home Delivered Meals provide well-balanced meals to clients to maintain optimal nutritional and health status. Each meal must comply with the Executive Office of Elder Affairs' Nutrition Standards, and be religiously and ethnically appropriate to the extent feasible. Home Delivered Meals service includes the preparation, packaging and delivery of meals by trained and supervised staff. More than one meal may be delivered each day provided that proper storage is available in the home. Home delivered meals do not include or comprise a full nutritional regimen.						
Specify applicable (if any) limits on the amount, frequency, or duration of this service:						
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian
Provider Specifications						
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:		
				Home Delivered Meal Providers		
Provider Qualifications						
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*			
Home Delivered Meal Providers			Education, Training, Supervision: Providers must ensure effective training of			

			staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy and Client Emergency in the Home Policy. Meals must comply with Elder Affairs Nutrition Standards.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Delivered Meal Providers	**ASAPs**	**Every 3 years**

Service Specification						
Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other						
Service Name: Home Delivery of Pre-packaged Medication						
☐ Service is included in approved waiver. There is no change in service specifications.						
☑ Service is included in approved waiver. The service specifications have been modified.						
☐ Service is not included in approved waiver.						
Service Definition (Scope)**:**						
Home Delivery of Pre-packaged Medication services provide delivery of medications by a pharmacy to a participant's residence. Medication can include, but is not limited to, pre-filled, blister packs, and pre-filled syringes. The cost of the medication is not included in the service. In addition to providing delivery of medications, the role of the provider includes: -Reporting to the case management entity any participant concerns, including medication non-adherence -Reporting to the case management entity within the same business day, when the participant does not answer the door -Notifying the case management entity the same business day, when the Physician has contacted the pharmacy regarding a change in prescription in order to convey the change in medication and if applicable, request a change in delivery schedule. This service does not duplicate services available through 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:
				Pharmacy

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Pharmacy	Pharmacist must meet licensing requirements of the Massachusetts Board of Registration in		Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for

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	Pharmacy		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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55(Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy and Client Emergency in the Home Policy. In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.
Verification of Provider Qualifications			

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Pharmacy	**ASAP**	**Every 3 years**

Service Specification						
Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other						
Service Name: Laundry						
	☑ Service is included in approved waiver. There is no change in service specifications.					
	☐ Service is included in approved waiver. The service specifications have been modified.					
	☐ Service is not included in approved waiver.					
Service Definition (Scope)**:**						
Laundry includes pick up, washing, drying, folding, wrapping, and returning of laundry.						
Specify applicable (if any) limits on the amount, frequency, or duration of this service:						
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E			☑	Provider managed
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Laundry Provider Agencies			Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy and Client Emergency in the Home Policy.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Laundry Provider Agencies	**ASAPs**	**Every 3 years**

Service Specification
Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other
Service Name: Medication Dispensing System
☐ 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)**:**

Medication Dispensing System is an automated medication dispenser that allows a participant with medication compliance problems to receive pill form medications at appropriate intervals through audible/visual cueing. This system organizes a pre-filled supply of pills and is programmed to deliver the correct dosage of medications when appropriate. The product is lockable and tamper-proof and has a provision for power failure. The cost of the medication is not included in the service.

The Medication Dispensing System shall be authorized only when a responsible formal/informal caregiver can demonstrate the ability to pre-fill medications and monitor the system. The provider must furnish detailed instructions to the caregiver regarding the operation of the system, as well as ensure that there is a signed, written agreement between the provider and the caregiver clearly delineating the responsibilities of each party.

Agencies that provide Medication Dispensing Systems under the waiver are not required to meet the requirements for participation in Medicaid, as provided in 130 CMR 409.00 (MassHealth Durable Medical Equipment regulations that describe the provider eligibility requirements and program rules). This service does not duplicate services available through the State Plan.

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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:
				Specialized Medical Equipment Provider

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Specialized Medical Equipment Provider			Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy and Client Emergency in the Home Policy. In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Specialized Medical Equipment Provider	**ASAPs**	**Every 3 years**

Service Type: ☐ Statutory ☐ Extended State Plan ☒Other

Service Name: Orientation and Mobility

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

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

☑ Service is not included in approved waiver.

Service Definition (Scope)**:**

Orientation and Mobility (O&M) services teach an individual with vision impairment or legal blindness how to move or travel safely and independently in his/her home and community and include (a) O&M assessment; (b) training and education provided to Participants; (c) environmental evaluations; (d) caregiver/direct care staff training on sensitivity to blindness/low vision; and (e) information and resources on community living for persons with vision impairment or legal blindness. O&M Services are tailored to the individual's need and may extend beyond the home setting to other community settings as well as public transportation systems.

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

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

Provider Specifications

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Orientation and Mobility Specialists (COMS)		Individual providers of Orientation and Mobility Services must have a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from an ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals) - certified university program.	Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual's customary environment. - Knowledge and/or experience in educating caregivers or direct care staff, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with vision impairment or legal blindness, in sensitivity to low vision/blindness.
Human Service Agencies		Individual providers and individuals employed by the agency providing	Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has

			Orientation and Mobility Services must have a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from an ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals)-certified university program.	successfully demonstrated, at a minimum, the following: - Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies. Staff providing services must have: - Master's degree in special education with a specialty in orientation and mobility; or -bachelor's degree with a certificate in orientation and mobility from an ACVREP certified university program Individuals providing services must also have: - Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual's customary environment. - Knowledge and/or experience in educating caregivers or direct care staff, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with vision impairment or legal blindness, in sensitivity to low vision/blindness.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Orientation and Mobility Specialists (COMS)	ASAPs	Every 3 years
Human Service Agencies	ASAPs	Every 3 years

Service Specification
Service Type: ☐ Statutory ☐ Extended State Plan ☑ Other
Service Name: Home Safety/Independence Evaluations (formerly Occupational Therapy)
☐ Service is included in approved waiver. There is no change in service specifications.
☑Service is included in approved waiver. The service specifications have been modified.

Deleted: Occupational Therapy

☐ Service is not included in approved waiver.

Service Definition (Scope):

Home Safety/Independence Evaluations is a periodic, episodic service provided by an Occupational Therapist (OT) to provide in-home evaluations to identify and mitigate home safety risks. The service includes observation and assessment of the participant's normal functioning and completion of day-to-day tasks, including but not limited to ADLs and IADLs, in their living environment. The service also includes recommendations to modify or adapt the participant's approach to such activities and tasks to prevent further injury or disability. The service could also include recommendations to enhance home safety, including recommendations for home repair, modification or assistive devices needed to enable the participant to engage in recommended self-care strategies

Home Safety/Independence Evaluation services must be authorized by the Case Manager in the service plan. This service is not subject to the Medical Referral Requirements found at 130 CMR 432.415 (MassHealth Therapist Regulations that describe the medical referral requirements necessary as a prerequisite to MassHealth payment) or the requirements for Prior Authorization found at 130 CMR 432.417 (MassHealth Therapist Regulations that describe the prior authorization process for therapy services). This service cannot be provided in settings other than the participant's place of residence. The Home Safety/Independence Evaluation service may not be provided at the same time that a participant is enrolled in the Goal Engagement Program waiver service.

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

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

Provider Specifications

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Homemaker/ Personal Care agencies	Home Safety/Independence Evaluation services must be performed by an Occupational Therapist with a valid Massachusetts license or by either a certified occupational therapy assistant or an occupational therapy student under the direct		Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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

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

Deleted: Adult Day Health or when the participant is receiving other services that include occupational therapy as part of the program

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

Deleted: Occupational Therapy

	supervision of a licensed Occupational Therapist		quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).
Health Care Agencies	The agency must be licensed as a Group Practice in accordance with 130 CMR 432.404 (MassHealth Therapist Regulations that describe the provider eligibility requirements for therapy providers) or as a Rehabilitation Center in accordance with 130 CMR 430.600 (MassHealth Rehabilitation Center Regulations that define provider eligibility requirements and program rules).		Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted

	Home Safety/Independence Evaluation services must be performed by an Occupational Therapist with a valid Massachusetts license or by either a certified occupational therapy assistant or an occupational therapy student under the direct supervision of a licensed Occupational Therapist		service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).
Home Health Agencies	The agency must be licensed as a Home Health Agency participating in MassHealth under 130 CMR 403.000 (MassHealth Home Health Agency regulations that define provider eligibility requirements and program rules). Home Safety/Independence Evaluation services must be performed by an Occupational Therapist with a valid Massachusetts license or by either a certified occupational therapy assistant or an occupational therapy student under the direct		Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay.

Deleted: Occupational Therapy

Deleted: Occupational Therapy

	supervision of a licensed Occupational Therapist		Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).
Individual Occupational Therapist	Home Safety/Independence Evaluation services must be performed by an Occupational Therapist with a valid Massachusetts license.		Individuals who provide this service shall ensure that they are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Deleted: Occupational Therapy

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Homemaker/Personal Care agencies	ASAPs	Every 3 years
Health Care Agencies	ASAPs	Every 3 years
Home Health Agencies	ASAPs	Every 3 years
Individual Occupational Therapist	ASAPs	Every 3 years

Service Specification							
Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other							
Service Name: Peer Support							
Alternative Service Title (if any):							
☐ Service is included in approved waiver. There is no change in service specifications.							
☐ Service is included in approved waiver. The service specifications have been modified.							
☑ Service is not included in approved waiver.							
Service Definition (Scope)**:**							
Peer Support is designed to provide targeted recovery services to older adults with behavioral health diagnoses. Peer Support assistance includes mentoring participants about self-advocacy and participation in the community, including, but not limited to, such activities as accessing a senior center, getting to medical appointments or a hospital for a medical procedure, assisting with care transitions, and housing paperwork, accompanying for walks to various community locations, and generally engaging to reduce isolation. Peer support may be provided in small groups or peer support may involve one peer providing support to another peer, the waiver participant. Peer support promotes and assists the waiver participant's ability to participate in self-advocacy. The service utilizes trained peers as coaches who have lived experience with mental illness to promote patient-centered care and attainment of measurable personalized recovery goals.							
Specify applicable (if any) limits on the amount, frequency, or duration of this service:							
Not to exceed 16 hours per week.							
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E			☑	Provider managed	
Specify whether the service may be provided by *(check each that*	☐	Legally Responsible	☑	Relative	☐	Legal Guardian	

applies):		Person					

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Peer Support Agencies		Individuals providing Peer Support must have a Certificate of successful completion of Certified Older Adults Peer Specialist (COAPS) training.	Peer Support provider agencies must employ individuals who meet all relevant state and federal licensure or certification requirements in their discipline. If the agency is providing activities where certification is necessary, the agency must demonstrate that individual staff hold such certification. In addition, agencies must demonstrate, 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, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists. In addition to having a Certificate of successful completion of Certified Older Adults Peer Specialist (COAPS) training, individual staff who provide Peer Support Services must meet requirements for individuals in such roles, including, but not limited to: - have been CORI checked; - have experience in providing peer support, self-advocacy, and skills training and independence; - be capable of handling emergency situations; - have ability to set limits; - accept and use supervision; - have ability to communicate effectively in the language and communication style of the individual for whom they are providing peer

				supports to; - have ability to communicate observances verbally and in writing; - have ability to meet legal requirements in protecting confidential information; - adapt to a variety of situations; - respect privacy and confidentiality; - respect and accept different values, nationalities, races, religions, cultures and standards of living. 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Peer Support Agencies	ASAPs	Every 3 years

Service Specification							
Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other							
Service Name: Senior Care Options (SCO)							
☑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 participants age 65 and older may choose to voluntarily enroll in a Senior Care Options (SCO) program, a Massachusetts managed care program for dually eligible elders. Waiver participants who choose to enroll in a SCO will receive all waiver services through the SCO. Senior care organizations authorize, deliver, and coordinate all services currently covered by Medicare and Medicaid, including primary, acute, and specialty care; community and institutional long-term care; behavioral health; medical transportation; and drugs.							
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:			
				Senior Care Organization			
Provider Qualifications							
Provider Type:	License *(specify)*		Certificate *(specify)*		Other Standard *(specify)*		
Senior Care					Senior Care Organizations enrolled under		

Organization			contract with MassHealth. A senior care organization is a qualified contractor selected to provide services to MassHealth members aged 65 or older who have chosen to participate in Senior Care Options. Under this program, senior care organizations provide a fully integrated geriatric model of care.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Senior Care Organization	**MassHealth Office of Long Term Services and Supports**	**Annually**

Service Specification							
Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other							
Service Name: Complex Care Training and Oversight (formerly Skilled Nursing)							
	☐ Service is included in approved waiver. There is no change in service specifications.						
	☑ Service is included in approved waiver. The service specifications have been modified.						
	☐ Service is not included in approved waiver.						
Service Definition (Scope)**:**							
Complex Care Training and Oversight is a periodic, episodic service that includes medication management (e.g., filling medication cassettes) as well as development and ongoing management and evaluation of the participant's Home Health Aide Plan of Care, for purposes of monitoring the participant's underlying conditions or complications to ensure the unskilled care is successfully addressing the participant's needs. Complex Care Training and Oversight services listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license. Agencies that provide Complex Care Training and Oversight services under the waiver do not need to meet the requirements for participation in Medicare, as provided in 42 CFR §489.28.							
Specify applicable (if any) limits on the amount, frequency, or duration of this service:							
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed			
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian	
Provider Specifications							
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☑	Agency. List the types of agencies:			
				Home Health Agencies			
				Homemaker/Personal Care Agencies			

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Deleted: Skilled nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from skilled nursing services in the State plan. The difference from the State plan is as follows:

Deleted: Skilled Nursing

Provider Qualifications			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agencies	Complex Care Training and Oversight services must be performed by a Registered Nurse, or a Licensed Practical Nurse under the supervision of a Registered Nurse. All nurses must have a valid Massachusetts license.		Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55(Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient

Deleted: Skilled nursing

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			and resident abuse prevention, reporting, investigation and registry requirements).
Homemaker/Personal Care Agencies	Complex Care Training and Oversight services must be performed by a Registered Nurse, or a Licensed Practical Nurse under the supervision of a Registered Nurse. All nurses must have a valid Massachusetts license.		Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55(Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting,

Deleted: Skilled nursing

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			investigation and registry requirements).

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agencies	**ASAPs**	**Every 2 years**
Homemaker/Personal Care Agencies	**ASAPs**	**Every 2 years**

Service Specification

Service Type: ☐ Statutory ☐ Extended State Plan ☒Other

Service Name: Supportive Day Program

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

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

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Supportive Day Programs provide support services in a group setting to help participants recover and rehabilitate from an acute illness or injury, or to manage a chronic illness; or for waiver enrollees have an assessed need for increased social integration and/or structured day activities. The services include assessments and care planning, health related services, social services, therapeutic activities, nutrition, and transportation. These services focus on the participant's strengths and abilities while maintaining their connection to the community and helping them to retain their daily skills.

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:
				Supportive Day Program Provider Agencies

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Supportive Day			Education, Training, Supervision:

Program Provider Agencies			Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: -Procedure for orientation of the participant. -Maintenance of a confidential record for each participant. Progress notes shall be written as indicated, at least quarterly, and maintained as part of each participant's record. -Compliance with the state mandatory reporting procedures for reporting suspected cases of abuse or neglect to the adult protective services agency. Staff must be

			trained in signs and indicators of potential abuse. Programs must ensure the following: -An interdisciplinary approach to meeting program goals. -A variety of services offered to meet the needs of participants. -A regular daily schedule to provide structure for the participants. -Sufficient flexibility to accommodate unanticipated needs and events. -Verbal and non-verbal communication between staff and participants to create a caring environment. -Sensitivity to various personalities and health conditions to form supportive and therapeutic relationships. -An adequate number of staff whose qualifications are commensurate with the defined job responsibilities to provide essential program functions. In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Supportive Day Program Provider Agencies	**ASAPs**	**Every 2 years**

Service Specification
Service Type: ☐ Statutory ☐ Extended State Plan ☒Other
Service Name: Supportive Home Care Aide
☐ Service is included in approved waiver. There is no change in service specifications.

	☑Service is included in approved waiver. The service specifications have been modified.
	☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Supportive Home Care Aides (SHCA) perform personal care and/or homemaking services in accordance with waiver definitions, in addition to providing emotional support, socialization, and escort services to clients with Alzheimer's Disease/Dementia or emotional and/or behavioral problems.

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

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

Provider Specifications

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agencies		Individuals employed by the agency to provide supportive home care aide services must have the following: -Certificate of 75-Hour Home Health Aide Training As well as an additional: -Certificate of 12 hour Supportive Home Care Aide Training in either Alzheimer's Disease Related Disorders or behavioral health disorders, including substance use disorders.	Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness:

Deleted: - Certificate of 60-Hour Personal Care Training ¶
Or¶

Deleted: Or ¶
-Certificate of Nurse's Aide Training

			Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements). All SHCAs must receive an additional 12 hours of initial training from one of the two SHCA training tracks; Alzheimer's Disease and Related Disorders (ADRD) or Mental Health (MH). The following topics are recommended for MH SHCA: limit setting; depression; personality and character disorders; substance abuse; abuse and neglect; and the stigma of mental illness and behavioral disorders. The following topics are recommended for ADRD SHCA: understanding Alzheimer's and Dementia; habilitation therapy, communication skills, personal care, behavior as communication and working with families. The Alzheimer's Association curriculum is required. An RN shall provide in-home supervision of SHCA's at least once every three months. LPN's may provide in-home supervision if the LPN has a valid license in Massachusetts, and works under the direction of an RN who is engaged in field supervision carried out by the LPN. In addition, each SHCA receives weekly support through training/in-services, team

			meetings, or supervision that occurs in-home, by telephone or in person. Team meetings are held at a minimum of two hours quarterly and inclusive of SHCAs, supervisors, and other appropriate personnel involved in providing SHCA services. The focus of these meetings is to provide training and group supervision, to conduct case reviews or interdisciplinary case conferences, and to provide support to the SHCA. In addition, providers shall ensure that individual personal care workers employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.
Homemaker/Personal Care Agencies		Individuals employed by the agency to provide supportive home care aide services must have the following: -Certificate of 75-Hour Home Health Aide Training As well as an additional: Certificate of 12 hour Supportive Home Care Aide Training in either Alzheimer's Disease Related Disorders or behavioral health disorders, including substance use disorders.	Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish 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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness:

Deleted: -Certificate of 60-Hour Personal Care Training ¶
Or¶

Deleted: -Certificate of Nurse's Aide Training ¶

Deleted: In addition to:¶

			Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements). All SHCAs must receive an additional 12 hours of initial training from one of the two SHCA training tracks; Alzheimer's Disease and Related Disorders (ADRD) or Mental Health (MH). The following topics are recommended for MH SHCA: limit setting; depression; personality and character disorders; substance abuse; abuse and neglect; and the stigma of mental illness and behavioral disorders. The following topics are recommended for ADRD SHCA: understanding Alzheimer's and Dementia; habilitation therapy, communication skills, personal care, behavior as communication and working with families. The Alzheimer's Association curriculum is required. An RN shall provide in-home supervision of SHCA's at least once every three months. LPN's may provide in-home supervision if the LPN has a valid license in Massachusetts, and works under the direction of an RN who is engaged in field supervision carried out by the LPN. In addition, each SHCA receives weekly support through training/in-services, team

			meetings, or supervision that occurs in-home, by telephone or in person. Team meetings are held at a minimum of two hours quarterly and inclusive of SHCAs, supervisors, and other appropriate personnel involved in providing SHCA services. The focus of these meetings is to provide training and group supervision, to conduct case reviews or interdisciplinary case conferences, and to provide support to the SHCA. In addition, providers shall ensure that individual personal care workers employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agencies	**ASAPs**	**Every 2 years**
Homemaker/Personal Care Agencies	**ASAPs**	**Every 2 years**

Service Specification

Service Type: ☐ Statutory ☐ Extended State Plan ☒Other

Service Name: Transitional Assistance

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

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

☐ Service is not included in approved waiver.

Service Definition (Scope)**:**

Transitional Assistance services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) assistance with housing search and housing application processes; (b) security deposits that are required to obtain a lease on an apartment or home; (c) assistance arranging for and supporting the details of the

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move; (d) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (e) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (f) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (g) moving expenses; (h) necessary home accessibility adaptations; and, (i) activities to assess need, arrange for and procure need resources related to personal household expenses, specialized medical equipment, or community services. Transitional Assistance Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Transitional Assistance Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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. Transitional Assistance services comprising home accessibility adaptations must be initiated during the 180 days prior to discharge.

(Only direct expenses for goods and services are reimbursable under this waiver. The case manager works with the participant to develop a list of needs for transition. The case manager coordinates the purchase and delivery of goods and services. This coordination is part of case management, not Transitional Assistance. The ASAP pays individual providers, such as landlords, utility companies, service agencies, furniture stores, and other retail establishments. Thus, "providers" of this service are any of the above, depending on the identified needs of the participant.)

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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:
				Any agency or vendor providing goods and services in accordance with the service description.

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Any agency or vendor providing goods and services in accordance with the service description.			Will meet applicable State regulations and industry standards for type of goods/services provided.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Any agency or vendor providing goods and services in accordance with the service description.	**ASAPs**	**Every 3 years**

Service Specification						
Service Type: ☐ Statutory ☐ Extended State Plan ☒ Other						
Service Name: 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) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.						
Specify applicable (if any) limits on the amount, frequency, or duration of this service:						
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☑	Provider managed		
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☑	Relative	☐	Legal Guardian

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

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Transportation Provider Agencies			Education, Training, Supervision: Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying

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			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 consumers by providing effective, efficient services. Availability: Providers must be able to provide contracted service(s) in the geographical areas they designate. Responsiveness: Providers must be able to initiate services with little or no delay. Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). Policies/Procedures: Providers must have policies and procedures that include: -Vehicle safety and maintenance -Assisting passengers on/off vehicles and from door to door -Ensuring drivers have current licenses as required -Tracking and scheduling trips In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Transportation Provider Agencies	**ASAPs**	**Every 3 years**

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

○	**Not applicable –** Case management is not furnished as a distinct activity to waiver participants.	
●	**Applicable –** Case management is furnished as a distinct activity to waiver participants. Check each that applies:	
	☐	As a waiver service defined in Appendix C-3 (*do not complete 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.*

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

Case management is provided as an administrative activity by Aging Services Access Points (ASAPs) under contract with the Executive Office of Elder Affairs. SCO participants' Case Management is provided by ASAP Case Management staff under contract with the SCO programs or SCO-employed Case Management staff or Registered Nurses.

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 (Commonwealth of Massachusetts required Criminal Offender Record Information checks), as well as 101 CMR 15.00 et seq (Executive Office of Health and Human Services required Criminal Offender Record Information checks), 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 through on-site audits. The U.S. Department of Health and Human Services, Office of Inspector General (OIG) may exclude individuals and entities from participation in federal health care programs, including MassHealth, if such individuals and entities have engaged in certain program-related misconduct or have been convicted of certain crimes. Once an individual or entity is excluded by OIG, federal regulations (42 CFR 1001.1901(b)) prohibit MassHealth from paying for any items or services furnished, ordered, or prescribed by the excluded individual or entity. MassHealth providers have the obligation to screen their employees and contractors, both individuals and entities, to determine if they have been excluded from participation in MassHealth. To comply with this mandate, the State requires that waiver service providers: 1) Develop policies and procedures for regular review of the OIG's List of Excluded Individuals/Entities at both the time of hire and/or contracting and on a monthly basis; 2) Immediately report any discovered exclusion of an employee or contractor to the EOHHS Compliance Office; and 3) Develop reliable, auditable documentation of when these procedures are performed. Provider compliance with these requirements is monitored as part of the initial enrollment and recredentialing process.
○	**No**. Criminal history and/or background investigations are not required.

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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, personal care workers, home health aides, personal care workers, and homemakers for the abuse, neglect, mistreatment of patients or residents or misappropriation of patient or resident property. ASAPs are required to verify provider agency compliance with 105 CMR 155.000 as part of on-site reviews.
○	**No**. The State does not conduct abuse registry screening.

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

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

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 those who are legal guardians, are permitted to provide waiver services. A relative may not be a legally responsible relative, must be employed by the provider agency, and must meet all qualifications. 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*:

Deleted: family member (defined as a spouse or any

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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. Waiver services are coordinated through the network of 26 Aging Services Access Points. In accordance with 651 CMR 14.04(5) (Financial Administrative Responsibilities of ASAPs) procurement of waiver services by ASAPs must be in compliance with Title 45 CFR Part 74, Subpart C, §§ 74.40 through 74.48 and with policies and procedures issued by the Executive Office of Elder Affairs (EOEA).

ASAPs must ensure they have a sufficient number of qualified providers within their geographic service areas that are capable of meeting the needs of Waiver participants through the delivery of timely, accessible, culturally-competent, efficient services. ASAPs must ensure that the provider network is responsive to the linguistic, cultural, and other unique needs of the populations served,

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including the ability to communicate with participants in languages other than English, and as necessary, with those participants who are deaf, hard of hearing, or deaf blind.

To ensure ASAPs conduct a continuous open enrollment for Frail Elder Waiver service providers, ASAPs must contract with any qualified provider who is willing to accept the terms and conditions of the ASAP.

EOEA requires ASAPs to use specific state standards and due process procedures for soliciting and contracting with providers to deliver waiver services. These standards were established to ensure that waiver services are obtained in an effective manner and in compliance with the provisions of applicable state and Federal statutes, regulations and executive orders, including the federal uniform administrative requirements contained in Title 45 CFR Part 74, subpart C, sections 74.40 through 74.48.

Providers can access information both on the Elder Affairs website and via direct mailings. ASAPs also conduct other outreach methods to reach potential providers, including taking affirmative steps to encourage the participation of small businesses, minority-owned business enterprises and women-owned business enterprises.

Providers interested in enrolling receive a standard package of service information and application documents. Providers of homemaker, personal care and supportive home care aides services may enroll centrally through EOEA while all other service providers enroll directly with the ASAP for the specific geographic area they wish to serve.

The SCOs must comply with the requirements at: 42 CFR 438.214, provider selection requirements for managed care organizations. Any provider contracting with a SCO must have and comply with written protocols including credentialing, re-credentialing, certification, and performance appraisal processes that demonstrate that all members of the Provider Network maintain current knowledge, ability, and expertise in the service or specialty in which they practice.

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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:	*All contracted waiver service providers required to maintain licensure/certification, in accordance with waiver/state requirements, adhered to these specifications.* *Numerator: Number of waiver service providers required to maintain licensure/certification that adhered to these specifications* *Denominator: Number of audited waiver service providers required to maintain licensure/certification.*

Deleted: *All waiver service providers required to maintain licensure/certification under this waiver shall do so, and shall adhere to all provider qualifications as described in Appendix C-3. Numerator: Number of contracted waiver providers required to maintain licensure/certification that demonstrate 100% compliance as result of an audit. Denom: Number of contracted licensed/certified providers audited.*

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*	
	ASAPs and Senior Care Organizations (SCO)	☐ *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

Performance Measure:	*Non-licensed/non-certified waiver service providers adhered to provider qualification specifications, in accordance with state requirements.* *Numerator: Number of non-licensed/non-certified waiver service providers that demonstrated compliance with qualification requirements* *Denominator: Number of non-licensed/non-certified waiver service providers audited*
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*	
	ASAPs and Senior Care Organizations (SCO)	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other* *Specify:*	
			☐ *Other Specify:*

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*

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Deleted: *shall*
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	☐ *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

Performance Measure:	*Waiver service providers participated in trainings, in accordance with state requirements.* *Numerator: Number of waiver service providers that produced documentation of required trainings* *Denominator: Number of waiver service providers audited*
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*	
	ASAPs and Senior Care Organizations (SCO)	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other* *Specify:*	
			☐ *Other Specify:*

Data Aggregation and Analysis

Deleted: *All providers of waiver services shall conduct and/or participate in training in accordance with the requirements described in Appendix C-3*

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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 Executive Office of Elder Affairs (EOEA), MassHealth and LTSS are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Aging Services Access Points (ASAPs) and Senior Care Organizations (SCOs). In the event problems are discovered with the management of the waiver program, ASAPs/SCOs, or waiver service providers, EOEA/MassHealth/LTSS 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, EOEA, MassHealth and LTSS 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***

Deleted: 100% of providers shall receive on-site reviews at least once during the first six months after the first services are provided, and at least once every three years after that. Where on-site reviews indicate that a provider is not meeting standards in the areas of legal/regulatory compliance the following action occurs: education/training of staff and/or adherence to continuous quality improvement practices, the ASAP/SCO will require that a corrective action plan be created and implemented by the provider.¶
¶
ASAPs and SCOs shall participate in an annual Participant Satisfaction Survey process. Where Participant Satisfaction Surveys indicate that a particular provider is performing in a substandard manner in terms of participant satisfaction and/or direct service quality, the ASAP/SCO will require a corrective action plan to be created and implemented by the provider.¶
¶
ASAPs/SCOs shall participate in a Staff/Participant Complaint/Compliment Log process. In each instance where Staff/Participant Complaint Logs indicate problems with participant satisfaction, ASAP/SCO staff satisfaction, compliance with internal quality assurance practices, and/or adherence to continuous quality improvement practices, the ASAP/SCO will require a corrective action plan be created and implemented by the provider.¶
¶
ASAPs/SCOs shall conduct surveys of staff on at least an annual basis. Where staff satisfaction surveys indicate that a particular provider is performing in a substandard manner in terms of staff satisfaction, provider availability and/or provider responsiveness, the ASAP/SCO will require a corrective action plan be created and implemented by the provider.¶

Deleted: The Executive Office of Elder Affairs' Provider Network Quality Assurance Manual requires ASAPs to develop corrective action plans with individual providers based on the nature of the problem (see response to C-1-a.ii). This same process applies to SCO providers also. When a provider deficiency is identified, the provider must develop a corrective action plan and submit the plan to the ASAP/SCO for approval. If necessary, the ASAP/SCO will request modifications to the plan to ensure that it addresses all aspects of the deficiency. The ASAP/SCO must continue to monitor provider performance until it meets acceptable standards. If necessary, the ASAP/SCO must perform an additional on-site audit to confirm the deficiency has been corrected. In the event that a provider is unable to conform to required standards of quality, the provider will no longer be permitted to serve waiver enrollees. ¶
¶
ASAPs/SCOs annually report provider deficiencies, corrective action plans, and outcomes to EOEA.

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

c. Timelines

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

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

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

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

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

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

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*

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 setting in which each waiver participant resides and the predominant settings wherein the services provided through this waiver are delivered are in the participant's private residence within the community.

The Massachusetts Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency, convened an interagency workgroup to address how best to comply with the requirements of the federal Home and Community Based (HCB) settings requirements at 42 CFR 441.301 (c)(4)-(5). The Executive Office of Elder Affairs (EOEA), an agency within EOHHS that has primary responsibility for day-to-day operation of the Frail Elder Waiver, was a member of the workgroup. EOEA undertook a review of all their regulations, standards, policies, service descriptions, and other provider requirements to ensure compliance of settings with the new federal requirements, as they apply within this waiver. The Frail Elder Waiver supports individuals who reside in their own homes or apartments, in homes and apartments with family members and other informal supports, or in a home or apartment of a caregiver with up to one additional waiver participant. These settings fully comply with the HCBS Regulations. Although this waiver does not provide residential services, Frail Elder Waiver Participants may receive the following waiver services outside their home: Supportive Day Program. Frail Elder Waiver participants may also reside in Congregate housing and receive their waiver services within this residential setting. As defined in Massachusetts, Congregate housing is a shared living environment designed to integrate housing and certain services needed by elders and younger disabled individuals who choose this environment as their home. Congregate housing is not a waiver service, nor is it a 24/7 staffed residence. Services are not inherent to the congregate setting, nor are residents required to receive services in order to reside in congregate housing.

EOEA's review and assessment process for these residential and non-residential settings included: a thorough review of regulations, policies and procedures; waiver service definitions; provider qualifications and quality management and oversight systems to determine whether the systemic infrastructure was consistent with the principles of community integration; development of an assessment tool based on the exploratory questions that CMS published; and review of the existing non-residential settings to determine if these settings meet standards consistent with the HCB settings requirement. As detailed in the Site-Specific Assessment and findings sections and summarized in Table 2 of the STP submitted to CMS in September 2016, fifty five out of fifty six Supportive Day Program providers available to Frail Elder Waiver Participants have been determined by EOEA to comply fully with the Community Rule. The Supportive Day Program found to be not compliant does not serve waiver participants and will be precluded from providing services to waiver participants in the future. 43 out of

44 Congregate Housing sites were found to be HCB setting compliant from the onset. One Congregate setting required minor modifications to become compliant. EOEA verified that this setting completed necessary program changes and physical alterations for continued compliance.
The systematic and site-specific oversight is completed ongoing by EOEA agents (the ASAPs). The ASAP reviews any new setting as necessary to ensure full compliance as required by EOEA.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Comprehensive Service Plan (CSP)

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 shall demonstrate experience or strong interest in the field of human services via previous employment, internships, volunteer activities and/or additional academic studies. Aging Services Access Points may request a waiver of the Bachelor's degree requirement from the Executive Office of Elder Affairs for candidates who offer special skills and/or backgrounds, such as those with bilingual ability and bicultural status.
☐	**Social Worker** *Specify qualifications:*
☐	**Other** *Specify the individuals and their qualifications:*

Deleted: ☐

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*:
	651 CMR 14.00 (Department of Elder Affairs regulations for Aging Services Access Points that describe the functions and responsibilities of ASAPs) prohibits Aging Services Access Points from providing waiver services, except for nutrition services. In regions where the local Aging Services Access Point is also a provider of Title III meals (usually the Area Agency on Aging or AAA), home delivered meals may be provided by the ASAP. Administrative separation between ASAP and AAA functions ensures that the service plan development process focuses on documented participant needs. In no circumstances are the same individuals responsible for service plan development and the direct provision of waiver services. Through the Interdisciplinary Case Management assessment process, participant needs are identified, the options for waiver and non-waiver services are discussed with the participant, and a service plan is developed. Each service plan is inclusive of participants' values, goals and preferences. Services are provided solely on the basis of assessed needs documented in the Comprehensive Data Set (CDS) assessment and the service plan. The State reviews a sample of service plans to ensure that all needs identified have been addressed through either waiver or non-waiver services. In addition, 651 CMR 14.00 permits the Secretary of Elder Affairs to grant a waiver and approve an ASAP's request to provide a service on the basis of public necessity and convenience. The waiver request must identify the conditions that make a waiver necessary, what steps have been taken to resolve current issues and ensure future waivers will not be necessary; the consequences to the participants of the ASAP of not granting the waiver request; and the consequences to the ASAP of not granting the waiver request. A Senior Care Organization does not provide direct waiver services.

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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 (Comprehensive Service Plan (CSP)) development process for all waiver participants (including SCO-enrolled participants) is driven by the waiver participant and facilitated by Case Managers or Registered Nurses utilizing a person-centered planning approach and assessment tool designed to promote the participant to live as independently and self-sufficiently as possible and as desired. EOEA has implemented a person-centered approach for all waiver participants. This approach is designed to put the participant at the center of the service planning process in the development of and in changes to his/her CSP. The process is designed to maximize participants' choice and control, including selection of waiver and non-waiver services appropriate to meet their needs and the manner in which such services are implemented.

The Case Manager or Registered Nurse meets with the participant or authorized representative prior to any Comprehensive Service Plan meeting to ensure the participant has the information he/she needs to exercise choice and control in the service planning process. This discussion includes:

- An explanation of the service planning process to the participant/representative.
- Identification of the participant's goals, strengths, and preferences regarding services and Interdisciplinary Case Management Team members (i.e., who participates in the CSP

development process).
- A review of all assessment materials and the participant's identified needs.
- A review of waiver services, State Plan and other services available to the participant and how they relate to and will support the participant's needs and goals.

In all CSP development or changes, Case Managers or Registered Nurses work with the Interdisciplinary Case Management team, which is comprised of the waiver participant, family members, and others identified by the participant. Some examples of who may be included as parts of the Interdisciplinary Case Management Team are: representatives from the waiver service provider, the ASAP or SCO registered nurse, and ASAP or SCO supervisory staff. EOEA requires that the Interdisciplinary Case Management team is centered around the participant and involves or consults with appropriate family members, referral sources, physicians, home health agencies, and other persons and organizations identified by the waiver participant. Any persons or organizations that the waiver participant wishes to exclude from the service plan development process are documented at the initial home visit and subsequently as needed or desired by the waiver participant. The participant may choose to identify other people, for example a family member, to be present for the assessment visit and to participate in comprehensive service plan development.

The CSP development process is conducted utilizing a person-centered planning approach designed to promote the independent functioning of the participant in the least restrictive environment and to ensure that services are provided in a manner acceptable to the participant. Case Managers must be aware of and know how to access a wide variety of community-based services in order to explain to participants the full array of waiver and non-waiver services available to meet the participant's needs.

The Interdisciplinary Case Management approach is designed to incorporate principles of person-centered planning, including emphasizing the need for information and training to allow for informed decision-making. Additional focus is placed on maximizing participant opportunities for control, including in the selection of services most appropriate to meet the participant's needs and the manner in which the CSP is implemented. The training emphasizes that all participants, regardless of disability, are capable of directing their own care, although the extent to which they do so will depend on each participant's preferences and ability.

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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):

For all waiver participants, Case Managers and Registered Nurses follow standard procedures and time frames in performing the intake, assessment, case conferencing, service planning, and review

process that ensure participants' strengths, needs, risk factors, personal goals and preferences are identified and appropriately addressed in the Comprehensive Service Plan (CSP).

Waiver participants' needs are identified throughout the referral, needs assessment, and the person-centered planning processes that lead to development of the CSP. Through the person-centered planning process and using a state-approved tool, the needs assessment gathers information on a participant's goals, strengths, clinical needs, support/service needs and need for training to enhance community integration and increase independence, including the opportunity to seek employment, engage in community life and control personal resources. The service needs assessment reflects the functioning of the participant in their current setting. Participants may be assessed in institutional settings in anticipation of returning to the community. 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 CSP development processes utilized in this waiver follow EOEA-mandated procedures in performing the intake/ assessment, ongoing assessment, case conferencing, service planning and supervisory review that ensure all participants' needs, risk factors and personal goals are identified and appropriately addressed.

The initial assessment for eligibility and development of the Comprehensive Service Plan (CSP) is conducted by a Case Manager or an ASAP RN. Assessments are documented on the Comprehensive Data Set (CDS), a uniform tool that includes demographic, ADL/IADL, social, emotional, cognitive, medical, environmental and nutrition information. The CDS contains, in its entirety, the MDS-HC. This information, as well as data regarding areas in which assistance is provided by existing formal and informal supports, and information about the individual's strengths, preferences and goals, informs the development of the Comprehensive Service Plan (CSP). The Case Manager or RN explains programs and services to the participant and assists him or her with clarifying his or her goals in order to support the participant in selecting an array of appropriate services and providers through which to receive preferred/needed services, while working toward goals and maintaining long term independence in the community.

Linked to the participant's vision, goals and needs, the Case Manager or Registered Nurse facilitates development of the CSP with the participant and engages the Interdisciplinary Case Management Team as the participant desires. The participant's representative, if applicable, and other formal and informal supports identified by the participant make up the Interdisciplinary Case Management Team and are part of the service planning process. This may include providers with knowledge and history of serving the participant. The Case Manager or Registered Nurse is responsible for providing information about non-waiver services and supports to address identified needs, coordinating and communicating Comprehensive Service Plans and/or changes to appropriate community agencies and ensuring that waiver participants have access, as appropriate, to waiver and Medicaid State Plan services. The Case Manager or Registered Nurse also identifies other public benefits to ensure that waiver participant needs are met.

The Case Manager or Registered Nurse's responsibilities include: facilitating the service planning process and development of the CSP with the participant and his/her representative, ensuring the final plan addresses the participant's expressed and assessed needs and is approved by the participant, monitoring the participant's satisfaction with the plan and assisting to ensure that the participant receives the services in the plan. In addition, the Case Manager or Registered Nurse is responsible for facilitating subsequent monitoring meetings, meeting routinely with the participant

to assess the CSP's success in supporting the participant's identified goals and making changes to the CSP with the participant as necessary or as requested by the participant. The Case Manager or Registered Nurse is also responsible for coordinating and communicating Comprehensive Service Plans/changes to the involved providers and appropriate community agencies to ensure that waiver participants have access, as eligible, to other public benefits/entitlements and other community services.

In instances when the participant is at a high risk and lacks adequate supports, the Case Manager or Registered Nurse is responsible for ensuring that a 24-hour back up plan is created for use in the event that waiver services become unavailable, and that the participant understands and is able to implement the 24-hour back up plan when necessary.

The participant/representative may choose to identify other people or other members of the Interdisciplinary Case Management Team, 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/representative may also choose to exclude individuals from the Comprehensive Service Plan development process.

The CSP will be written in plain language and in a manner accessible to the participant. If the primary language of the program participant, or his/her representative, is not English, the information in service plans must be translated into his/her primary language and/or explained with the assistance of an interpreter. If the participant is unable to read or exhibits cognitive deficits (e.g. memory disorder) that may compromise his/her understanding of the service plan, and he or she does not have a representative, the case manager shall ensure that the information is cognitively accessible.

Participants will receive a scheduled visit either by the RN or Case Manager at least every six months or more frequently, as needed, to respond to changes in the participant's health condition, formal or informal supports or other changes. Visits are scheduled at times convenient for the participant /representative and include any persons the participant/representative wishes to be present. In addition, the Case Manager maintains regular telephone contact with the participant/representative between visits. The CSP may be revised at any point by the Case Manager with the approval of the participant/representative, based on changes in the participant's needs or circumstances, effectiveness, or at the participant's request.

Reassessments of the waiver participant are documented through the CDS/MDS-HC or a comparable assessment tool. For all participants, the Case Manager or RN who completes the visit with the participant enters case notes that document each reassessment in the participant's record. Case notes are also used to document all contact with the participant, family, vendors and any other persons involved with the participant. Adjustments to the service plan are made in consultation with the participant, service providers and informal supports to ensure that the service plan continues to promote the independent functioning of the participant in the community and that the services continue to be provided in a manner acceptable to 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.

Deleted: The service plan development processes utilized in this waiver follow EOEA-mandated procedures in performing the intake, assessment, case conferencing, service planning and supervisory review that ensure participants' needs, risk factors and personal goals are identified and appropriately addressed. Participant needs are identified beginning at referral and continuing through assessment. The initial assessment is generally conducted by a case manager and then referred for further assessment by a registered nurse. Assessment findings are documented on a uniform tool, the CDS (MDS-HC), which includes demographic, ADL/IADL, social, emotional, cognitive, medical, environmental and nutrition information. The CDS contains, in its entirety, the MDS-HC. This information, as well as data regarding areas in which assistance is provided by existing formal and informal supports, informs the development of the Initial Service Plan (ISP). The case manager or RN explains programs and services to the elder and assists him or her in selecting an array of services that addresses his or her needs and goals to help maintain long term independence in the community.¶
¶
An Initial Service Plan that has been developed with and signed by the participant is required in order for the case manager to initiate services. The ISP is then reviewed through interdisciplinary case conferencing, team presentation, and supervision to ensure that all identified need areas are appropriately addressed, including health care. Modifications may be suggested by interdisciplinary team members; any changes proposed by other team members are discussed with the participant, and the Service Plan is formalized. ¶
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The case manager is also responsible for information about and referral to non-waiver services and supports to address identified needs, coordinating and communicating service plans/changes to appropriate community agencies and ensuring that waiver participants have access, as eligible, to other public benefits and other community services. ¶
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Based on clinical factors and the complexity of the service plan, the participant will be identified as requiring either a quarterly or a semi-annual home visit by the Case Manager. Monitoring visits by the Registered Nurse may either substitute for or be in addition to the case management visits. Additional visits by the Case Manager or RN may be triggered in response to changes in the participant's health condition, formal or informal supports or other changes. Home visits are scheduled at times convenient for the participant and include any persons the participant wishes to be present. In addition, the case manager maintains regular telephone contact with the consumer between home visits. The service plan is subject to revision at any point, based on changes in the consumer's needs or circumstances.¶
¶
Reassessments of the waiver participant are documented through a revision of the CDS/MDS-HC. Journal entries are used to document all contact with the client, family, vendors and any other persons involved with the participant. Adjustments to the service plan are made in consultation with the client, service providers and informal support ... [1]

The evaluation and management of risk is an integral component of interdisciplinary care management provided to all participants in the Frail Elder Waiver.

Risk assessment and mitigation are a core part of the service planning process. Through multiple assessments that are specific to the participant and reviewed during the comprehensive service planning process, potential risks to the participant's health and safety and the participant's ability to remain in the community are identified by the participant with the case manager or Registered Nurse's assistance. With the participant, the case manager or Registered Nurse leads the Interdisciplinary Case Management Team in the development of prevention and response strategies that will mitigate these risks. Having the participant at the center of this process ensures that the responses are sensitive to his or her needs and preferences.

During the initial comprehensive assessment, and the development of the Comprehensive Service Plan (CSP), potential risks to the participant's health and safety and the participant's ability to remain in their community setting are identified. Areas of potential risk are discussed with the participant and the Interdisciplinary Case Management team to identify services or interventions to mitigate those risks. Risk factors reviewed include, but are not limited to, health risks and/or daily care needs, behavioral risks, and risks to personal safety.

When a participant is determined to be high risk as identified by the risk assessment process, the Case Manager or RN works with the participant and/or representative to create a back-up plan to mitigate the identified risks. The Case Manager or RN documents the specific risks the Interdisciplinary Case Management team has identified, along with preventive measures or supports that would minimize these identified risks. At each reassessment visit, the participant together with the case manager and other Interdisciplinary Case Management team members, family members, or other identified individuals, as appropriate, will review any identified risks as well as any incidents associated with the participant's identified risk factors, and steps to further minimize these risks, and will revise the plan as appropriate based on updated information. Once the back-up plan is created and included in the participant's record, Waiver service providers have the primary responsibility for ensuring coverage of the participant's service plan and communicating when services cannot be provided as scheduled.

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 comprehensive service planning process case management staff review with participants the range of waiver and non-waiver services available to address the participant's identified needs and preferred services. The Interdisciplinary Case Management team works with the participant to identify any specific preferences or requirements, such as a need or preference for 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 agency best able to meet the requirements and preferences of the waiver participant. The participant contacts his/her case manager or other members of the Interdisciplinary Case Management team to report any dissatisfaction with the service providers. At each visit the case manager inquires as to the participant's satisfaction with both the service plan and the service providers. The participant may request a change in workers or vendor agencies as desired.

Deleted: The evaluation and management of risk has become an integral component of interdisciplinary care management provided to participants in the Waiver Program. Participants are assessed for risk and assigned a Risk Level numeric value of 1 through 4 in accordance with instructions contained in PI-11-06 Requirements for the Identification and Management of Risk in Participants. Risk is assessed at least once annually and updated when a participant's circumstances change. Potential risk areas identified through the assessment process are discussed with the participant and/or caregiver to identify services or interventions to mitigate those risks. Risk factors are categorized as health risks and/or daily care needs, behavioral risks, and risks to personal safety. The list of risk factors within each category is not exhaustive; assessors may encounter other risk factors that they must take into consideration in the risk assessment process. If a participant has multiple health risks and/or behavioral or personal safety risks, the assessor must evaluate the participant's informal supports in order to determine the Risk Level, and potential for support given those risks. For participants with a critical or high risk level the case managers must complete the Risk Identification and Management assessment form as described in the PI-11-06. The Risk Assessment Form lists specific risks the Care manager, nurse, participant and other members of the team identify, along with preventive measures or supports that would minimize these identified risks. At each visit, case management and nursing staff discuss identified risks and steps to minimize these risks. The form provides a framework for discussions with participants and their caregivers about the risks. In addition, The case manager or nurse will review any concerns with the participant and ensure that participants are aware of how to contact the agency to report any incidents or concerns, including when a worker does not arrive as scheduled. Any informal supports available to the participant are identified at the initial assessment and updated at each visit. Information is obtained regarding the availability of these informal supports to assist the participant. The ASAP must communicate to providers of personal assistance services (home health aide, supportive home care aide, homemaker, personal care, and companion) the protocols contained in the PI 11-06 regarding service priority for participants with a Risk Level 1 or 2. Providers must ensure to the best of their abil ... [2]

Deleted: For waiver participants enrolled in a SCO, any identified risks including but not limited to health risks, daily care needs, behavioral risks, or risks to personal safety are outlined in the participant's care plan with intervention steps offered to each participant. In the end the participant assumes the amount of risk they are comforta ... [3]

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g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The CDS/MDS-HC is completed for all waiver participants to support the waiver service plan. The identified needs of the participant are outlined in a Comprehensive Service Plan (CSP). Records are reviewed by ASAP and SCO supervisory staff to assure that the assessed needs including the applicable safeguards and standards of care are met by either waiver services or through other means. In addition, EOEA reviews a statistically significant sample of waiver records to ensure assessed needs are being met as well as that any health and welfare concerns are being addressed. The Office of Long Term Services and Supports reviews a sample of SCO waiver participants' records to ensure assessed needs are met and health and welfare concerns are addressed.

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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:*
	Electronic service plan records are recorded by ASAP staff and maintained in the Senior Information Management System (SIMS). Written copies of the Comprehensive Service Plan are maintained in the participant's record by the ASAP in accordance with 651 CMR 14.030 and Elder Affairs Documentation Standards. Similarly, SCOs maintain electronic and paper records on all waiver participants. All records are maintained for seven years after the date the case is closed.

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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 with the support of other members of the Interdisciplinary Case Management team has overall responsibility for monitoring the implementation of the Comprehensive Service Plan (CSP) to ensure that the participant is satisfied with waiver services and that services are furnished in accordance with the CSP, meet the participant's needs and achieve their intended outcomes. This is done through scheduled reassessments and ongoing contact with the participant, his/her representatives and members of the Interdisciplinary Case Management team.

The participant receives, at a minimum, an in-person visit by either an ASAP or SCO case manager or RN every 6 months. The case manager or RN may determine that additional visits would be necessary in response to changes in the participant's health condition, formal or informal supports or other changes. Visits are scheduled at times convenient for the participant and include any persons the participant wishes to be present. In addition, the case manager maintains regular contact with the participant through a variety of means and in the ways the participant prefers between the in-person visits. The CSP may be revised at any point by the case manager at the direction of the participant, based on changes in the participant's goals, needs or circumstances.

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

Case managers or RN monitor services to ensure they are delivered in accordance with the service plan and that they are meeting the participant's needs and preferences. If problems are identified they are promptly addressed with the provider.

EOEA promotes person-centered empowerment and supporting personal choice as a core value and 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 Interdisciplinary Case Management Team around their goals and preferences in the identification of community supports and strategies to minimize these risks while ensuring maximum opportunities for independence.

For high-risk participants the case manager reviews the identified risks and back-up plan and updates, as needed, as a component of the participant's service planning process. The case manager ensures that the participant, and his or her representative/informal supports as appropriate, understand and are able to implement the back-up plan when necessary. Case managers work with the participant's service providers to ensure that the identified risks are appropriately managed.

There are several additional quality management processes that assure that individual participants are getting the services they need and that their health and welfare is protected. These processes are described more fully in other appendices, and include but are not limited to:

a) Assessment of Health & Welfare concerns such as abuse, neglect, poor hygiene, environmental

safety, falls risk, and medication management needs at least every 6 months
b) incident reporting and management (described in Appendix G)
c) investigations process (described in Appendix G)
d) risk assessment and management system
e) periodic progress and update meetings
f) ongoing contact with the participant and service providers.

By contract, waiver service providers must report all incidents and changes in the participant's condition or health and welfare concerns to the Case Manager or GSSC immediately. Any incident that is considered to be a Critical Incident is reported to EOEA and LTSS for SCO enrolled participants. A critical incident that must be shared with EOEA and LTSS may include: death, exposure to hazardous materials, medication errors, natural disasters, communicable diseases, physical injury, suspected criminal activity, neglect, missing persons, or significant property damage. EOEA and LTSS track incidents ensuring appropriate follow up to any reported incident, as well as trends with providers and/or particular home care aides. The ASAP or SCO ensures proper reporting of all incidents as part of ongoing provider monitoring and agency oversight which may result in investigation and corrective action as needed. ASAPs and SCOs share any corrective action plans with EOEA to ensure action is complete and thorough.

Individuals and families are provided with information on whom to contact in an emergency and how to access emergency services as needed.

Deleted: Case managers monitor services to ensure they are delivered in accordance with the service plan and that they are meeting the participant's needs. If problems are identified they are promptly addressed with the provider. The case manager visits the participant at regular intervals, makes periodic telephone contact, and initiates more frequent visits if determined necessary. All waiver participants receive in-person visits by case managerss at a minimum of every six months. Based on clinical criteria and the complexity of the service plan, a subset of participants are required to receive quarterly monitoring by case management staff. ¶

Deleted: At each assessment the case manager reviews the care plan with the participant and confirms the participant's satisfaction with the plan and services. Any changes necessitated by a participant's change in function, changes in formal or informal supports or due to concerns conveyed by the participant results in a revision of the care plan to meet these needs.¶

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*:
	651 CMR 14.00 (Executive Office of Elder Affairs regulations for Aging Services Access Points that describe the functions and responsibilities of ASAPs) prohibits Aging Services Access Points from providing waiver services, except for nutrition services. In regions where the local Aging Services Access Point is also a provider of Title III meals (usually the Area Agency on Aging), home delivered meals may be provided by the ASAP. Administrative separation between ASAP and AAA functions ensures that the service plan development process focuses on documented participant needs. In no circumstances are the same individuals responsible for service plan development and the direct provision of waiver services. Through the Interdisciplinary Case Management review process, changes in a participant's needs are identified, the options for waiver and non-waiver services are discussed with the participant, provider options are discussed, and the service plan is implemented, monitored, reviewed, and updated as needed. To ensure participants' service plans have all needs identified and addressed through either waiver or non-waiver services,

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	the State reviews a statistically significant sample of participant records. SCOs do not provide direct waiver services to their enrollees.

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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:	*The required assessment tool was completed for all waiver participants.* *Numerator: Number of waiver participants with a completed assessment on the required tool* *Denominator: Number of waiver participants*		
Data Source *(Select one) (Several options are listed in the on-line application):* Other			
If 'Other' is selected, specify:			
SIMS data 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*	☐ *Stratified:*

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				☐ Other Specify:

Data Source *(Select one) (Several options are listed in the on-line application):*
Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

SCO quality report

	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*	
	Senior Care Organizations (SCO)	*☐ Continuously and Ongoing*	*☑ Stratified: Describe Group:*
		☐ Other Specify:	*By SCO: 95% confidence interval, +/- 5% margin of error*
			☐ Other Specify:

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*
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Performance Measure:	*The service plans addressed assessed needs through waiver or non-waiver services.* *Numerator: Number of waiver participants with service plans addressing assessed needs* *Denominator: Number of waiver participants*
Data Source *(Select one) (Several options are listed in the on-line application):* Other	
If 'Other' is selected, specify:	
EOEA review of data in SIMS	

	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% confidence interval, +/-5% margin of error*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

Data Source *(Select one) (Several options are listed in the on-line application):* Reports to State Medicaid Agency on delegated Administrative functions	
If 'Other' is selected, specify:	
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*
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	☑ Other Specify:	☑ Annually		
	Senior Care Organizations (SCO)	☐ Continuously and Ongoing		☑ Stratified: Describe Group:
		☐ Other Specify:		By SCO: 95% confidence interval, +/- 5% margin of error
				☐ Other Specify:

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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 service plan development in accordance with its policies and procedures.

i. Performance Measures

Performance Measure:	No longer needed in new QM system.

Deleted: *The approved service plan is completed for all waiver participants in accordance with EOEA policies and procedures regarding the person-centered planning (PCP) process. Num: The number of participants in the reporting period with a completed service plan developed in accordance with the PCP process and approved service plan tool. Denom: The number of waiver participants in the reporting period.*

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

Performance Measure:	*Case Managers documented their review of waiver participants' service plans within the past year.* *Numerator: Number of waiver participants with a documented review/update of their service plan within the past year.* *Denominator: Number of waiver participants*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	

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If 'Other' is selected, specify:

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

Data Source *(Select one) (Several options are listed in the on-line application):* Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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*
[redacted]	☐ *Operating Agency*	☐ *Monthly*	☑ *Less than 100% Review*
[redacted]	☐ *Sub-State Entity*	☐ *Quarterly*	[redacted] ☐ *Representative Sample; Confidence Interval =*
[redacted]	☑ *Other Specify:*	☑ *Annually*	[redacted]
	Senior Care Organizations (SCOs)	☐ *Continuously and Ongoing*	[redacted] ☑ *Stratified: Describe Group:*
		☐ *Other Specify:*	[redacted] *By SCO: 95% confidence interval, +/- 5% margin of error*

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Deleted: *Senior Care Organizations (SCO)*

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				☐ *Other Specify:*

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:*

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

Performance Measure:	*Service deliveries entered in the data system for the participant were in accordance with the service plan.* *Numerator: Number of service delivery units entered for all waiver participants* *Denominator: Number of service delivery units ordered for all waiver participants*		
Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:			
Service plan data and service delivery data from SIMS			
	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*	

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

Data Source *(Select one) (Several options are listed in the on-line application):Other*			
If 'Other' is selected, specify:			
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*	
	SCOs	☐ *Continuously and Ongoing*	☑ *Stratified: Describe Group:*
		☐ *Other Specify:*	*By SCO: 95% confidence interval, +/- 5% margin of error*
			☐ *Other Specify:*

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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:*

e. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

i. Performance Measures

Performance Measure:	*No longer needed in new QM system.*

Deleted: *Waiver participant records contain a signed Initial Service Plan. Numerator: Number of waiver participants' records in the reporting period that contain a signed Initial Service Plan. Denominator: The number of waiver participants in the reporting period.*

Performance Measure:	*No longer needed in new QM system.*

Deleted: *Waiver Participants are aware of their choice between HCBS waiver services and nursing facility services as indicated by their signature on the Recipient Choice Form. Numerator: The number of waiver participants in the reporting period with a signed Recipient Choice Form. Denominator: The number of waiver participants in the reporting period.*

Performance Measure:	*Waiver participants were afforded choice when offered services/providers.* *Numerator: Number of waiver participants who were afforded choice when offered waiver services/providers* *Denominator: Number of waiver participants*

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

If 'Other' is selected, specify:

EOEA review of data in SIMS

	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% confidence interval, +/-5% margin of error*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

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

If 'Other' is selected, specify:

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*	
	Senior Care Organizations (SCO)	☐ *Continuously and Ongoing*	☑ *Stratified: Describe Group:*
		☐ *Other Specify:*	*By SCO: 95% confidence interval, +/- 5% margin of error*
			☐ *Other Specify:*

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*
	☐ *Specify:*
	No longer needed.

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

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Deleted: ASAPs/SCOs will be responsible to perform 100% review of each of these areas and will report the results to EOEA on an annual basis. In addition, as part of the quality oversight responsibility of EOEA and OLTSS will include conducting retrospective reviews to validate the results of ASAP/SCO data reporting. A statistically significant sample of waiver participant records will be randomly selected from ASAPs and SCOs and will be reviewed by EOEA and OLTSS staff to validate data reporting elements.¶

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 Executive Office of Elder Affairs (EOEA), MassHealth and LTSS are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Aging Services Access Points (ASAPs) and Senior Care Organizations (SCOs). In the event problems are discovered with the management of the waiver program, ASAPs/SCOs, or waiver service providers, EOEA/MassHealth/LTSS 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, EOEA, MassHealth and LTSS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

Deleted: ASAP/SCO staff will be responsible for corrective action and any specific requirements recommended by Medicaid Agency staff. Timelines for remediation will be outlined by Medicaid Office staff and will be reflective of the nature and severity of the issue to be addressed.¶

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.**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Individuals are afforded the opportunity to request a fair hearing in all instances when they: (a) are not provided the choice of home and community-based services as an alternative to institutional care; (b) are denied the service(s) of their choice or the provider(s) of their choice; and/or, (c) their services are denied, suspended, reduced or terminated.

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

Whenever an action is taken that adversely affects a waiver participant after enrollment (e.g., services are denied, reduced or terminated), the participant is notified in writing by letter ("Notice") on a timely basis in advance of the date of implementation of the action. The Notice includes information about how the participant may seek Review of the adverse action before an Internal Case Review Committee. The Notice informs the participant that services will be continued, as appropriate, at their present level during the appeals process. A participant who disagrees with the Review decision of the Internal Case Review Committee may request an Appeal of the Committee's decision to a Hearing Officer and is informed in writing of that right upon receipt of the Review decision. A participant who disagrees with the Appeal decision of the Hearing Officer can seek further review of the Appeal decision with the Division of Administrative Law Appeals and is informed in writing of that right upon receipt of the Hearing Officer's Appeal decision. Individuals are notified that decisions of the Division of Administrative Law Appeals are reviewable in the Superior Court. It is up to the participant to decide whether to request a Fair Hearing.

All notices regarding the right to review or appeal provide a description of the review and appeals

Deleted: Procedures for notifying individuals of the opportunity to request a Fair Hearing encompass the following adverse actions: (a) not providing an individual the choice of home and community-based services as an alternative to institutional care; (b) denying an individual the service(s) of their choice or the provider(s) of their choice; and, (c) actions to deny, suspend, reduce or terminate services.¶

processes and instructions regarding how to initiate those processes. The notices describe the procedures for requesting and receiving a fair hearing for any decision adverse to the individual.

All reviews and appeals are conducted in accordance with Massachusetts Administrative Procedures Act (M.G.L. c. 30A) and the Executive Office of Administration and Finance Standard Adjudicatory Rules of Practice and Procedure (801 CMR 1.00 et seq.).

Written copies of notices of adverse actions and the notices regarding Fair Hearings are maintained in the participant's paper record kept by the ASAP.

In addition, pursuant to federal regulation 42 CFR 438 and SCO contract requirements, each SCO offers a grievance and appeal system to all of its enrollees, including waiver participants. After exhausting the internal appeal process, a participant may request a Fair Hearing in accordance with the process for Fair Hearings described above, and pursuant to the Senior Care Options Contract and 42 CFR 438.

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Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

●	**No. This Appendix does not apply**
○	**Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

●	**No. This Appendix does not apply**
○	**Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one*:

●	**Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
○	**No. This Appendix does not apply** (*do not complete Items b through e).* *If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.*

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Executive Office of Elder Affairs defines and establishes requirements for reporting critical incidents in the EOEA "Critical Incident Reporting Form" and in accompanying instructions, "Critical Incident Report Form: Instructions," that EOEA issues to the ASAPs. The Critical Incident Report Form and Critical Incident Report Form: Instructions define critical incidents as sudden or progressive events that require immediate attention and action to prevent/minimize a negative impact on the health and welfare of a waiver participant served by an ASAP or SCO. Critical incidents may include, but are not limited to: death of a participant due to unnatural causes, exposure to hazardous material, medication error, unauthorized restraints, natural disaster, serious physical injuries, criminal activity impacting the participant, serious neglect, missing persons, and significant property damage.

ASAP, SCO, and Waiver service provider staff are required to report any event of concern, unanticipated changes in the participant, or critical incidents to their respective agencies immediately. Each ASAP/SCO receives and responds to critical incidents directly. All critical incidents involving waiver participants are communicated to EOEA and the MassHealth Office of Long Term Services and Supports by phone on the day the ASAP/SCO staff learns of the incident or through secure email on the prescribed Critical Incident Report Form within two business days. EOEA reviews the information reported to ensure that the appropriate response to the critical incident has occurred to ensure participant safety. EOEA logs incidents and tracks for trends related to agencies or providers. EOEA communicates any agency, provider, or systemic trends to the

ASAPs, and specifies action steps to address the identified issue(s), through regular meetings and ongoing communication with the ASAPs. The MassHealth Office of Long Term Services and Supports SCO unit communicates with SCO programs to address health and welfare concerns identified through critical incident tracking for waiver participants receiving SCO services. Through regular communication and meetings with the ASAPs and SCOs, respectively, EOEA and the MassHealth Office of Long Term Services and Supports identify needed changes in policy and/or programming based on critical incidents trends and address concerns raised by ASAPs and SCO regarding barriers they encounter specific to securing elders' health and well-being.

Additionally, a secondary level of reporting is required for critical incidents involving abuse, neglect, or exploitation. These include incidents of physical abuse, sexual abuse, emotional abuse, self-neglect, caregiver neglect, and financial exploitation. All ASAP/SCO case managers and RN's are Mandated Reporters and are required to report incidents of abuse, neglect and financial exploitation to protective services.

The Executive Office of Elder Affairs administers a statewide system for receiving and investigating reports of elder abuse and neglect and for providing needed protective services to abused and neglected elders when warranted in accordance with M.G.L. Chapter 19A, Section 14 et seq. In furtherance of this responsibility, EOEA has established 20 designated Protective Service (PS) agencies throughout the Commonwealth to respond to reports of elder abuse. The goal of Protective Services is to remedy or alleviate the abusive situation and to prevent the reoccurrence of abuse.

Chapter 19A of the Massachusetts General Laws contains provisions governing the "Elder Protective Services" (PS) program. Section 14 of Chapter 19A defines abuse as "an act or omission which results in serious physical or emotional injury to an elderly person; or financial exploitation of an elderly person; or the failure, inability or resistance of an elderly person to provide for him or herself." The scope of the PS program includes the investigation of all cases of abuse where the alleged abuser is a family member; an informal or unpaid caretaker; has a fiduciary relationship or a voluntary relationship with the elder. Cases are screened for appropriate intervention and follow-up. These cases include: physical abuse, sexual abuse, emotional abuse, threats, intimidation, financial exploitation, neglect and self-neglect. In making decisions about the presence of physical, sexual and emotional abuse, caretaker neglect, financial exploitation and self-neglect, PS workers and their supervisors make reasoned and careful decisions about each elder's situation. Therefore, it is essential for investigations to be conducted and documented in accordance with the requirements.

EOEA operates a 24 hour a day, 7 days a week Central Intake Unit's Elder Abuse Hotline to allow for reports to be made at any time. The Hotline provides a telephone number for calling as well as a web-based reporting format through the Commonwealth of Massachusetts' website.

Each of the 20 Protective Service Units across the state have the capacity to receive and respond to Emergency and rapid response reports of abuse on a 24 hour per day, seven day per week basis. Each report is screened by a Protective Services Supervisor to determine whether the allegation constitutes a Reportable Condition to Protective Services and to determine if an Emergency, Rapid Response or Routine response is needed.

For all reports screened in as "Emergency," an assessment of the allegedly abused elder must occur within 24 hours of the report. For reports screened in as rapid response, an assessment of the allegedly abused elder must occur within 72 hours. For other non-emergency reports, an

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assessment of the allegedly abused elder must occur within 5 days of the report.

In accordance with 651 CMR 5.19: Reporting to District Attorneys, if an elder has died as a result of abuse, the death shall be immediately reported to the District Attorney of the County in which the abuse occurred.

In accordance with 105 CMR 155.00: PATIENT AND RESIDENT ABUSE PREVENTION, REPORTING, INVESTIGATION, PENALTIES AND REGISTRY, the Massachusetts Department of Public Health (DPH) is responsible for investigating all reports of patient abuse, neglect and financial exploitation by paid caregivers such as home health aides and homemakers. DPH also must maintain a registry that contains any findings which conclude that the individual about whom the complaint was registered, did, in fact, commit the acts. The programs operated by the Department of Public Health and EOEA protect the health and welfare of all residents aged 60 and over, including 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.

Waiver participants receive a packet of information from the ASAP when they are first enrolled for services with the ASAP. It is the responsibility of the ASAP case manager/RN to give the packet of information to and verbally review the packet with the participant, and document that the information was reviewed, received, and verbally reinforced with the participant. The packet includes a brochure developed by the Executive Office of Elder Affairs Protective Services Unit entitled "Help Prevent Elder Abuse, Neglect, Financial Exploitation and Self-Neglect." The brochure is available in 11 languages. The brochure describes what elder abuse is; who is protected; who must report it; how to report it and what happens after a report is made. The materials are customized for each ASAP to specify which of the 20 local Protective Services Agencies covers the ASAP's service area, and provides the Protective Services Agency's contact information as well as the state's 24 hour/ 7 day a week Critical Intake Unit's Elder Abuse Hotline telephone number. Also included in this packet is how the participant can contact the agency and case manager to let them know if he or she has a concern related to abuse, neglect or financial exploitation.

Similarly, waiver participants enrolled in a SCO receive written information about abuse neglect and exploitation, including how to report such abuse. SCO case managers are responsible for verbally review this information with the participant, and documenting that the information was reviewed, received, and verbally reinforced with the participant. The information provided includes the brochure described above as well as information about how participant can contact the SCO and their case manager to let them know if he or she has a concern related to abuse, neglect or financial exploitation.

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Deleted: In some PS cases that determine abuse, neglect or financial exploitation has occurred, results are reported to the Massachusetts District Attorney Additional regulations, 105 CMR 155.00, regarding "PATIENT AND RESIDENT ABUSE PREVENTION, REPORTING, INVESTIGATION, PENALTIES AND REGISTRY" exist within the Massachusetts Department of Public Health (DPH). This agency

Deleted: As mandated reporters, ASAP , SCO and provider agency personnel are required to report all critical incidents when any of the following occur: abuse, neglect, financial exploitation, emotional intimidation, unanticipated absences from home, alleged thefts, alleged damage to a client's possessions, and injury to an employee or client. Each ASAP/SCO handles these critical incidents directly with providers. Appropriate referrals are made to PS or DPH when warranted. Incidents of a serious nature which directly involve waiver participants are communicated to EOEA and MassHealth's Office of Long Term Services and Supports. Through the monthly meeting with ASAP Executive Directors many areas related to health and welfare are discussed by EOEA and ASAP leadership. The SCO unit also is responsible for regular communication with SCO programs to address health and welfare concerns for waiver participants receiving SCO services. These forums allow EOEA and MassHealth Office of Long Term Support Services to identify areas which need clarification, improved communication, and changes in policy and/or programming. It also allows ASAPs and SCOs to bring to EOEA and MassHealth's Office of Long Term Services and Supports attention any new concerns, updates or barriers they experience specific to securing elders' health and well being.¶
¶
Reportable Incidents¶
In case of alleged Protective Services cases (i.e. abuse, neglect or financial exploitation) the mandated report must be made according to state regulations and regulatory timelines.¶
¶
In the case of incidents of accidental damage or damage to client property by provider's employee, or theft or client and/or employee injury, the provider must report the incident to the ASAP or SCO prior to beginning any internal investigation.¶
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Deleted: The ASAP case manager also has a responsibility to verbally reinforce written materials given to participants.

Deleted: SCO waiver participants also receive a SCO Member Handbook when they are first enrolled in the SCO/Waiver. This handbook includes the following information: Welcome and Overview of SCO; Features of SCO; Eligibility; Benefits and Coverage; Exclusions and Limitations; Acces ... [5]

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.

ASAP/SCO have established procedures with ASAP/SCO staff and waiver service providers to ensure incidents effecting the health and welfare of any waiver participant are identified, assessed and triaged and that remediation occurs. ASAP/SCO staff are trained to identify, gather and report critical incidents to supervisors and management personnel. Additional methods for receiving critical incident report information include Participant Grievance Process,-Participant Satisfaction Surveys,-Vendor Comment Log (from participants and ASAP Staff).

Waiver service providers are required to report to the ASAP or SCO on same business day any hospitalization, addition or loss of household member, unexplained absences from home, alleged theft, alleged breakage of participant's possessions, injury to employee or participant, participant employee complaint, change in participant's status regarding cognitive, physical, or behavioral functioning. ASAP/SCO review and evaluate Waiver service provider reports within 24 hours to determine remediation of event and escalation to EOEA per critical incident report procedure.

Waiver service provider agencies are required to report to the ASAP/SCO immediately (day or night) for physical abuse, sexual abuse, emotional abuse, self-neglect, caregiver neglect, and financial exploitation in accordance with 105 CMR 155.00: PATIENT AND RESIDENT ABUSE PREVENTION, REPORTING, INVESTIGATION, PENALTIES AND REGISTRY (the state's mandated reporter regulation). Protective Service reports are then screened and investigated per state regulation as described below.

In accordance with 651 CMR 5.00: ELDER ABUSE REPORTING AND PROTECTIVE SERVICES PROGRAM, (651 CMR 5.10 Investigation) the applicable Protective Service Agency completes an investigation, generally comprised of one or more visits to the residence of the elder, designed to assess the allegations of abuse reported; evaluate the condition of the elder including the decisional capacity and functional capacity of the elder to determine if there is reasonable cause to believe that the elder is suffering from abuse; and establish a basis for offering services if the existence of abuse is confirmed. The regulation (651 CMR 5.10(2) Process) establishes timelines for completing the investigation as follows: for all reports screened in as "Emergency," an assessment of the allegedly abused elder must occur within 24 hours of the report; for reports screened in as rapid response, an assessment of the allegedly abused elder must occur within 72 hours; for other non-emergency reports, an assessment of the allegedly abused elder must occur within 5 days of the report. All investigations must be completed within 30 days.

The Protective Services regulation provides that Mandated Reporters are notified in writing of the action taken in response to the report within 45 calendar days of the report; other reporters are notified upon request. 651 CMR 5.08(2)(e)(3)

EOEA is informed of any critical incident reports of a serious nature. These reports are made directly to the Director of Home and Community Programs or the Chief of Staff as well as documented in writing. SCO programs report all critical incidents involving waiver participants to the LTSS as required for all MassHealth programs.

Deleted: Internal operations at each ASAP site and SCO Program involves various methods and processes to ensure incidents effecting the health and welfare of any waiver participant are identified, assessed and triaged and that remediation occurs. Specific policies and procedures are in place to address health and welfare issues. These include: ¶
-Protective Services/Mandated Reporting and Documentation Policy¶
-Participant Allegation of Theft / Property Damage from a Service Provider¶
-Critical Incident Reporting¶
-Participant Grievance Process¶
-Participant Satisfaction Surveys¶
-Vendor Comment Log (from participants and ASAP Staff)¶
-Serving Non-English Speaking/Disabled participants/TTY Instructions¶
-Emergency Procedures¶
-Evacuation/Emergency Procedures¶
-CORI Policy for all ASAP Staff, SCO staff and Sub-contracted Providers' staff¶
¶
Other activities that specifically address the overall health, welfare and safety of elders include:¶
-Critical Case Conferences¶
-Confidential Critical Incident Logs¶
-Consultations with waiver RN and Protective Services worker¶
¶

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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, EOEA is responsible for the oversight of the reporting of and response to critical incidents or events that affect all waiver participants. Critical incidents are addressed and reported as they occur by EOEA 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 EOEA, meet at least monthly and on an ad hoc basis whenever necessary.

Every critical incident report submitted is reviewed and must include steps taken to mitigate risk, and prevent future incidents. If any required information is not included in the report, EOEA or LTSS request the necessary information from the ASAP or SCO to ensure proper follow up is completed. This follow up may include: reassignment of provider, corrective action required by provider, or a formal plan to ensure the participant's safety. Incidents involving fatalities of a suspicious nature, imminent risk, employee misconduct and those with media involvement are also shared with EOHHS leadership.

MassHealth's LTSS is the state entity responsible for the oversight of the reporting of and response to critical incidents or events that affect waiver participants enrolled in SCO. Any critical incident which falls under Protective Services is investigated by the PS unit according to state regulations (651 CMR 5.00), and is maintained by this unit in regards to oversight of the case after the report is substantiated. Any critical incident received by LTSS or the PS unit is shared with EOEA and tracked to ensure proper follow up on each waiver participant.

The Massachusetts Department of Public Health is the other state agency responsible for the oversight of the reporting and response to all reports of abuse, neglect and financial exploitation of any waiver participants by paid caregivers, such as home health aides and homemakers. Oversight is done on a case-by-case basis and substantiated findings are maintained in a DPH registry.

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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:
	Within EOHHS, EOEA and DPH receive reports of the unauthorized use of restraints or seclusion through protective service reports or provider complaints. In accordance with 105 CMR 155 et seq (Department of Public Health Patient and Resident Abuse Prevention, Reporting, Investigation, Penalties, and Registry) and 651 CMR 5.00 et seq (Elder Abuse Reporting and Protective Services Program) all reports of abuse, neglect and mistreatment, including restraining or secluding an elder, require investigation. As noted in Appendix G-1-e, critical incidents are reported by EOEA to EOHHS in accordance with EOHHS policies and procedures for such reporting. In addition EOEA provides an annual summary report of incidents to MassHealth. Additionally, EOEA reports and monitors consumer assessment data for any indications of 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:

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:
	Within EOHHS, EOEA and DPH receive reports of the unauthorized use of restrictive interventions through protective service reports or provider complaints. In accordance with 105 CMR 155 et seq (Department of Public Health Patient and Resident Abuse Prevention, Reporting, Investigation, Penalties, and Registry) and 651 CMR 5.00 et seq (Elder Abuse Reporting and Protective Services Program) all reports of abuse, neglect and mistreatment, including restrictive interventions involving an elder, require investigation. As noted in Appendix G-1-e, critical incidents are reported by EOEA to EOHHS in accordance with EOHHS policies and procedures for such reporting. In addition EOEA provides an annual summary report of incidents to MassHealth. Additionally, EOEA reports and monitors consumer assessment data for any indications of unauthorized use of restrictive interventions.
○	**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.

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Deleted: EOEA and DPH are the state agencies to receive reports of the unauthorized use of restraints or seclusion through protective service reports or provider complaints. Both agencies have state regulations in place which require investigating all reports of abuse and neglect and mistreatment, which would include the unauthorized use of restraints or seclusion. These regulations may be found at 105 CMR 155 et seq (Department of Public Health Patient and Resident Abuse Prevention, Reporting, Investigation, Penalties, and Registry) and 651 CMR 5.00 et seq (Elder Abuse Reporting and Protective Services Program). As noted in Appendix G-2-a, critical incidents including the unauthorized use of restraints, are reported by EOEA to EOHHS in accordance with EOHHS policies and procedures for such reporting. In addition EOEA provides an annual summary report of incidents to Office of Medicaid staff.¶

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:

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:
	EOEA and DPH are the state agencies to receive reports of the unauthorized use of seclusion through protective service reports or provider complaints. Both agencies have state regulations in place which require investigating all reports of abuse and neglect and mistreatment, which would include the unauthorized use of seclusion. These regulations may be found at 105 CMR 155 et seq. (Department of Public Health Patient and Resident Abuse Prevention, Reporting, Investigation, Penalties, and Registry) and 651 CMR 5.00 et seq. (Elder Abuse Reporting and Protective Services Program). As noted in Appendix G-2-a, critical incidents including the unauthorized use of seclusion, are reported by EOEA to EOHHS in accordance with EOHHS policies and procedures for such reporting. In addition EOEA provides an annual summary report of incidents to MassHealth. Additionally, EOEA reports and monitors consumer assessment data for any indications of 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.

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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.

With the exception of Respite services, waiver participants are served only in their own personal residences. When receiving waiver services in a respite location other than their home, 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, Rest Homes and Skilled Nursing Facilities. Assisted Living Residences are certified by EOEA. Oversight is provided in accordance with 105 CMR 130.00 (Department of Public Health regulations governing hospital licensure), 105 CMR 150.00 (Department of Public Health regulations governing licensing of long-term care facilities), 105 CMR 158.000 (Department of Public Health Licensure of Adult Day Health Programs), 651 CMR 12.00 (EOEA regulations describing certification procedures and standards for Assisted Living Residences in Massachusetts), MGL c. 94C (Massachusetts Controlled Substances Act) and MGL c. 112 s. 74 and 74A (Mass General Laws regarding registration of Registered Nurses and Licensed Practical Nurses). Oversight of Hospitals, Rest Homes, Skilled Nursing Facilities and Assisted Living Residences is conducted every two years.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and (c) the State agency (or agencies) that is responsible for follow-up and oversight.

State oversight and follow-up of medication management is conducted as part of the licensing or certification process for the applicable respite care setting. Oversight is provided in accordance with 105 CMR 130.00 (Department of Public Health regulations governing hospital licensure), 105 CMR 150.00 (Department of Public Health regulations governing licensing of long-term care facilities), 105 CMR 158.000 (Department of Public Health Licensure of Adult Day Health Programs), 651 CMR 12.00 (EOEA regulations describing certification procedures and standards for Assisted Living Residences in Massachusetts), MGL c. 94C (Massachusetts Controlled Substances Act) and MGL c. 112 s. 74 and 74A (Mass General Laws regarding registration of Registered Nurses and practical nurses).

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

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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).

State oversight and follow-up of medication administration is conducted in accordance with 105 CMR 130.00 (Department of Public Health Hospital Licensure Regulations that describes the standards for the maintenance and operations of hospitals in Massachusetts), 105 CMR 150.00 (Department of Public Health regulations governing licensing of long-term care facilities), 105 CMR 158.000 (Department of Public Health Licensure of Adult Day Health Programs), 651 CMR 12.00 (EOEA regulations describing certification procedures and standards for Assisted Living Residences in Massachusetts), MGL c. 94C (Massachusetts Controlled Substances Act), and MGL c. 112 s. 74 and 74A (Mass General Laws regarding registration of Registered Nurses and Licensed Practical Nurses).

iii. Medication Error Reporting. *Select one of the following:*

●	**Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).** *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	The Massachusetts Department of Public Health for all DPH licensed facilities and the Executive Office of Elder Affairs for Assisted Living Residences.
	(b) Specify the types of medication errors that providers are required to *record:*
	All medication errors in DPH licensed facilities must be recorded. DPH requires a Medication Occurrence Report when there is an event that results from the breach of one of the 5 "R's", namely right individual, right medication, right time, right dose and right route. There are 5 types of reportable occurrences— "the 5 wrongs" are wrong individual, wrong medication (which includes administering medication without an order), wrong time (which includes a forgotten dose), wrong dose and wrong route.
	(c) Specify the types of medication errors that providers must *report* to the State:
	Medication Occurrence Reports must be submitted to DPH within 24 hours of the incident for any reportable medication occurrence in a DPH licensed facility. A reportable occurrence is any medication error followed by a medical intervention, illness, injury or death. The DPH maintains a designated 24 hour hotline to receive all Medication Occurrence Reports. Assisted Living Residences must report any medication error with an adverse effect requiring medical attention.
○	**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.** Specify the types of medication errors that providers are required to record:

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

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State oversight and follow-up of medication administration errors is conducted in accordance with 105 CMR 130.00 (Department of Public Health regulations governing hospital licensure), 105 CMR 150.00 (Department of Public Health regulations governing licensing of long-term care facilities), 105 CMR 158.000 (Department of Public Health Licensure of Adult Day Health Programs), 651 CMR 12.00 (EOEA regulations describing certification procedures and standards for Assisted Living Residences in Massachusetts), MGL c. 94C (Massachusetts Controlled Substances Act) and MGL c. 112 s. 74 and 74A (Mass General Laws regarding registration of Registered Nurses and Licensed Practical Nurses).

The Department of Public Health is responsible for oversight of Hospitals and Nursing Facilities. Licenses for these facilities are renewed every two years. In addition, the Department of Public Health conducts investigations into reported complaints, which would include any complaints regarding medication management. The regulation citation is 105 CMR 130.00 (Department of Public Health regulations governing hospital licensure).

Medication management in Assisted Living Residences is overseen by EOEA in accordance with 651 CMR 12.00, the state regulations governing certification of Assisted Living Residences. Assisted Living Residences are re-certified every two years. The regulation citation is 651 CMR 12.00 (EOEA regulations describing certification procedures and standards for Assisted Living Residences in Massachusetts).

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

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Deleted: The MassHealth Agency is responsible for the oversight and monitoring of Adult Day Health (ADH) and Adult Foster Care (AFC) providers. All ADH and AFC providers must meet the MassHealth provider regulation eligiblityeligibility requirements as described in 130 CMR 404.000 (MassHealth Adult Day Health regulations that define provider eligibility requirements and program rules) and 130 CMR 408.000 (MassHealth Adult Foster Care regulations that define provider eligibility requirements and program rules). The MassHealth agency conducts periodic inspections of ADH and AFC providers to ensure compliance with all provider participation requirements.¶

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:	*H & W 1: Waiver participants were assessed to identify concerns of abuse and neglect.* *Numerator: Number of waiver participants with a documented assessment of abuse and neglect* *Denominator: Number of waiver participants*		
Data Source *(Select one) (Several options are listed in the on-line application): Other*			
If 'Other' is selected, specify:			
SIMS data 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%*

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	☐ Sub-State Entity	*☑ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
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Data Source *(Select one) (Several options are listed in the on-line application): Other*			
If 'Other' is selected, specify:			
Analysis of SCO MDS submissions			
	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*	
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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*
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☐ Operating Agency	*☐ Monthly*
☐ Sub-State Entity	*☐ Quarterly*
☐ Other Specify:	*☑ Annually*

	☐ *Continuously and Ongoing*
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Performance Measure:	*H & W 4: Case management entity staff received training on their responsibilities as mandated reporters of abuse and neglect.* *Numerator: Number of case management entity staff that were trained on abuse, neglect and mandated reporter requirements* *Denominator: Number of case management entity 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*	
	ASAPs and Senior Care Organizations (SCO)	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other* *Specify:*	
			☐ *Other Specify:*

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*
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☐ *Sub-State Entity*	☐ *Quarterly*
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Performance Measure:	*H & W 5: Provider performance monitoring ensured waiver service providers were trained on responsibilities as mandated reporters of abuse and neglect.* *Numerator: Number of waiver service provider agencies audited with documented staff training on abuse, neglect, and mandated reporter requirements.* *Denominator: Number of waiver service provider agencies audited.*
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: ASAPs and Senior Care Organizations (SCO)	☑ Annually ☐ Continuously and Ongoing	☐ Stratified: Describe Group:
		☐ Other Specify:	
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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

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

Performance Measure:	*H & W 6: Case management entity staff had Criminal Offender Record Information (CORI) checks at the required times.* *Numerator: Number of case management entity staff that had CORI checks at the required times.* *Denominator: Number of case management entity staff.*
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
CORI Verification Reporting for ASAPs and SCOs	

	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*	
	ASAPs and Senior Care Organizations (SCO)	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other* *Specify:*	
			☐ *Other Specify:*

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*

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Performance Measure:	*H & W 7: Waiver service provider staff had Criminal Offender Record Information (CORI) checks at required times.* *Numerator: Number of waiver service providers audited whose staff had CORI checks at required times.* *Denominator: Number of waiver service providers audited.*
Data Source *(Select one) (Several options are listed in the on-line application): Provider performance monitoring*	
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*	
	ASAPs and Senior Care Organizations (SCO)	*☐Continuously and Ongoing*	*☐Stratified: Describe Group:*
		☐Other Specify:	
			☐Other Specify:

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

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	Specify:

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.

Performance Measure:	*Reported critical incidents affecting waiver participants had follow-up, according to applicable EOEA requirements.* *Numerator: Number of reported critical incidents affecting waiver participants that had follow-up, according to applicable EOEA requirements* *Denominator: Number of reported critical incidents affecting waiver participants*
Data Source *(Select one) (Several options are listed in the on-line application):* *Critical Events and Incident Reports*	
If 'Other' is selected, specify:	
ASAP and SCO Incident reporting	

	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*	
	ASAPs and Senior Care Organizations (SCOs)	☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	
			☐ *Other Specify:*

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*

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☐ *Sub-State Entity*	☐ *Quarterly*
☐ *Other* *Specify:*	☑ *Annually*
	☐ *Continuously and Ongoing*
	☐ *Other* *Specify:*

c. Sub-assurance: The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measure:	*Reported incidents of the unauthorized use of restraints/restrictive interventions had follow-up, according to EOEA requirements.* *Numerator: Number of reported incidents of the unauthorized use of restraints/restrictive interventions that had follow-up, according to EOEA requirements* *Denominator: Number of reported incidents of the unauthorized use of restraints/restrictive interventions*
Data Source *(Select one) (Several options are listed in the on-line application):* Critical Events and Incident Reports	
If 'Other' is selected, specify:	
ASAP and SCO Incident reporting	

	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*	
	ASAPs and Senior Care Organizations (SCOs)	☑ *Continuously and Ongoing*	☐ *Stratified: Describe Group:*
		☐ *Other* *Specify:*	
			☐ *Other Specify:*

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Data Aggregation and Analysis

Responsible Party for data	***Frequency of data aggregation***

aggregation and analysis *(check each that applies*	***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:*

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.

Performance Measure:	*H & W 2: Waiver participants were assessed to identify housing environmental safety risks.* *Numerator: Number of waiver participants with a documented assessment of housing environmental safety risks* *Denominator: Number of waiver participants*
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
SIMS data report	

	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:*

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

Deleted: *Every waiver*

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Deleted: *Senior Care Organizations (SCO)*

Reports to State Medicaid Agency on delegated Administrative functions			
If 'Other' is selected, specify:			
Analysis of SCO MDS submissions			
	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:*

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:	*Waiver participants were assessed to identify fall risks.* *Numerator: Number of waiver participants with a documented assessment of fall risk* *Denominator: Number of waiver participants*
Data Source *(Select one) (Several options are listed in the on-line application):* Other	
If 'Other' is selected, specify:	
SIMS data reports	

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Deleted: *Senior Care Organizations (SCO)*

	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:*

Data Source *(Select one) (Several options are listed in the on-line application):* **Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:
Analysis of SCO MDS submissions

	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:*

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	*H & W 3: Waiver participants were assessed for their ability to manage medications and their need for assistance.* *Numerator: Number of waiver participants with a documented assessment of their ability to manage medications* *Denominator: Number of waiver participants*

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

If 'Other' is selected, specify:

SIMS data 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:*

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

If 'Other' is selected, specify:

Analysis of SCO MDS submissions

	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:*

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.

Deleted: EOEA's Quality Management System within the ASAP/SCO network approaches quality from three perspectives: the individual, the provider and the system. The focus is on the discovery of issues, remediation and service improvement. Information gathered on the individual and provider level is used not only to remedy situations on those levels, but also to understand systemic concerns and to improve overall system performance.¶

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 Executive Office of Elder Affairs (EOEA), MassHealth and LTSS are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Aging Services Access Points (ASAPs) and Senior Care Organizations (SCOs). In the event problems are discovered with the management of the waiver program, ASAPs/SCOs, or waiver service providers, EOEA/MassHealth/LTSS 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, EOEA, MassHealth and LTSS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii. **Remediation Data Aggregation**

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

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.

Deleted: The ASAP/SCO Network, which includes case managers, nurses and other professional staff, is the cornerstone of the monitoring and oversight system for waiver participants. The case manager is responsible for assessing the participants needs as well as their potential risk areas; developing a comprehensive service plan; maintaining on-going contact with the participant; overseeing and implementing the service plan; modifying the plan when needs change; and addressing issues of concern as they arise. Supervisory oversight ensures that each participant's plan of care addresses all needs, that implementation of the service plan is consistent with what is delineated in the plan, that the case manager is maintaining required visits and contacts with the participant; and that they are involved in addressing health and safety related issues as they emerge.¶
¶
ASAP/SCO staff have the responsibility of filing reports of critical incidents as mandated reporters.¶
¶
The ASAP/SCO Network also has the responsibility of determining and assuring that all providers they contract with for waiver services are qualified. All providers are required to go through a pre-qualification process. Standards have been developed by EOEA in regards to all aspects of provider monitoring. The Provider QA Manual guides ASAPs through the provider review process in order to ensure provider qualifications to support the health, safety and quality of life for participants. These standards also apply to SCO providers. The reviews involve provider site visits, observations of service delivery, participant satisfaction surveys, critical incident logs, complaint logs and record reviews. Providers receive licensure and certification depending on the level of their supports (i.e. Home Health Aids). Providers are required to correct issues of immediate jeopardy within 24-48 hours with follow-up conducted by ASAP/SCO staff. Follow-up on other issues is done within 60 days.¶
¶
Generally, if an incident or complaint regarding provider performance is not of a minor nature (easily resolved by reporter with a conversation with the provider), the reporter will document it on the provider Report Form, or bring it to the designated ASAP/SCO staff member for documentation. (The designated staff member will return the form to the reporter for sign off and forward the form to the ASAP/SCO provider monitor.) ¶
The provider monitor determines the degree of concern and proceeds as follows:¶
• . calls the provider to discuss the situation, and documents the action taken;¶
OR¶
• . forwards the concern to the provider for a documented response within a timely fashion.¶
¶
Upon receipt of the provider response, a determination will be made by the provider monitor as to whether or not a satisfactory resolution has taken place. If so, the resolution is documented. If not, the provider Monitor again contacts the provider and requests specific action.¶
¶
The provider's failure to appropriately address inadequate performance may lead to suspension or termination.¶

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;
- 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.

EOEA's data-focused quality improvement strategy (QIS) is designed to assure that essential safeguards are met with respect to health, safety, and quality of life for waiver participants, A continuous loop of quality management enables the identification of issues, notification to responsible parties, correction/remediation, follow-up, analysis of patterns and trends, and system improvement activities. Quality is tracked through performance measures based on waiver assurances and sub-assurances as well as state law, regulations, and sub-regulatory policies and guidance. These performance metrics measure participant health and safety and other quality-of-life domains, including participant access, person-centered planning, service delivery, rights and responsibilities, and participant satisfaction.

Quality is approached from three perspectives: the participant, the provider, and the system. Each tier focuses on prevention of adverse events, discovery of issues, remediation, monitoring, and system improvement. Information gathered on the participant and provider levels is managed directly by each Aging Services Access Point (ASAP) and Senior Care Organization (SCO); EOEA and MassHealth have oversight responsibilities in the areas of level of care determinations, service plans, qualified providers, health and welfare, administrative authority, and financial accountability to ensure compliance with EOEA's and MassHealth's policies and procedures. Information gathered on the individual and provider levels is used both to remedy situations on those levels, and to inform overall system performance and improvement efforts.

Systems level improvements are organized on two levels—the case management (CM) entity level and system-wide. CM entities, as described in Appendix A, include ASAPs and SCOs, which work most closely with waiver participants and waiver service providers through the service planning and oversight process. Ultimately EOEA and MassHealth are accountable for assuring that identified quality improvement efforts are implemented and reviewed both within individual ASAPs/SCOs and across the system.

EOEA and MassHealth collaborate to facilitate prevention, discovery, remediation, monitoring, planning, and overall system quality improvement strategies. EOEA staff (Director of Home and Community Programs, Waiver Program Manager, and Quality Manager) and MassHealth Office of Long Term Services and Supports (LTSS) staff (Director of Coordinated Care and Contract Managers) maintain overall responsibility for designing and overseeing the waiver's QIS and assuring that appropriate data are collected, disseminated, and reviewed and service improvement targets are established.

Tier I – The Participant Level
Activities related to quality oversight at the participant level include reviews within the CM entity and at the state level of level of care, person-centered care plans, timely participant documentation, critical incidents, and investigation and resolution of complaints.

Tier II – The Provider Level
At the provider level, the state ensures that providers are qualified and performing effectively on an on-

going basis. SCOs primarily utilize ASAP-procured waiver service providers. The following activities apply to all waiver providers; unless variations are noted below.
- Providers receive onsite audits at least once during the first six months after initial services are delivered, and thereafter once every 2-3 years, depending on provider type, to ensure compliance.
- ASAPs administer annual consumer and staff satisfaction surveys to evaluate provider performance.
- ASAPs maintain a staff/consumer complaint/compliment log as an additional mechanism to gather feedback regarding provider performance.
- SCOs administer an annual SCO-level CAHPS survey to all participants, including the Persons with Mobility Impairment Supplemental Questions, using an approved CAHPS vendor and report the CAHPS results data to LTSS.

Tier III – the System Level

Information from the participant and provider levels informs the third tier of the quality improvement strategy, providing information to enable the state to identify and resolve issues, analyze patterns and trends, and implement system-wide corrections and improvements. Ultimately, this process supports the state's ability to ensure optimal operation of the waiver and to meet the needs of participants.

1. Reports: System-wide reports are generated from both the participant and provider levels, and EOEA and LTSS review and analyze aggregated data to identify issues and trends and to address and improve system-wide performance, service, and satisfaction. Data and reports come from the SIMS client information system, online and Excel reports, as well as from SCO reporting. ASAPs and SCOs review and submit reports, enabling EOEA to undertake systemic review.

2. Ongoing Monitoring and Improvement Projects: EOEA and LTSS perform ongoing monitoring and analysis that informs their efforts to plan and undertake quality improvement projects.

Monthly and yearly monitoring: EOEA monitors measures monthly and/or annually, reviewing both quantitative and qualitative data in SIMS. LTSS monitors SCO performance through similar procedures. The state communicates with its waiver Case Management entities about any problems that are uncovered and manages proper remediation.

Committee and waiver quality improvement: EOEA periodically convenes a project-based quality improvement committee, currently composed of EOEA staff and ASAP representatives, which focuses on sharing best practices and standardizing current procedure to improve quality. EOEA and this Committee research approaches to monitoring and remediating quality, tracking trends, and using quality improvement tools and practices to strengthen the state's ability to meet waiver assurances.

LTSS conducts quarterly meetings with SCO leadership at which waiver quality improvement is a standing agenda item and also holds an annual meeting focused on waiver oversight.

Designation/Contracting reviews: EOEA conducts site visits at each of the ASAPs and LTSS conducts site visits at each of the SCOs once or more during the five-year waiver cycle, reviewing practices on monitoring, remediating, and improving performance on waiver quality measures. Results of the reviews inform the state's continued contracting with the CM entities, assures appropriate compliance and adherence to requirements, and provides any technical assistance as needed.

In addition, the SCO contract has extensive requirements to assure that a high quality of clinical care and support services are delivered to SCO enrollees, since SCOs must authorize, coordinate, and deliver all levels of primary, acute, preventive, behavioral health, and long-term care, as well as HCBS. SCOs must report to the state and to CMS on a full spectrum of geriatric clinical indicators developed

by the National Committee for Quality Assurance (NCQA).

Processes for Trending

EOEA tracks trends on all measures through reports and through the use of quality improvement tools. EOEA tracks data by measure, by ASAP or SCO as well as statewide to identify trends that indicate areas needing additional analysis and scrutiny. Tracking each measure by entity allows EOEA to zero in on a particular problem area to both identify issues within an organization, and to identify a potential problem that requires systemic course correction and/or training. EOEA and LTSS jointly review the quality management data. LTSS communicates all issues and corrective actions to each SCO as appropriate, based on the contract. In addition, EOEA and LTSS closely monitor critical incident data to identify trends, specific areas of concern at the provider and staff level and any clusters of issues.

This ongoing monitoring of the measures enables EOEA to identify which measures are showing lower performance, focus its investigation of the causes and remedies for them, including providing clarity and direction to the system, produce formal guidance documentation, and provide training.

Processes for Prioritizing System Improvements

EOEA has formalized and standardized its processes for identifying and prioritizing system improvements and maintains a catalog of system improvement options. While EOEA conducts monthly and yearly discovery and remediation activities, it updates the catalog, as items are addressed and as new ideas arise. EOEA reviews the catalog at least monthly to ensure that new ideas are recorded and all items prioritized.

When considering an idea for implementation, EOEA asks the following questions:
Does the improvement idea address

- Issues from incident reports?
- Concerns that participants/informal caregivers reported?
- Concerns that ASAPs or SCOs reported?
- Concerns that other stakeholders, such as advocacy groups, reported?
- Other risks to waiver participants, especially health and welfare concerns?
- Low/declining performance on measures?

The criteria on incident reports, concerns of participants/informal caregivers, and risks to participants are weighted the most heavily.

EOEA also considers criteria to assess the feasibility of implementing improvement options, for ASAPs and SCOs, as well as for LTSS and EOEA. The process allows EOEA to systemically assess and prioritize improvement options, and determine implementation timing.

Processes for Implementing System Improvements

EOEA undertakes formal process-improvement projects to ensure organized and structured procedures for implementation of all required system improvements. EOEA bases its methods on tested and well-respected frameworks, such as the Institute for Healthcare Improvement's (IHI's) Model for Improvement, including the Plan Do Study Act (PDSA) process.
EOEA tracks current improvement projects, completed projects, and identifies new projects. Tracking allows EOEA to maintain a high-level view of all projects and the relationship of systems

improvements to the problems being addressed. EOEA follows up to determine the impact that improvement projects have on system quality and whether such projects have the anticipated effects. When outcomes do not demonstrate the planned impact, alternate approaches are considered and implemented. EOEA undertakes the standard PDSA cycle to test different approaches to improvements—planning the test and making predictions, implementing the test and documenting results, analyzing the results, deciding if something should be changed to achieve the improvement, and planning the next PDSA cycle.

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.

Process for Monitoring and Analyzing the Effectiveness of System Design Changes

MassHealth and EOEA have a strong commitment to a quality improvement system that continuously evaluates the processes in place to monitor waiver activities, participant outcomes, and system design changes. EOEA use elements of such frameworks as the IHI Model for Improvement to conduct certain improvement initiatives, leading to system design changes. EOEA utilizes various tools, such as run or control charts, to evaluate the effectiveness of its improvement initiatives. These charts allow for tracking a performance measure over time, identifying the point in time when an improvement was made, identifying trends and determining whether an initiative successfully addresses improvement goals. Such charts give EOEA the ability to observe performance before and after an improvement was made, to evaluate the effectiveness of the change.

Other methods of determining the effectiveness of system design changes are more qualitative, such as feedback from ASAPs staff, Program Managers and Nurse Managers, at designation reviews and through participant and caregiver feedback. EOEA home care unit meets regularly to discuss specific initiatives and the success or failure of that improvement initiative, as well as meeting routinely with

Deleted: EOEA'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 use of data and related information is necessary to promote ongoing quality improvement efforts. While there are multiple approaches in place to allow for a robust system, the overall quality management and improvement system continues to evolve and improve.¶
. ¶
EOEA's quality management and improvement strategy is based on the following key operational principles:¶
¶
- The system is designed to create a continuous loop of quality including the identification of issues, notification to concerned parties, correction/remediation, follow-up analysis of patterns and trends, and service improvement activities.¶
- Quality is measured based upon a set of outcome measures, which are based on EOEA's mission statement, CMS assurances, Commonwealth of Massachusetts' regulations, Waiver Quality Measure reports and Waiver Quality Record Review findings. The system measures health and safety for participants and also places a strong emphasis on other quality of life domains including participant access, person-centered planning and service delivery, rights and responsibilities, and participant satisfaction.¶
Three Tiers of Quality Management and Improvement¶
¶
EOEA's 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 and service improvement. Information gathered on the individual and provider level is managed directly by each ASAP and/or SCO. EOEA and the Office of Medicaid have oversight responsibilities in the areas of LOC Determination, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability to ensure that each ASAP and/or SCO is in compliance with EOEA's/Office of Medicaid's policies and procedures. ¶
¶
Tier I- The Individual Level: Case managers, in partnership with assessing nurses (RNs), are the cornerstone of the monitoring and oversight system for participants. In their respective roles, the case manager is responsible for developing, working directly with the Participant, the individual's service plan based on the comprehensive assessments that have been completed, including the clinical assessment completed by the RN. The case manager also maintains on-going contact with the participant, oversees implementation of the service plan, works with the participant to modify the plan when needs change, and addresses areas of concern as they arise. Quality management activities relating to the above mentioned responsibilities include:¶
¶
1. . Reviews of appropriate Level of Care determinations and re-determinations using the approved tool.¶
... [7]

LTSS staff for similar purposes. EOEA may adjust its course of action depending on the results of these discussions.

Roles and Responsibilities

EOEA's Director of Home and Community Programs, the Assistant Director of Home and Community Programs, the Waiver Program Manager, the Quality Manager, and the Director of Home and Community Based Services Policy Lab are responsible for evaluating the processes and systems in place for the waiver program. In addition, the 26 ASAPs conduct their own evaluations, make agency-wide improvements as necessary, and assess these changes, while adhering to program requirements. ASAP quality managers meet every other month to share information and best practices, enhancing quality across the state. Similarly, the MassHealth Office of Long Term Services and Supports reviews quality data that the SCOs provide, and shares all data with EOEA. EOEA and MassHealth review all systemic findings and issues related to ongoing operation of the waiver program. LTSS, with the guidance and direction of EOEA and MassHealth, amends the SCO contract, issues subcontractual guidance and provides technical assistance to the SCO plans as required to ensure adherence to program requirements and implementation of best practices.

EOEA's quality improvement strategy systematically uses the processes of discovery, remediation, improvement design and implementation, trend identification, and evaluation of design changes to ensure that the 1915(c) Frail Elder Waiver program operates as intended. These continuous quality activities are embedded in all aspects of the operation of the waiver. MassHealth and EOEA have designed an effective quality improvement strategy for the waiver program, which identifies consumer-focused quality indicators and uncovers and evaluates system-wide improvements.

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

Process to Evaluate the Quality Improvement Strategy

In collaboration with MassHealth, EOEA is committed to the ongoing evaluation of the processes and systems in place that form the quality improvement strategy. EOEA holds annual internal meetings to evaluate the quality improvement strategy, and is in the process of creating an improved tool with which it assesses the waiver QIS. EOEA is developing questions for different members of the team to elicit information from various perspectives on the quality improvement strategy. Through the use of this assessment tool, EOEA will be able to objectively and logically evaluate the strategy, considering all of its aspects.

Though EOEA formally evaluates the quality improvement strategy as a whole once a year, it also considers what might be changed throughout the year and decides on improvement projects as described in the previous section. For example, an ongoing dialogue between EOEA and the ASAPs identified the need for user-friendly, streamlined, and uniform waiver quality measure tracking processes for all ASAPs and for EOEA to use. As a result, EOEA has undertaken the initiative to improve reporting, which is meeting this need, and continually strengthening the overall quality improvement strategy.

Deleted: The Office of Medicaid and EOEA have a strong commitment to a quality management system which continuously evaluates the processes in place to monitor waiver activities and participant outcomes. ¶
¶
The Waiver Quality Record Review process provides concrete, discovery data which, when aggregated and analyzed, allows for prioritization of any assurance areas which need immediate quality improvement strategies to remedy the findings. The process also identifies current processes that may be implemented in a specific ASAP, which are considered "a best practice' and should be recommended for implementation across the ASAP network to ensure uniformity and the assurance that a standard is being met.¶
¶
For Massachusetts', the overarching quality management approach is designed to utilize and build on the CMS Quality Assurance and Sub-assurance areas, which entails establishing a system that focuses on quality management and attempts to ensure the following quality outcomes: ¶
¶
-Individuals have access to 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 with quality services. ¶
-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 ensures the delivery of quality service to individuals who choose 1915(c) Frail Elder Waiver services.¶
¶ ... [8]

Deleted: In collaboration with the Office of Medicaid, EOEA is committed to ongoing evaluation of the processes and systems in place which comprise our quality management strategy. ¶
¶
EOEA's Quality Manager, the Director of Home Care and the Waiver Coordinator are initially responsible for evaluating the processes and systems currently in place for the 1915(c) Waiver program. Input from the Office of Medicaid, CMS, EOHHS and internal leadership at EOEA also shape the process and the focus on specific assurance areas in the quality management strategy.¶
¶
SIMS data also drives quality improvement initiatives. Aggregated data is analyzed to determine if outcomes are being met. Custom reports separate waiver participants from the general home care population and findings from these reports are utilized for on-going quality improvement activities. Reports are constantly being refined to assist with on-going quality activities.¶

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) Each provider is required to annually submit an independent audit and the Uniform Financial Statements and Independent Auditor's Report (the UFR) to the Commonwealth's Executive Office of Administration and Finance's Operational Services Division. Operational Services Division regulation 808 CMR 1.00, Compliance, Reporting and Auditing for Human and Social Services, is the primary regulation covering contract compliance, financial reporting and auditing requirements for waiver service providers. These regulations are derived from M.G.L. c.29 s.29B, applicable industry auditing and accounting standards set by the American Institute of Certified Public Accountants (AICPA), federal restrictions, the Internal Revenue Service (IRS) and other relevant sources.

(b) The integrity of provider billing data for Medicaid payment of waiver services is managed by ASAP staff utilizing the Senior Information Management System (SIMS) and the Medicaid Management Information System (MMIS). ASAP staff utilize SIMS to confirm the delivery of services, the units of delivered services and the cost of all services prior to submitting claims to Medicaid. SIMS also contains each participant's comprehensive service plan (CSP) and supports the ability to ensure that the services rendered are in accordance with the CSP prior to provider payment. The EOEA hosts, maintains, and has access to all data within SIMS and reviews and approves this data on a monthly basis. MMIS sets payment ceilings to ensure integrity of the payment and also confirms each participant's Medicaid waiver eligibility as a condition of payment.

(c) For members enrolled through a Senior Care Organization (SCO) receiving waiver services from providers participating in the Frail Elder Waiver:
The SCO carries out primary program integrity activities to identify any potential overpayments made to providers due to fraud, waste and abuse. MassHealth's Office of Long

Deleted: EOEA, through its contractors, conducts on-site Quality Assurance Audits of providers to ensure that services are being provided in compliance with established Standards of Service/Practice as well as legal, legislative and programmatic requirements. These reviews occur as specified in Appendix C. During these on-site audits, ASAPs review the licensure and certifications status of direct care staff to ensure compliance with staff licensing requirements and network standards. In addition, staff conduct off-site evaluations of service provision through the use of participant and provider staff surveys; these evaluations measure the quality of service provision through client and staff feedback.

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Term Services and Supports (LTSS) regularly carries out audits of SCOs against a set of compliance metrics as required in the SCO's contract with EOHHS. In addition, SCOs are required by contract to develop and maintain a comprehensive internal anti-fraud, waste and abuse program plan to detect and prevent fraud, waste, and abuse by providers. Similarly, by contract, and in accordance with 42 CFR 438.608, SCOs must have administrative and management arrangements or procedures, including a mandatory compliance plan, which are designed to guard against fraud, waste and abuse. Finally, MassHealth has developed system edits within MMIS to deny fee-for-service claims billed for members enrolled in a SCO.

(c) For members served through the ASAPs:
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).

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)

Deleted: The Executive Offices of Elder Affairs and Health and Human Services are subject to audit by the Massachusetts "Single State Audit", which is performed by outside auditors on behalf of the federal government and the state. KPMG is the contractor that currently performs the Single State Audit for the Commonwealth of Massachusetts. The Single State Audit is a federally mandated, comprehensive annual audit that encompasses the accounts and activities of all state agencies. As required by federal regulation the MassHealth Program Integrity Unit is responsible for post payment reviews of paid claims data to identify duplicate, inconsistent or excessive activity that may be considered fraudulent or abusive. This is accomplished by developing reports/algorithms and/or conducting audits to uncover aberrant billing patterns in which an improper payment may have been made.

entails generating a random sample of all members receiving services over the audit review period. For audits and desk reviews, MassHealth and PCU will perform a random sample of members at a 90% confidence level and review all claims and associated medical records for each member over a specified timeframe (typically 4 to 6 months). A margin of error is calculated and determined only for reviews and audits in which MassHealth intends to extrapolate overpayments based on the findings from the review or audit to the provider's full census. Where extrapolation may be performed, MassHealth and PCU typically pull a sample of 25 members and use the lower 90% confidence interval amount as the extrapolated overpayment amount to be recouped. The margin of error for the extrapolated amount can vary depending upon the total number of members the provider has served during the audit period. Where the provider has served fewer than 25 members over the audit period, MassHealth and PCU will review all of the members and associated claims, resulting in a margin of error of +/- 0%.

On average, MassHealth and PCU run between 30 and 40 algorithms and SURS reports to identify recoveries as well as target providers for desk reviews and on-site audits. Because SURS reports and algorithms do not always identify providers exhibiting aberrant billing behavior, and because member complaints or program staff concerns are raised on an ad hoc basis, there is no scheduled number of desk reviews or on-site audits to be conducted on a year-to-year basis. When MassHealth identifies findings through SURS reports and algorithms, it is MassHealth practice to conduct a desk review or on-site audit within one month.

As part of its post-payment review activities, MassHealth and PCU regularly carry out desk reviews and on-site audits of providers. When initiating a provider desk review, auditors will request medical records, including individualized plans of care, for a sample of MassHealth members receiving services from the provider and compare them against claims data to ensure all paid claims are supported by accurate and complete documentation. As part of on-site audits, MassHealth and PCU develop an audit scope document that identifies specific regulatory requirements to be reviewed. Based on this scope, PCU will develop an audit tool to record the auditors' findings related to compliance or noncompliance of each regulatory requirement being reviewed. During their on-site visit, auditors will collect medical records for a sample of members to review for completeness and accuracy. Finally, to verify that services were rendered, auditors will visit a random sample of member homes, interview the members, and observe living conditions to ensure services are rendered consistently with each member's plan of care. The sampling process for home visits is to select a random sample of three to five members. MassHealth and PCU select a smaller sample size for home visits than for desk reviews due to the logistics of conducting on-site audits within a two to three day timeframe.

Upon completion of an on-site audit or desk review, MassHealth will review the findings of noncompliance, if any, with regulatory requirements and determine whether to issue a notice of overpayment or sanction to the provider, depending on whether the provider was found in violation of applicable regulatory requirements. The notice of overpayment or sanction identifies and explains each instance of noncompliance, and notifies the provider of the associated sanctions and identifies the related overpayments. Within the notice, the provider receives the detailed results of the audit review, including lists of each regulatory requirement, the description of the provider's noncompliance, and the associated sanction or overpayment

amount. On a case-by-case basis, MassHealth may meet with the provider to review the audit findings and discuss the appropriate corrective actions.
Providers have the opportunity to appeal MassHealth's determination of sanction or overpayment and dispute the related findings. While the appeal is processed, MassHealth will withhold the identified amount of identified overpayments or impose sanctions of administrative fines from future payments to the provider. If the sanctions or overpayment determinations are not appealed, MassHealth will work with the provider to establish a payment plan where a percentage of the overpayment amount is withheld from future payments of the provider's claims until the entire balance of the overpayment or sanction of administrative fines have been recouped.

As a result of a desk review or on-site audit, MassHealth may also require the provider to submit a plan of correction and may identify the provider to be re-audited after a specified period of time (e.g., 6 months) to ensure corrections are made.

Unlike desk reviews and on-site audits where reviewers are manually reviewing claims for a sample of members over a four to six month time period, algorithms and SURS reports generally look back over a longer timeframe up to five years for all claims associated with one or more provider types.

In addition to the activities described above, MassHealth maintains close contact with the attorney general's Medicaid Fraud Division (MFD) to refer potentially fraudulent providers for MFD review and to ensure MassHealth is not pursuing providers under MFD's review.

KPMG is the contractor that performs the Single State Audit for the Commonwealth of Massachusetts.

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability Assurance**

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-assurances:

a Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

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:	*Services were billed in accordance with established waiver service payment rates.* *Numerator: Processed MMIS claims for waiver participants* *Denominator: Total service claims submitted for waiver participants*		
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)*

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	☑ *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 provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measure:	*Provider payment rates were consistent with the state's rate methodology. Numerator: Number of payment rates, by service type, that were set in accordance with the state's rate methodology Denominator: Number of provider payment rates, by service type*		
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	***Frequency of data collection/generation:***	***Sampling Approach*** *(check each that*

	collection/generation *(check each that applies)*	*(check each that applies)*	*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:*

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.*

For all fee-for-service (FFS) claims, the Aging Services Access Points (ASAPs) are responsible for ensuring that provider billing is in accordance with the services authorized in the service plan and that services are billed in accordance with the contracted rate for the service provided. If any discrepancy is noted the ASAP will report the error to the service provider and the services will only be claimed upon reconciliation of the discrepancy. Claims that cannot be reconciled will be reported by the ASAP to the Executive Office of Elder Affairs (EOEA) and MassHealth. If the ASAP or EOEA identify any pattern of problems with provider billing, EOEA/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.

Deleted: Results of the performance measure will be documented in reports by the Medicaid agency. Any necessary corrective action will be noted. Results will be specific to each ASAP/SCO. ASAP/SCO staff will be responsible for corrective action and any specific requirements noted in the report. Timelines for remediation will be outlined in the report and will be reflective of the nature and severity of the issue to be addressed.¶

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).

Rates for each waiver service in the Frail Elder Waiver are established in one the following ways:

1. For waiver services for which there is a comparable Medicaid State Plan rate, payment for waiver services is made at the comparable State Plan rate pursuant to MGL Chapter 118E, Sections 13C (Establishment of rates of payment for health care services) and 13D (Duties of ratemaking authority; criteria for establishing rates) and regulations governing those specific rates as cited below. 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 (i.e. payments consistent with efficiency, economy, and quality of care, etc.). There are no differences in the rate methodology between these State Plan and waiver services. No additional cost adjustment factor (CAF) was used for the waiver services which use the comparable State Plan rate. This applies to the following waiver services:

- Complex Care Training and Oversight, Home Health Aide, and Home Safety/Independence Evaluation (set in accordance with 101 CMR 350: Home Health Services)

State law 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.

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 (Duties of ratemaking authority); see also MGL Chapter 30A Section 2 (Regulations requiring hearings). 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.

Deleted: Rates for Home Health Aide and Skilled Nursing are set by the Executive Office of Health and Human Services. The rate regulation for these services is 114.3 CMR 50.00. The rates are approved at a public meeting of the Center for Health Information & Analysis (CHIA). M.G.L.c. 118g s.7 governs the rate approval responsibilities of CHIA (CHIA is the successor agency to the Division of Health Care Finance and Policy). Upon rate approval, rates are entered into the Executive Office of Elder Affairs database, Senior Information Management System (SIMS).

Deleted: Other rates are negotiated by each ASAP with written guidance from EOEA. Common factors in individual ASAP negotiations of waiver service rates with providers, for waiver services other than Home Health and Skilled Nursing, include complying with EOEA written guidance on procurement rules, reviewing data from provider Uniform Financial Reports (UFR), and establishing rates that are in compliance with EOEA established minimum wages and benefits levels for direct service workers.

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 (Duties of ratemaking authority; criteria for establishing rates).

2. For waiver services with no comparable State Plan or EOHHS rate, each ASAP negotiates a market rate price with its contracted providers for services provided through the Elder Affairs Home Care Program. The Home Care Program is a large state-funded program serving up to 60,000 elders in the Commonwealth. Each ASAP negotiates the rates for the purchase of services from contracted providers for all elders enrolled in the Home Care program, including the subset of elders participating in the Frail Elder Waiver. Rates are negotiated leveraging the relative market power of this large program and leading to efficiencies and economies of scale. Utilizing this approach ensures that the rates paid for Frail Elder Waiver services are at the market rate for similar services (i.e., the rates paid by ASAPs under the Home Care Program).

For Homemaker, Personal Care, and Supportive Home Care Aide waiver services, which represent the majority of service utilization in this waiver, ASAPs must follow EOEA-issued written guidance for determining the rates, which guidance specifies the cost factors that must be taken into account in establishing these rates for the Home Care program (Notice of Intent to Contract (NOI) and NOI Administrative Overview). Such cost factors include base wages, employee benefit compensation (holiday, sick, personal, vacation, bereavement pay), travel expense, day care, training wages, administrative costs and overhead. In addition, for all services with no comparable State Plan or EOHHS rate, a standardized, formal process consistent with sub-regulatory requirements in EOEA Program Instruction PI #94-11 (Non-Homemaker Purchased Services/Determination of Rates) is required by EOEA through its contracts with the ASAPs. While rates for such services are not directly established by state law, these rates are influenced and informed by legislative mandates regarding direct service worker salary requirements. All rates in this category are reviewed and renegotiated by the ASAP annually. On at least an annual basis EOEA monitors the rates, EOEA's ongoing rate monitoring evidences little variation in rates by service across the state. Through the ASAP rate negotiation process, the state seeks to ensure optimal availability and provision of services while allowing ASAPs the flexibility to reflect geographic cost variables such as variations in transportation costs, labor costs, and ability to hire sufficient staff with appropriate language and cultural competence. Upon successful contract negotiation, the related service rates are entered into the Senior Information Management System (SIMS) and are available for EOEA review. This approach applies to the following waiver services:

- Alzheimer's/Dementia Coaching
- Chore
- Companion
- Enhanced Technology/Cellular PERS
- Evidence Based Education Programs
- Goal Engagement Program
- Grocery Shopping and Delivery

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- Home Based Wandering Response Systems
- Home Delivered Meals
- Home Delivery of Pre-packaged Medication
- Homemaker
- Home Safety/Independence Evaluation
- Laundry
- Medication Dispensing System
- Personal Care
- Respite
- Supportive Day Program
- Supportive Home Care Aide
- Transportation

ASAPs negotiate a market rate price as well as a provision for discounting rates for personal care and homemaking waiver services for situations in which there is high volume of hours provided within a site in which there are several waiver participants, such as in an elderly housing complex.

3. Payment rates for Orientation and Mobility services are based on the historic rate for such services from 101 CMR 356.00: Rates for Money Follows the Person Demonstration Services, consistent with other Massachusetts HCBS waivers.

4. For Peer Support, the waiver service rate was set at the comparable EOHHS Purchase of Service (POS) rate (101 CMR 414.00: Rates for Family Stabilization Services) as established in regulation after public hearing pursuant to MGL Chapter 118E, Sections 13C (Establishment of rates of payment for health care services) and 13D (Duties of ratemaking authority; criteria for establishing rates). All POS rates are established in regulation pursuant to this statutory requirement. POS rates are developed using Uniform Financial Reporting (UFR) data submitted to the Massachusetts Operational Services Division, in accordance with UFR reporting requirements under 808 CMR 1.00: Compliance, Reporting and Auditing for Human and Social Services. EOHHS uses UFR data to calculate rates that meet statutory adequacy requirements described above. No productivity expectations and administrative ceiling calculations were used in establishing these rates. UFR data demonstrates expenses of providers of a particular service for particular line items. Specifically, UFRs include line items such as staff salaries; tax and fringe benefits; expenses such as training, occupancy, supplies and materials, or other expenses specific to each service; and administrative allocation. EOHHS uses these line items from UFRs submitted by providers as components in the buildup for the rates for particular services by determining the average for each line item across all providers. In determining the rates for Peer Support, EOHHS used the most recent complete state fiscal year UFR available and determined the average across providers of that service for each line item, which are then used to build each rate.

5. Purchase of goods as waiver services are paid according to the cost of the good. This approach applies to the following waiver services:
- Transitional Assistance Service

- Environmental Accessibility Adaptations

6. Capitation rates for the Senior Care Options managed care program (SCO) are set by MassHealth based on actuarially sound Medicaid capitation rate ranges developed by the state's actuarial firm, Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC.

The primary data source used in the SCO capitation rate range development process is Medicaid FFS data for populations similar to SCO enrollees in addition to SCO experience data. The base data, collected directly from Medicaid's MMIS, includes claims and eligibility data. MassHealth and Mercer perform significant data analysis in order to develop base data that represents an actuarially-equivalent, non-enrolled population. In preparing the actuarially sound capitation rate ranges Mercer utilizes enrollment, eligibility, claim, reimbursement level, benefit design, financial data and other information provided by MassHealth and the SCO plans.

No adjustments are made to the base data for non-State Plan services. The substitution of approved services approach was described and discussed at the CMS Medicaid Managed Care Rate Setting conference in Baltimore, Maryland on October 25, 2002. Subsequently, the CMS regional office in Boston had provided guidance indicating that this adjustment was not necessary for the SCO Medicaid capitation rates, as long as enrollees are not receiving HCBS waiver services on a FFS basis while also receiving services from the SCO. This is the case in the MassHealth SCO program.

All Frail Elder Waiver participants choosing to enroll in SCO fall within a Community NHC rating category. This rating category covers enrollees residing in the community who are at nursing home level of care.

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

The flow of billing for waiver services delivered to participants who are not enrolled in a SCO is through an intermediary, the Aging Services Access Point (ASAP). The ASAP receives waiver billing from the provider and compares billing with the participant's person-centered comprehensive service plan, approved service contract rate, and units utilizing the participant database, Senior Information Management System (SIMS). The ASAP submits claims to the state's MMIS via SIMS. On a routine/monthly basis, the claim data is electronically submitted to MMIS for claim editing and processing. Providers may bill the state directly.

SCOs may contract either with ASAPs or with individual community service providers for

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HCBS (waiver) services. In either case, the SCO primary care team must coordinate and authorize all medical and waiver services for each SCO enrollee.

If the SCO has a contract with an ASAP that includes the arrangement of services, the ASAP uses its existing community service network to provide the services to SCO members in accordance with each member's plan of care, and bills the SCO according to the terms of its contract. The ASAP receives payment from the SCO and pays its network providers according to its subcontracts. When the SCO has an arrangement with individual service providers, those providers bill the SCO directly for the services under the terms of their contracts.

The SCO receives an all-inclusive Medicaid capitation payment from the state, and is responsible for payment and delivery of all waiver services.

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

●	**No. State or local government agencies do not certify expenditures for waiver services.**
○	**Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.** *Select at least one:*
	☐ **Certified Public Expenditures (CPE) of State Public Agencies.** Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	☐ **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 ASAPs verify and confirm MassHealth eligibility routinely; at a minimum, monthly. The Medicaid Management Information System (MMIS) maintains date specific eligibility on Medicaid waiver participants. Only service claims for clients whose MassHealth waiver eligibility is verified are submitted for payment processing. MMIS also maintains

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eligibility data to ensure that a client is enrolled in a Medicaid waiver program prior to payment of claims. The Senior Information Management System (SIMS) verifies all provider invoices prior to payment to ensure that services delivered are in the approved Comprehensive Service Plan and do not exceed the authorized amount of service and contractual service rate.

For Waiver Services Delivered to Participants Enrolled in SCO:

The SCO plans receive daily eligibility and enrollment files which enable the SCO plans to validate waiver eligibility. Additionally, all SCO plans have appropriate systems in place to ensure waiver claims are authorized and approved prior to payment. The SCOs verify that all waiver services delivered are in the approved Comprehensive Service Plan and do not exceed the authorized amount.

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e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

●	**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
○	**Payments for some, but not all, waiver services are made through an approved MMIS.** Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	**Payments for waiver services are not made through an approved MMIS.** Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.** Describe how payments are made to the managed care entity or entities:

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

☑	**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
☐	**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
☑	**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.** Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
	ASAPs are reimbursed by EOEA based upon a participant's enrollment in the program and receipt of services. Payments to ASAPs are made through the state accounting system (MMARS). Direct service providers (ex. homemaker agencies) are reimbursed by the ASAP on a monthly basis subsequent to the provision of services, the confirmation that services are consistent with the Comprehensive Service Plan, and upon receipt of an invoice. SIMS maintains the audit trail for services provided and claimed for Federal Financial Participation.

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☑	**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. The SCO processes claims for waiver service to the billing provider via a standard 837 claims transaction.

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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*:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

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.

	(a) The SCO program, implemented in partnership with the Centers for Medicare & Medicaid Services, delivers and coordinates all Medicare and Medicaid covered services, including all Frail Elder Waiver services, for eligible Massachusetts seniors managed through a geriatric model of care using Senior Care Organizations contracted under the provisions of Sections 1915(a) and 1932 of the Social Security Act, as described in the Massachusetts Title XIX State Plan. See, TN 04-003. Waiver participants age 65 or older may voluntarily elect to receive all waiver and all Medicare and Medicaid covered services through a SCO. (b) SCO services are currently available in all counties except Dukes and Nantucket counties. (c) All waiver services and all State Plan MassHealth services are furnished by the SCO network of providers. (d) The SCO receives an all-inclusive Medicaid capitation payment from the state. SCOs are approved Medicare Advantage-Part D Special Needs Plans. In addition to Medicaid capitation payments, SCOs receive Medicare capitation payment for each dual eligible beneficiary in accordance with their contracts with CMS. SCOs do not provide waiver services to SCO enrollees on a fee for service basis as all SCO contracts are capitation based. All SCO contracts and SCO capitation payments meet the requirements for risk contracts within the meaning of 42 CFR Part 438.
○	**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 §1115f waiver specifies the types of health plans that are used and how payments to these plans are made.**

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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:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

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

●	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
○	**Applicable** *Check each that applies:*

☐	**Appropriation of Local Government Revenues.** Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:
☐	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

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

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

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

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

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

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

As specified in Appendix C waiver services are provided in residential settings other than the personal home of the individual only on a respite basis.

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*)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

●	**No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
○	**Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.** Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded; and (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care *(specify)*:			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	$12,498.67	$14,645.51	$27,144.18	$49,049.38	$1,738.77	$50,788.15	$23,643.97
2	$12,701.14	$14,942.42	$27,643.56	$50,043.77	$1,774.02	$51,817.79	$24,174.23
3	$12,891.75	$15,244.80	$28,136.55	$51,056.48	$1,809.92	$52,866.40	$24,729.85
4	$13,006.71	$15,552.18	$28,558.89	$52,085.93	$1,846.41	$53,932.34	$25,373.45
5	$13,102.94	$15,864.05	$28,966.99	$53,130.41	$1,883.44	$55,013.85	$26,046.86

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)	Level of Care:
		Nursing Facility
Year 1	19,200	19,200
Year 2	19,400	19,400
Year 3	19,600	19,600
Year 4	19,800	19,800
Year 5	20,000	20,000

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.

All estimates are derived from the Waiver Year (WY) 2016 CMS-372 for the Frail Elder Waiver MA.0059 for WY1.

The Average Length of Stay (ALOS) reflects the weighted average ALOS data from waiver participants enrolled in the Fee-For-Service (FFS) system and enrolled in SCO in WY 2016. Changes in the estimated ALOS throughout the waiver renewal period result from shifts in the projected proportion of FFS- and SCO-enrolled waiver participants from year to year. Thus the average length of stay during the five-year waiver renewal period is estimated as follows: 280.99 (WY1); 280.79 (WY2); 280.58 (WY3); 280.35 (WY4); 280.09 (WY5).

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 for these estimates is as follows:

Factor D costs are based on the following:

- Number of Users:
The estimated number of users for each waiver service, except those noted below, is based on actual utilization data for the Frail Elder Waiver in prior waiver years. For most services, service utilization was based on the number of users reported on the

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Waiver Year 2016 CMS-372 report. For Home Based Wandering Response System, of which there was no utilization in 2016, the estimate of 10 new users per year is based on consultation with state agency program staff and anticipated need. For new waiver services, the estimated number of users is estimated as follows:

- Cellular PERS: based on February 2018 utilization data from a similar population in the Commonwealth's state-funded Home Care Program, and consultation with state agency program staff, estimated at 2% of the enrolled FFS waiver population in WY1 and adding an additional 2% in each subsequent waiver year.

- Evidence Based Education Program: based on consultation with state agency program staff, programmatic goals, and utilization of this service by a similar population in the Commonwealth's state-funded Home Care Program, estimated at 2% of the enrolled FFS waiver population in WY1, 3% in WY2, 4% in WY3, 6% in WY4, and 8% in WY5.

- Goal Engagement Program: based on information provided by state agency program staff, anticipated need and programmatic goals, estimated at 1% in WY1, 2% in WY2, and 3% in WY3-5.

- Orientation and Mobility Services: based on experience in the Massachusetts MFP-CL HCBS waiver (MA.1027) in MFP-CL Waiver Year 2016 (reflected in claims data reported in the WY 2016 CMS-372 report for MA.1027), anticipated need, and programmatic goals, estimated at 10 users in WY1, 20 users in WY2, 30 users in WY3, 40 users in WY4, and 50 users in WY5.

- Peer Support: based on experience in the Massachusetts MFP-CL HCBS waiver (MA.1027) in MFP-CL Waiver Year 2016 (reflected in claims data reported in the WY 2016 CMS-372 report for MA.1027), anticipated need, and programmatic goals, estimated at 1% in WY1, 2% in WY2, and 3% in WY3-5.

The estimated number of users per year for participants enrolled in SCO, the managed care delivery system, is based on actual enrolled members for the base year of 2016, and trended forward based on actual SCO-FEW enrollment growth in Waiver Years 2014 – 2016.

- Average Units per User:
The average units per user for all waiver services except those noted below are based on actual utilization for the Frail Elder Waiver, as reflected on the WY 2016 CMS-372 report. For Home Based Wandering Response System, of which there was no utilization in 2016, average units per user is estimated as one installation per user and ongoing monthly utilization based on the average length of stay for the waiver population. For new waiver services, average units per user is estimated as follows:

Deleted: Estimates for the number of users who use FFS providers were based on 2011 372 data for each service in the Frail Elder Waiver MA.0059 except as noted below. The projected number of total unduplicated participants each year was based on the Executive Office of Elder Affairs (EOEA) experience with this waiver to date and expected growth.The estimated number of users for the following services was based on EOEA's experience with the waiver to date: Personal Care, Home Health Aide, Supportive Home Care Aide, Companion Service, Transitional Assistance, and Home Based Wandering System (installation and monthly monitoring). The following services are new to the Frail Elder Waiver and the projected number of users in future waiver years is based on EOEA experience with the waiver population to date and similar state-funded services: Alzheimer's/Dementia Coaching, Medication Dispensing System (installation and monthly monitoring), Home Delivery of Medication, and Occupational Therapy.

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- Cellular PERS: one installation per user; ongoing monthly utilization based on the average length of stay for the waiver population.

- Evidence Based Education Program: based on consultation with state agency program staff, programmatic goals, and utilization of this service by a similar population in the Commonwealth's state-funded Home Care Program, estimated at 12 classes (which represents 6 classes each of two courses) per year (see service limit description in Appendix C-1/C-3).

- Goal Engagement Program: based on information provided by state agency program staff, anticipated need and programmatic goals, estimated at one episode per year (see service limit description in Appendix C-1/C-3).

- Orientation and Mobility Services: based on experience in the Massachusetts MFP-CL HCBS waiver (MA.1027) in MFP-CL Waiver Year 2016 (reflected in claims data in the WY 2016 CMS-372 report for MA.1027) and anticipated need, and adjusted for the ALOS in this waiver, estimated at 15 units per year.

- Peer Support: based on experience in the Massachusetts MFP-CL HCBS waiver (MA.1027) in MFP-CL Waiver Year 2016 (reflected in claims data in the 2016 CMS-372 report for MA.1027) and anticipated need, and adjusted for the ALOS in this waiver, estimated at 529 units per year.

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 2016 reflected in the WY 2016 CMS-372 report. For Home Based Wandering Response System, for which there were no waiver service claims in WY 2016, average cost per unit for both installation and monthly fee are based on the average cost per unit of this service in the state-funded Home Care program at the time of this submission. For new waiver services, average cost per unit is estimated as follows:

- Cellular PERS (installation and monthly fee): based on average cost per unit for this service in the state-funded Home Care program at the time of this submission.

- Evidence Based Education Program: based on the per class rate for this service in the state-funded Home Care program at the time of this submission.

- Goal Engagement Program: based on the anticipated rate for this service in the state-funded Home Care Program at the time of this submission.

- Orientation and Mobility Services: estimated at the actual average per unit rate for this service in the Moving Forward Plan – Community Living Waiver (MA.1027), reflected in claims data in the WY 2016 CMS-372 report for MA.1027.

Deleted: The average units per user were based on CY 2011 372 data for each service in the Frail Elder Waiver MA.0059 except as noted below. EOEA projected the average units per user for the following services based on experience with the waiver population to date: Personal Care, Home Health Aide, Companion Service, Transitional Assistance, and Home Based Wandering System (installation and monthly monitoring). The following services are new to the Frail Elder Waiver and the projected average units per user in future waiver years is based on EOEA experience with the waiver population to date and similar state-funded services: Alzheimer's/Dementia Coaching, Medication Dispensing System (installation and monthly monitoring), Home Delivery of Medication, and Occupational Therapy. ¶

- Peer Support: estimated at the actual rate for this service in the Massachusetts MFP-CL HCBS waiver (MA.1027) in MFP-CL Waiver Year 2016, reflected in claims data in the WY 2016 CMS-372 report for MA.1027.

For members enrolled in SCO, the total cost of services included in capitation was determined using capitation rates developed by the state's actuarial firm, Mercer Health and Benefits, LLC (Mercer) for Community Long-Term Care. To determine the total cost of services included in capitation, the Calendar Year 2018 rates were adjusted to account for the portion designated to cover waiver services.

The Factor D was determined by dividing the total projected costs of service for both FFS and SCO by the total projected enrollment for both in each respective waiver year.

Trend:
The rates described above were trended forward annually to WY 2019, as well as for subsequent waiver years, by 2.1%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 12-mos. ended March 2018).

Deleted: The average cost per unit was based on EOEA's most recent actual Senior Information Management System (SIMS) data (January 2013 through May 2013 unless otherwise noted below) and trended annually. The average cost per unit for Environmental Accessibility Adaptation and Transitional Assistance was based on CY 2011 372 data for the Frail Elder Waiver MA.0059.

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Deleted: , multiplied by the projected SCO enrollees in the Frail Elder Waiver and adjusted for average length of stay

Deleted: The rates described above were trended annually using the Consumer Price Index of 3.1% for subsequent years.

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

Factor D' costs are based on WY 2016 utilization of all other Medicaid services (D') by MA.0059 Waiver participants as reported on the 2016 CMS-372. The Factor D' reflected on the WY 2016 372 is comprised of both the FFS and SCO Average Per Capita Other Medicaid Expenditures.

WY 2016 costs were trended forward annually by 2.1%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 12-mos. ended March 2018), to estimate Factor D' for WY 2019 (Waiver Year 1), as well as for subsequent waiver years.

As Factor D' costs are based on WY 2016 data, the cost and utilization of prescription drugs in the base data reflects the full implementation of Medicare Part D. Therefore no Medicare Part D drug costs or utilization are included in the Factor D' estimate.

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

Factor G costs are based on the facility component (G) costs for WY 2016 as reported on the 2016 CMS-372 for Waiver MA.0059.

Factor G on the 2016 CMS-372 was derived from the cost per member for MassHealth members who resided in a nursing facility in WY 2016. Actual costs were included for

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all members who were in a facility for at least 180 continuous days (a long-stay), although only the claims that occurred during WY 2016 for the period of facility stays were included in the set. 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.

WY 2016 costs were trended forward annually by 2.1%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 12-mos. ended March 2018) to estimate Factor G for WY 2019 (Waiver Year 1), as well as for subsequent waiver years.

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Deleted: Consumer Price Index (3.1%)

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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 2016 for MassHealth members residing in a nursing facility in a long-stay as reported on the CMS-372 for the Frail Elder Waiver 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.

WY 2016 costs were trended forward annually by 2.1%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 12-mos. ended March 2018) to estimate Factor G' for WY 2019 (Waiver Year 1), as well as for subsequent waiver years.

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Deleted: Consumer Price Index (3.1%)

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d. Estimate of Factor D. *Select one:* Note: Selection below is new.

●	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

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**
Alzheimer's/Dementia Coaching	Visit	75	1	$157.65	$11,823.75
Home Health Aide	15 Min.	3,947	3,366	$5.93	$78,783,619.86
Homemaker	15 Min.	10,709	753	$5.70	$45,964,098.90
Personal Care	15 Min.	7,188	1,580	$5.49	$62,350,149.60
Respite	Per Diem	46	11	$255.84	$129,455.04
Cellular PERS					$102,123.43
	Install	331	1	$38.53	
	Monthly	331	9	$30.00	
Chore	15 Min.	1,221	103	$7.91	$994,785.33
Companion	15 Min.	2,583	809	$4.64	$9,695,962.08
Complex Care Training and Oversight (formerly Skilled Nursing)	Visit	2,336	6	$85.59	$1,199,629.44
Environmental Accessibility Adaptation	Item	1,973	2	$164.59	$649,472.14
Evidence Based Education Programs	Class	331	12	$50.00	$198,600.00
Goal Engagement Program	Episode	166	1	$3,200.00	$531,200.00
Grocery Shopping and Delivery	Order	341	21	$22.50	$161,122.50
Home Based Wandering Response Systems					$3,436.30
	Install	10	1	$38.53	
	Monthly	10	9	$33.90	
Home Delivered Meals	Meal	7,870	161	$6.58	$8,337,320.60
Home Delivery of Pre-packaged Medication	Monthly	46	9	$19.67	$8,143.38
Home Safety/Independence Evaluation (formerly Occupational Therapy)	Visit	68	1	$71.20	$4,841.60

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**
Laundry	Order	2,031	28	$26.36	$1,499,040.48
Medication Dispensing System					$159,139.16
	Install	31	1	$48.57	
	Monthly	497	7	$45.31	
Orientation and Mobility	15 Min.	10	15	$31.02	$4,653.00
Peer Support	15 Min.	166	529	$6.68	$586,597.52
Senior Care Options (SCO)	PMPM	2,631	9	$610.34	$14,452,240.86
Supportive Day Program	15 Min.	33	37	$25.59	$31,245.39
Supportive Home Care Aide	15 Min.	698	3,028	$6.47	$13,674,629.68
Transitional Assistance	Item	2	1	$80.49	$160.98
Transportation					$440,982.86
	Mile	262	103	$1.91	
	One-Way Trip	905	12	$35.86	
GRAND TOTAL:					$239,974,473.88
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					19,200
FACTOR D (Divide grand total by number of participants)					$12,498.67
AVERAGE LENGTH OF STAY ON THE WAIVER					280.99

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**
Alzheimer's/Dementia Coaching	Visit	74	1	$160.96	$11,911.04
Home Health Aide	15 Min.	3,926	3,366	$6.05	$79,950,241.80
Homemaker	15 Min.	10,651	753	$5.82	$46,677,581.46
Personal Care	15 Min.	7,149	1,580	$5.61	$63,367,306.20
Respite	Per Diem	46	11	$261.21	$132,172.26
Cellular PERS					$195,200.07
	Install	330	1	$39.34	
	Monthly	661	9	$30.63	
Chore	15 Min.	1,215	103	$8.08	$1,011,171.60
Companion	15 Min.	2,569	809	$4.74	$9,851,241.54
Complex Care Training and Oversight (formerly Skilled Nursing)	Visit	2,324	6	$87.39	$1,218,566.16
Environmental Accessibility Adaptation	Item	1,963	2	$168.05	$659,764.30
Evidence Based Education Programs	Class	494	12	$51.05	$302,624.40
Goal Engagement Program	Episode	330	1	$3,267.20	$1,078,176.00
Grocery Shopping and Delivery	Order	339	21	$22.97	$163,523.43
Home Based Wandering Response Systems					$6,623.20
	Install	10	1	$39.34	
	Monthly	20	9	$34.61	
Home Delivered Meals	Meal	7,828	161	$6.72	$8,469,269.76
Home Delivery of Pre-packaged Medication	Monthly	46	9	$20.08	$8,313.12
Home Safety/Independence Evaluation (formerly Occupational Therapy)	Visit	68	1	$72.70	$4,943.60
Laundry		2,020	28	$26.91	$1,522,029.60
Medication Dispensing System					$161,504.37
	Install	31	1	$49.59	
	Monthly	494	7	$46.26	
Orientation and Mobility	15 Min.	20	15	$31.67	$9,501.00
Peer Support	15 Min.	330	529	$6.82	$1,190,567.40
Senior Care Options	PMPM	2,920	9	$610.34	$16,039,735.20
Supportive Day Program	15 Min.	33	37	$26.13	$31,904.73
Supportive Home Care Aide	15 Min.	694	3,028	$6.61	$13,890,465.52
Transitional Assistance	Item	2	1	$82.18	$164.36

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**
Transportation					$447,609.00
	Mile	260	103	$1.95	
	One-Way Trip	900	12	$36.61	
GRAND TOTAL:					$246,402,111.12
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					19,400
FACTOR D (Divide grand total by number of participants)					$12,701.14
AVERAGE LENGTH OF STAY ON THE WAIVER					280.79

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**
Alzheimer's/Dementia Coaching	Visit	74	1	$164.34	$12,161.16
Home Health Aide	15 Min.	3,897	3,366	$6.18	$81,064,926.36
Homemaker	15 Min.	10,573	753	$5.94	$47,291,125.86
Personal Care	15 Min.	7,097	1,580	$5.73	$64,251,979.80
Respite	Per Diem	46	11	$266.70	$134,950.20
Cellular PERS					$291,188.43
	Install	327	1	$40.17	
	Monthly	988	9	$31.27	
Chore	15 Min.	1,206	103	$8.25	$1,024,798.50
Companion	15 Min.	2,551	809	$4.84	$9,988,593.56
Complex Care Training and Oversight (formerly Occupational Therapy)	Visit	2,307	6	$89.23	$1,235,121.66
Environmental Accessibility Adaptation	Item	1,948	2	$171.58	$668,475.68
Evidence Based Education Programs	Class	654	12	$52.12	$409,037.76
Goal Engagement Program	Episode	491	1	$3,335.81	$1,637,882.71
Grocery Shopping and Delivery	Order	337	21	$23.45	$165,955.65
Home Based Wandering Response Systems					$9.943.50
	Install	10	1	$40.17	
	Monthly	30	9	$35.34	
Home Delivered Meals	Meal	7,771	161	$6.86	$8,582,758.66
Home Delivery of Pre-packaged Medication	Monthly	46	9	$20.50	$8,487.00
Home Safety/Independence Evaluation (formerly Occupational Therapy)	Visit	67	1	$74.23	$4,973.41
Laundry	Order	2,006	28	$27.48	$1,543,496.64
Medication Dispensing System					$163,899.04
	Install	31	1	$50.63	
	Monthly	491	7	$47.23	
Orientation and Mobility	15 Min.	30	15	$32.34	$14,553.00
Peer Support	15 Min.	491	529	$6.96	$1,807,783.44
Senior Care Options	PMPM	3,240	9	$610.34	$17,797,514.40
Supportive Day Program	15 Min.	33	37	$26.68	$32,576.28
Supportive Home Care Aide	15 Min.	689	3,028	$6.75	$14,082,471.00
Transitional Assistance	Item	2	1	$83.91	$167.82

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**
Transportation					$453,446.34
	Mile	258	103	$1.99	
	One-Way Trip	893	12	$37.38	
GRAND TOTAL:					$252,678,267.86
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					19,600
FACTOR D (Divide grand total by number of participants)					$12,891.75
AVERAGE LENGTH OF STAY ON THE WAIVER					280.58

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Alzheimer's/Dementia Coaching	Visit	73	1	$167.79	$12,248.67
Home Health Aide	15 Min.	3,860	3,366	$6.31	$81,984,315.60
Homemaker	15 Min.	10,473	753	$6.06	$47,790,184.14
Personal Care	15 Min.	7,030	1,580	$5.85	$64,978,290.00
Respite	Per Diem	45	11	$272.30	$134,788.50
Cellular PERS					$390,316.68
	Install	324	1	$41.01	
	Monthly	1,312	9	$31.93	
Chore	15 Min.	1,194	103	$8.42	$1,035,508.44
Companion	15 Min.	2,526	809	$4.94	$10,095,057.96
Complex Care Training and Oversight (formerly Skilled Nursing	Visit	2,285	6	$91.10	$1,248,981.00
Environmental Accessibility Adaptation	Item	1,930	2	$175.18	$676,194.80
Evidence Based Education Programs	Class	972	12	$53.21	$620,641.44
Goal Engagement Program	Episode	486	1	$3,405.86	$1,655,247.96
Grocery Shopping and Delivery	Order	334	21	$23.94	$167,915.16
Home Based Wandering Response Systems					$13,398.90
	Install	10	1	$41.01	
	Monthly	40	9	$36.08	
Home Delivered Meals	Meal	7,697	161	$7.00	$8,674,519.00
Home Delivery of Pre-packaged Medication	Monthly	45	9	$20.93	$8,476.65
Home Safety/Independence Evaluation (formerly Occupational Therapy)	Visit	66	1	$75.79	$5,002.14
Laundry	Order	1,987	28	$28.06	$1,561,146.16
Medication Dispensing System					$165,646.83
	Install	31	1	$51.69	
	Monthly	486	7	$48.22	
Orientation and Mobility	15 Min.	40	15	$33.02	$19,812.00
Peer Support	15 Min.	486	529	$7.11	$1,827,938.34
Senior Care Options	PMPM	3,595	9	$610.34	$19,747,550.70
Supportive Day Programs	15 Min.	32	37	$27.24	$32,252.16
Supportive Home Care Aide	15 Min.	682	3,028	$6.89	$14,228,511.44
Transitional Assistance	Item	2	1	$85.67	$171.34

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Transportation					458,786.24
	Mile	256	103	$2.03	
	One-Way Trip	885	12	$38.16	
GRAND TOTAL:					$257,532,902.25
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					19,800
FACTOR D (Divide grand total by number of participants)					$13,006.71
AVERAGE LENGTH OF STAY ON THE WAIVER					280.35

Waiver Year: Year 5 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Alzheimer's/Dementia Coaching	Visit	72	1	$171.31	$12,334.32
Home Health Aide	15 Min.	3,814	3,366	$6.44	$82,676,230.56
Homemaker	15 Min.	10,348	753	$6.19	$48,232,752.36
Personal Care	15 Min.	6,946	1,580	$5.97	$65,518,839.60
Respite	Per Diem	45	11	$278.02	$137,619.90
Cellular PERS					$492,227.20
	Install	320	1	$41.87	
	Monthly	1,632	9	$32.60	
Chore	15 Min.	1,180	103	$8.60	$1,045,244.00
Companion	15 Min.	2,496	809	$5.04	$10,177,090.56
Complex Care Training and Oversight (formerly Skilled Nursing)	Visit	2,258	6	$93.01	$1,260,099.48
Environmental Accessibility Adaptation	Item	1,907	2	$178.86	$682,172.04
Evidence Based Education Programs	Class	1,281	12	$54.33	$835,160.76
Goal Engagement Program	Episode	480	1	$3,477.38	$1,669,142.40
Grocery Shopping and Delivery	Order	330	21	$24.44	$169,369.20
Home Based Wandering Response Systems					$16,996.70
	Install	10	1	$41.87	
	Monthly	50	9	$36.84	
Home Delivered Meals	Meal	7,605	161	$7.15	$8,754,495.75
Home Delivery of Pre-packaged Medication	Monthly	45	9	$21.37	$8,654.85
Home Safety/Independence Evaluation (formerly Occupational Therapy)	Visit	66	1	$77.38	$5,107.08
Laundry	Order	1,963	28	$28.65	$1,574,718.60
Medication Dispensing System					$166,996.20
	Install	30	1	$52.78	
	Monthly	480	7	$49.23	
Orientation and Mobility	15 Min.	50	15	$33.71	$25,282.50
Peer Support	15 Min.	480	529	$7.26	$1,843,459.20
Senior Care Options	PMPM	3,989	9	$610.34	$21,911,816.34
Supportive Day Programs	15 Min.	32	37	$27.81	$32,927.04
Supportive Home Care Aide	15 Min.	674	3,028	$7.03	$14,347,330.16
Transitional Assistance	Item	2	1	$87.47	$174.94

Waiver Year: Year 5 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Transportation					$462,554.61
	Mile	253	103	$2.07	
	One-Way Trip	874	12	$38.96	
GRAND TOTAL:					$262,058,796.35
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					20,000
FACTOR D (Divide grand total by number of participants)					$13,102.94
AVERAGE LENGTH OF STAY ON THE WAIVER					280.09

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The service plan development processes utilized in this waiver follow EOEA-mandated procedures in performing the intake, assessment, case conferencing, service planning and supervisory review that ensure participants' needs, risk factors and personal goals are identified and appropriately addressed. Participant needs are identified beginning at referral and continuing through assessment. The initial assessment is generally conducted by a case manager and then referred for further assessment by a registered nurse. Assessment findings are documented on a uniform tool, the CDS (MDS-HC), which includes demographic, ADL/IADL, social, emotional, cognitive, medical, environmental and nutrition information. The CDS contains, in its entirety, the MDS-HC. This information, as well as data regarding areas in which assistance is provided by existing formal and informal supports, informs the development of the Initial Service Plan (ISP). The case manager or RN explains programs and services to the elder and assists him or her in selecting an array of services that addresses his or her needs and goals to help maintain long term independence in the community.

An Initial Service Plan that has been developed with and signed by the participant is required in order for the case manager to initiate services. The ISP is then reviewed through interdisciplinary case conferencing, team presentation, and supervision to ensure that all identified need areas are appropriately addressed, including health care. Modifications may be suggested by interdisciplinary team members; any changes proposed by other team members are discussed with the participant, and the Service Plan is formalized.

The case manager is also responsible for information about and referral to non-waiver services and supports to address identified needs, coordinating and communicating service plans/changes to appropriate community agencies and ensuring that waiver participants have access, as eligible, to other public benefits and other community services.

Based on clinical factors and the complexity of the service plan, the participant will be identified as requiring either a quarterly or a semi-annual home visit by the Case Manager. Monitoring visits by the Registered Nurse may either substitute for or be in addition to the case management visits. Additional visits by the Case Manager or RN may be triggered in response to changes in the participant's health condition, formal or informal supports or other changes. Home visits are scheduled at times convenient for the participant and include any persons the participant wishes to be present. In addition, the case manager maintains regular telephone contact with the consumer between home visits. The service plan is subject to revision at any point, based on changes in the consumer's needs or circumstances.

Reassessments of the waiver participant are documented through a revision of the CDS/MDS-HC. Journal entries are used to document all contact with the client, family, vendors and any other persons involved with the participant. Adjustments to the service plan are made in consultation with the client, service providers and informal supports to ensure that the service plan continues to promote the independent functioning of the participant in the least restrictive environment and that the services continue to be provided in a manner acceptable to the participant.

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The evaluation and management of risk has become an integral component of interdisciplinary care management provided to participants in the Waiver Program. Participants are assessed for risk and assigned a Risk Level numeric value of 1 through 4 in accordance with instructions contained in PI-11-06 Requirements for the Identification and Management of Risk in Participants. Risk is assessed at least once annually and updated when a participant's circumstances change. Potential risk areas identified through the assessment process are discussed with the participant and/or caregiver to identify services or interventions to mitigate those risks. Risk factors are categorized as health risks and/or daily care needs, behavioral risks, and risks to personal safety. The list of risk factors within each category is not exhaustive; assessors may encounter other risk factors that they must take into consideration in the risk assessment process. If a participant has multiple health risks and/or behavioral or personal safety risks, the assessor must evaluate the participant's informal supports in order to determine the Risk Level, and potential for support given those risks. For participants with a critical or high risk level the case managers must complete the Risk Identification and Management assessment form as described in the PI-11-06. The Risk Assessment Form lists specific risks the Care manager, nurse, participant and other members of the team identify, along with preventive measures or supports that would minimize these identified risks. At each visit, case management and nursing staff discuss identified risks and steps to minimize these risks. The form provides a framework for discussions with participants and their caregivers about the risks. In addition, The case manager or nurse will review any concerns with the participant and ensure that participants are aware of how to contact the agency to report any incidents or concerns, including when a worker does not arrive as scheduled. Any informal supports available to the participant are identified at the initial assessment and updated at each visit. Information is obtained regarding the availability of these informal supports to assist the participant. The ASAP must communicate to providers of personal assistance services (home health aide, supportive home care aide, homemaker, personal care, and companion) the protocols contained in the PI 11-06 regarding service priority for participants with a Risk Level 1 or 2. Providers must ensure to the best of their ability that participants who are Risk Level 1 do not experience a service interruption and that participants who are Risk Level 2 have service priority. All waiver service providers are required to report circumstances when the participant is not present when services are scheduled, for example when the participant does not answer the door for the personal care worker or home delivered meal driver. These reports result in follow-up contact to participants to confirm their well-being. Waiver service provider agencies are responsible for providing back-up workers when the original worker is unavailable.

For waiver participants enrolled in a SCO, the SCO provides a single, toll-free telephone line, with 24-hours-per-day, 7-days-per-week access to an on-call skilled health-care professional who has immediate access to the Centralized Enrollee Record, is able to address the participant's medical and social needs; has the experience and knowledge to provide clinical triage; and is able to provide options other than waiting until business hours or going to the emergency room.

The SCO must follow federal and State regulations about 24-hour service availability (for example, hospital, home health, and hospice require 24-hour availability; adult day health, homemaker, and chore services do not).

The SCO maintains a triage system for the management of Emergency Conditions and Urgent Care. The triage system, including the identification of the appropriate level of care, must be driven by clinically based criteria consistent with clinical research and industry standards. The clinical criteria must include protocols about the processes for access to, and communication with, appropriate PCPs or other providers.

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For waiver participants enrolled in a SCO, any identified risks including but not limited to health risks, daily care needs, behavioral risks, or risks to personal safety are outlined in the participant's care plan with intervention steps offered to each participant. In the end the participant assumes the amount of risk they are comfortable accepting. SCOs are responsible to provide necessary services to minimize risks and to review risks regularly. In the event that necessary services are unavailable the SCO provides a single, toll-free telephone line, with 24-hours-per-day, 7-days-per-week access to an on-call skilled healthcare professional who has immediate access to the Centralized Enrollee Record, is able to address the participant's medical and social needs, has the experience and knowledge to provide clinical triage and is able to provide options other than the participant waiting until normal business hours or going to the emergency room.

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As mandated reporters, ASAP , SCO and provider agency personnel are required to report all critical incidents when any of the following occur: abuse, neglect, financial exploitation, emotional intimidation, unanticipated absences from home, alleged thefts, alleged damage to a client's possessions, and injury to an employee or client. Each ASAP/SCO handles these critical incidents directly with providers. Appropriate referrals are made to PS or DPH when warranted. Incidents of a serious nature which directly involve waiver participants are communicated to EOEA and MassHealth's Office of Long Term Services and Supports. Through the monthly meeting with ASAP Executive Directors many areas related to health and welfare are discussed by EOEA and ASAP leadership. The SCO unit also is responsible for regular communication with SCO programs to address health and welfare concerns for waiver participants receiving SCO services. These forums allow EOEA and MassHealth Office of Long Term

Support Services to identify areas which need clarification, improved communication, and changes in policy and/or programming. It also allows ASAPs and SCOs to bring to EOEA and MassHealth's Office of Long Term Services and Supports attention any new concerns, updates or barriers they experience specific to securing elders' health and well being.

Reportable Incidents

In case of alleged Protective Services cases (i.e. abuse, neglect or financial exploitation) the mandated report must be made according to state regulations and regulatory timelines.

In the case of incidents of accidental damage or damage to client property by provider's employee, or theft or client and/or employee injury, the provider must report the incident to the ASAP or SCO prior to beginning any internal investigation.

Depending upon the severity of the allegation, the provider agency employee(s) may be temporarily reassigned from all waiver participant cases until the investigation is completed.

All provider employees are oriented to the fact that they may be temporarily reassigned. Orientations also include limitations of involvement in client's personal or financial affairs and emphasis on keeping a professional distance between the client and employee's personal or financial matters.

Initial reports can be verbal, but they must be documented in the provider's log book. Provider agencies must make an immediate oral report followed by a written report.

When a client is absent from the home for any reason, providers inform the appropriate case manager. In cases in which a case manager first learns of absences from the home, he/she will inform the appropriate providers.

The care manager will also call the hospital or nursing home to request that the client's social worker or discharge planner share information about the client's discharge plan with the ASAP care manager. Home Care services may then be reassessed.

Reports Required of Provider

Report immediately, day or night:

-Abuse

-Neglect

-Financial Exploitation

-Emotional Intimidation

Report on same business day:

-Any hospitalization

-Addition or loss of household member

-Absences from home

-Alleged theft

-Alleged breakage of client's possessions

-Injury to employee or client

-Client complaint

Report by next business day:

-New address, name, telephone number

-New M.D.

-New diagnosis

-Relevant Employee complaint

ASAP and SCO programs have numerous activities in place to address many facets of an elder's safety, health and welfare. First and foremost, all case managers and RN's are Mandated Reporters. As they are the eyes and ears of the system, it is vital they have the ability to assess each elder's situation for potential abuse, neglect, and exploitation. Additional skills are necessary to assess medication administration needs and to assess the safety of every elder's housing environment.

DPH also provides training specific to “Preventing Patient Abuse, Neglect and Misappropriation”, which also includes Mandated Reporting Information. The ASAP network and provider agencies and trade organizations, such as The Massachusetts Council for Home Care Services, have all participated in these trainings.

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SCO waiver participants also receive a SCO Member Handbook when they are first enrolled in the SCO/Waiver. This handbook includes the following information: Welcome and Overview of SCO; Features of SCO; Eligibility; Benefits and Coverage; Exclusions and Limitations; Access to After-Hours Care and Emergency Care; Health & Education Resource and Your (member) Rights.

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Performance Measure:16	*H & W 3: Every wWaiver participants has beenwere assessed for on their ability to administer manage medications and their need for assistance.* *Numerator: Number of waiver participants in the reporting period with a documented assessment of their ability to administer manage medications as indicated in their assessment.* *Denominator: Number of waiver participants in the reporting period.*
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If ‘Other’ is selected, specify:	
SIMS and SCO data 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*	
	Senior Care Organizations (SCO)	*☐ Continuously and Ongoing*	*☐ Stratified: Describe Group:*
		☐ Other Specify:	
			☐ Other Specify:

Data Source *(Select one) (Several options are listed in the on-line application): Other*
If ‘Other’ is selected, specify:

Analysis of SCO MDS submissionsSIMS and SCO data 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*
[redacted]	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
[redacted]	☐ *Sub-State Entity*	☐ *Quarterly*	[redacted] ☐ *Representative Sample; Confidence Interval =*
[redacted]	☐☑ *Other Specify:*	☑ *Annually*	[redacted]
	Senior Care Organizations (SCO)	☐ *Continuously and Ongoing*	[redacted] ☐ *Stratified: Describe Group:*
		☐ *Other Specify:*	[redacted]
			[redacted] ☐ *Other Specify:*
			[redacted]

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:*

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EOEA'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 use of data and related information is necessary to promote ongoing quality improvement efforts. While there are multiple approaches in place to allow for a robust system, the overall quality management and improvement system continues to evolve and improve.

EOEA's quality management and improvement strategy is based on the following key operational principles:

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

- Quality is measured based upon a set of outcome measures, which are based on EOEA's mission statement, CMS assurances, Commonwealth of Massachusetts' regulations, Waiver Quality Measure reports and Waiver Quality Record Review findings. The system measures health and safety for participants and also places a strong emphasis on other quality of life domains including participant access, person-centered planning and service delivery, rights and responsibilities, and participant satisfaction.

Three Tiers of Quality Management and Improvement

EOEA's 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 and service improvement. Information gathered on the individual and provider level is managed directly by each ASAP and/or SCO. EOEA and the Office of Medicaid have oversight responsibilities in the areas of LOC Determination, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability to ensure that each ASAP and/or SCO is in compliance with EOEA's/Office of Medicaid's policies and procedures.

Tier I- The Individual Level: Case managers, in partnership with assessing nurses (RNs), are the cornerstone of the monitoring and oversight system for participants. In their respective roles, the case manager is responsible for developing, working directly with the Participant, the individual's service plan based on the comprehensive assessments that have been completed, including the clinical assessment completed by the RN. The case manager also maintains on-going contact with the participant, oversees implementation of the service plan, works with the participant to modify the plan when needs change, and addresses areas of concern as they arise. Quality management activities relating to the above mentioned responsibilities include:

1. Reviews of appropriate Level of Care determinations and re-determinations using the approved tool.

2. Development, with the participant of a service plan that meets the participant's assessed needs and desired services.

3. Complete and timely documentation in participant's record of activities on behalf of waiver

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The Office of Medicaid and EOEA have a strong commitment to a quality management system which continuously evaluates the processes in place to monitor waiver activities and participant outcomes.

The Waiver Quality Record Review process provides concrete, discovery data which, when aggregated and analyzed, allows for prioritization of any assurance areas which need immediate quality improvement strategies to remedy the findings. The process also identifies current processes that may be implemented in a specific ASAP, which are considered “a best practice’ and should be recommended for implementation across the ASAP network to ensure uniformity and the assurance that a standard is being met.

For Massachusetts’, the overarching quality management approach is designed to utilize and build on the CMS Quality Assurance and Sub-assurance areas, which entails establishing a system that focuses on quality management and attempts to ensure the following quality outcomes:

-Individuals have access to 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 with quality services.

-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 ensures the delivery of quality service to individuals who choose 1915(c) Frail Elder Waiver services.

This quality strategy employs an approach for systematically using the processes of discovery, remediation, and improvement to ensure the 1915(c) Frail Elder Waiver program has the intended impact, and if not, that the Commonwealth will identify areas that need improvement, understand reasons for the issues, and implement positive on-going changes. These continuous quality management process activities are embedded in all aspects of the operation of the waiver —from provider qualification and reporting requirements to payment and service delivery verification systems.

The Office of Medicaid and EOEA have designed an effective quality management strategy for the Waiver program which identifies consumer focused quality indicators and systemic improvement areas.