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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

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

-Adding two new waiver services: Assisted Transportation and Assistive Technology - Electronic Comfort Animals.
-Adding clarifying language in the Complex Care Training and Oversight service definition.
-Revising some of the provider qualifications for the Transportation service.
-Adding a self-direction option for two waiver services: Companion and Homemaker.
-Completing Appendix E, which outlines the processes by which the state will offer self-direction in this waiver; includes the state's goals for participation in self-direction over the course of this waiver renewal period; and describes the contracting process with a Fiscal Intermediary that will be responsible for supporting the participant as the employer of self-directed services.
-Expounding on the description of the current Critical Incident Reporting systems.
-Updating descriptions of operational and administrative processes to reflect current procedures and systems, including replacing any mention of the Senior Information Management System (SIMS) with its new name – EOEA Designated Cloud-Based Data Enterprise System.
-Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report has not been finalized for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been finalized. Upon expiration of the Appendix K amendment, Massachusetts will gather and submit any outstanding 372 reports as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 report(s) within a timeframe between 90 days and up to 6-months (to be negotiated with the state) of receiving the final quality review report and 372 report acceptance decision.
-The state will not use funding from section 9817 of the American Rescue Plan Act of 2021 for the changes associated with this waiver renewal.
-None of the changes in this waiver renewal are related to the state's unwinding activities as a result of the COVID-19 public health emergency.

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

1. Request Information (1 of 3)

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**

Original Base Waiver Number: MA.0059
Waiver Number:MA.0059.R08.00
Draft ID: MA.022.08.00

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

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

01/01/24

Approved Effective Date: 03/29/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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 age 21 and under as provided in42 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 level of care:

1. Request Information (3 of 3)

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)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§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 Eligiblity 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, qualify reporting and other aspects of waiver administration.

Elder Affairs contracts with and oversees the on-going responsibilities of 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 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.

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

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver

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

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

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

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (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 in **Appendix H**.

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

Massachusetts outreached broadly to the public and to interested stakeholders to solicit input on the Frail Elder Waiver renewal application.

All the information pertaining to the public input process, including the draft waiver renewal application and information on how to request a hard copy of the renewal application is available on MassHealth's website (https://www.mass.gov/info-details/home-and-community-based-services-waiver-renewal-and-amendment-applications-public).

Public notices were issued in the Boston Globe, Worcester Telegram and Gazette, and the Springfield Republican. In addition, emails were sent on July 10, 2023, to key advocacy organizations as well as the Native American tribal contacts. The newspaper notices and emails provided the link to the MassHealth website, the dates of the public comment period (July 10, 2023 – August 11, 2023), and both email and mailing addresses for the submission of written comments. The state also held a public listening session on August 1, 2023. Participants were able to join the listening session on Zoom or by phone.

The state received 6 comments (oral and written) from provider associations, advocacy organizations, and legislators.

In response to commenters, the state has added some clarifying language to Appendix E-1-a and Appendix E-1-c.

MassHealth outreached to and communicated with the Tribal governments about the Frail Elder Waiver renewal at the regularly scheduled tribal consultation quarterly meetings on February 17, 2023, and May 15, 2023. These meetings afforded MassHealth the opportunity for direct discussion with Tribal government contacts about the waiver renewal. The Tribal governments did not offer any comments or advice on the waiver renewal.

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 is 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: 3rd Floor

City: Boston

State: **Massachusetts**

Zip: 02108

Phone: (617) 573-1751 **Ext:** ☐ **TTY**

Fax: (617) 573-1894

E-mail: amy.bernstein@mass.gov

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

Last Name: Vidler

First Name: Lynn

Title: Director of Home and Community Programs

Agency: Executive Office of Elder Affairs

Address: One Ashburton Place

Address 2: 3rd floor

City: Boston

State: **Massachusetts**

Zip:

02108

Phone:

(617) 222-7589 **Ext:** ☐ **TTY**

Fax:

(617) 727-9368

E-mail:

lynn.vidler@mass.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Mike Levine

State Medicaid Director or Designee

Submission Date: Mar 20, 2024

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

Last Name:

Levine

First Name:

Mike

Title:

Assistant Secretary and Director of MassHealth

Agency:

Executive Office of Health and Human Services

Address:

One Ashburton Place

Address 2:

City:

Boston

State: **Massachusetts**

Zip:

02108

Phone:

(617) 573-1600 **Ext:** ☐ **TTY**

Fax:

(617) 573-1894

E-mail:

Mike.Levine@mass.gov

Attachments

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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continued from Appendix J-2-c-i: Factor D Derivation:

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:

-Assistive Technology for Telehealth: This service is currently available under Appendix K authority. The estimated average cost per unit reflects the limited expenditure experience available as of the time of the preparation of this amendment application.

-Enhanced Technology/Cellular PERS (installation and monthly fee): This service is currently available in the state-funded Home Care program. The estimated average cost per unit reflects Home Care program expenditure data.

-Evidence Based Education Program: This service is currently available in the state-funded Home Care Program. The average cost per unit reflects current per-class costs.

-Goal Engagement Program: There is currently no comparable service in the Commonwealth; however this service will be implemented concurrently in the state-funded Home Care Program. The cost per unit for this service reflects the anticipated rate for this service in the Home Care Program.

-Orientation and Mobility Services: This service is currently available in the Massachusetts MFP-CL Waiver (MA.1027). The average cost per unit is based on the actual average per unit rate for Orientation and Mobility Services as reflected in claims data in the WY 2016 CMS-372 report for the MFP-CL Waiver, which was the most recently-accepted 372 report for that waiver at the time of the submission of the FEW renewal application.

-Peer Support: This service is currently available in the Massachusetts MFP-CL Waiver (MA.1027). The average cost per unit is based on the actual average per unit rate for Peer Support as reflected in claims data in the WY 2016 CMS-372 report for the MFP-CL Waiver, which was the most recently-accepted 372 report for that waiver at the time of the submission of the FEW renewal application.

- Virtual Communication and Monitoring (VCAM) (monthly fee): The estimated average cost per unit was based on pilot program data.

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).

Below is the state's response to the questions from the waiver amendment RAI received on 9/9/21:

The following services may be provided via telehealth: Alzheimer's/Dementia Coaching, Companion, Evidence Based Education Programs, Peer Support, and Transitional Assistance.

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

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

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

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

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

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

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

The person-centered planning process will address participants' needs including community integration regardless of the service delivery method. In-person community activities will continue to be a priority for the participant based on the person-centered planning process. A telehealth service will complement and promote community integration. Providing waiver services via telehealth is a way to offer avenues for community integration that might not have otherwise existed. For example, waiver participants may now have access to providers or education programs in other parts of the state they would be unable to access physically.

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

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

Telehealth delivery is not utilized for ADL supports so there is no inherent privacy concern in instances of toileting, dressing, etc. Just as with in-person service delivery, services are delivered on a scheduled basis and therefore participants may prepare for engagement with the provider. All devices used for telehealth purposes are entirely within the control of the participant at all times. Education and training related to privacy and the use of the device are available to participants and the need for such training is identified during the person-centered planning process.

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

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

officer?

Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 19A, Section 23(a), to protect the privacy and security of the participant's protected health information. EOEA/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by EOEA and EOHHS officials.

Below is the state's response to the waiver renewal IRAI received on 10/31/18:

I-2a: Rate Determination Methods

For waiver services with no comparable State Plan or EOHHS rate, each ASAP negotiates the rates for the purchase of such services from contracted providers for all elders enrolled in the state-funded Home Care program, which includes the subset of elders participating in the Frail Elder Waiver. The Home Care Program, established under state law, serves up to 60,000 elders in the Commonwealth. Rates negotiated under the Home Care Program leverage the relative market power of the program, leading to efficiencies and economies of scale. In negotiating rates, ASAPs contract for one set of rates, without distinction between Home Care Program-funded services and services funded through the Frail Elder Waiver. 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 for Frail Elder Waiver services are the same rates paid under the Home Care Program). The state, through the Executive Office of Elder Affairs (EOEA), maintains oversight of Home Care Program/Frail Elder Waiver rates and ensures that rates are sufficient through regular and ongoing review and monitoring of the ASAP negotiated rates. This occurs through several mechanisms as described in Appendix I-2-a of the application and explained further below.

First, for Homemaker, Personal Care, and Supportive Home Care Aide services, which represent the majority of service needs and utilization in this waiver, EOEA reviews and approves each prospective service provider's proposed rate(s) prior to their contracting with any ASAP to provide services under the state Home Care Program/Frail Elder Waiver. This is accomplished through a Notice of Intent (NOI) process in which prospective service providers submit rate proposals to EOEA. EOEA's review of rate proposals ensures that providers' proposed rates are based on required rate development information (i.e., cost factors including but not limited to base wages, benefits, administrative overhead) and are sufficient, but not excessive. EOEA's NOI provider acceptance system electronically records and stores provider rate development information. Prospective providers whose proposed rates are not based on required rate development information or that are determined to be excessive are declined. Providers must remedy identified deficiencies and be approved by EOEA prior to contracting with any ASAP.

Second, for all services with no comparable State Plan or EOEA rate, each year EOEA reviews the contracted rates ASAPs have negotiated with service providers to ensure that across the Commonwealth, rates for each service are comparable while taking into consideration variation due to geographic area, workforce, cultural needs, or other relevant factors. Specifically, EOEA reviews, among other things, service costs and utilization, which EOEA uses to determine and monitor the average rate per service. 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, reporting and analysis.

In addition, EOEA maintains regular, ongoing communication with the statewide ASAP network regarding all aspects of service delivery within the state Home Care Program/Frail Elder Waiver, including rates, workforce issues, provider changes (e.g., new providers, mergers, closings), and challenges such as difficulty securing service providers or staff. EOEA maintains oversight of, and close involvement with, these issues, including service rates and workforce issues, by holding monthly meetings with ASAP Executive Directors, separate monthly meetings with ASAP Fiscal Directors, as well as separate quarterly meetings with the ASAP Nurse Managers, ASAP Program Managers, ASAP Quality Managers and ASAP Contracts Managers. EOEA also holds quarterly meetings with the two trade associations involved with providers of Home Care Program/Frail Elder Waiver services. Through this extensive oversight and close involvement, the state, through EOEA, is able to ensure the sufficiency of rates.

Finally, the state also monitors utilization/provision of services according to waiver plans of care to ensure participants are receiving services as planned, i.e. as a further demonstration that rates are sufficient.

It is the responsibility of each ASAP to ensure that costs incurred for Transitional Assistance and Environmental Accessibility

Adaptation services through the Frail Elder Waiver are reasonable. Consistent with practice in other Massachusetts HCBS waiver programs, the ASAPs consider the following factors to determine that such costs are reasonable:
•The amount of time required to complete the service/item;
•The degree of skill required to complete the service/item;
•The severity or complexity of the service/item;
•The lowest price charged or accepted from any payer for the same/similar service/item, including, but not limited to any shelf price, sale price, advertised price, or other price reasonably obtained by a competitive market for the service or item; and
•The established rates, policies, procedures, and practices of any other purchasing governmental unit in purchasing the same or similar services/items.

EOEA provides consultation to the ASAPs regarding any questions regarding these or other services. Should EOEA determine at any time through its analysis of service utilization and claims data that such costs do not appear to be reasonable, EOEA will provide guidance to the ASAPs through regular communication with ASAP Fiscal Directors, Program Managers, and other staff, or through written program instruction.

The state does not require multiple bids from multiple providers.

The state specifies that they do not require multiple bids for Transition Assistance / Environmental Accessibility Services, but examines “The lowest price charged or accepted from any payer for the same/similar service/item, including, but not limited to any shelf price, sale price, advertised price, or other price reasonably obtained by a competitive market for the service or item” when determining if a cost is reasonable.

The state tracks the cost of Transition Assistance and Environmental Accessibility Services on an annual basis through claims data that demonstrates cost and utilization of these services.

ASAPs must follow EOEA written guidance for determining payments for services. The state’s annual review of claims data has indicated that cost and utilization of these services has been, and remains, reasonable. The state has determined that imposing a maximum allowable cost is not necessary.

All waiver services, including Transitional Assistance and Environmental Accessibility services, must be authorized in the waiver Plan of Care. The Case Manager is responsible for making such authorization based on the needs addressed through the person-centered planning process. The Plan of Care is reviewed by the ASAP RN and Supervisor. When potential purchases for Transitional Assistance or Environmental Accessibility services are more than standard purchase authorizations, they are reviewed by the ASAP Director of Client Services and/or Fiscal Manager.

EOHHS is required to complete a public comment process. This includes public hearings. The state only applies this public comment process to services for which there is a comparable Medicaid State Plan rate. The state does not describe public comment processes for the other defined rate methodologies.

The state ensures that stakeholders have opportunity to voice concerns over rates and rate determination methods by maintaining regular communication with both provider and participant stakeholders. At the provider level, EOEA holds quarterly meetings with provider trade associations that are a platform to discuss all aspects of service delivery within the state Home Care Program and Frail Elder Waiver, including rates and workforce issues.

Additionally, opportunity for public comment regarding rate determination methods is provided formally through the waiver public comment process. As described in the Main Module, Massachusetts outreaches broadly to the public and to interested stakeholders to solicit input on the waiver application—which includes the rate determination methods—by posting the waiver application and a summary of major changes to MassHealth’s website, issuing public notices in multiple newspapers, and emailing key advocacy organizations as well as the Native American tribal contacts directly. The newspaper notices and email provide the link to the MassHealth website that includes the draft application, the public comment period, information regarding a public listening session at which comments can be submitted orally or in writing, and, for anyone wishing to send comments, both email and mailing addresses.

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.

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.

(Complete item A-2-a).

○ **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).*

Appendix A: Waiver Administration and Operation

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. The most recent agreement took effect on April 1, 2022 and extends through March 31, 2025. The agreement is renewed on a three-year cycle. 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 Integrated 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.

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.

Appendix A: Waiver Administration and Operation

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. The 3rd Amended and Restated contract between EOHHS and the Senior Care Organizations was executed September 18, 2023, it is evaluated and amended as needed and is available upon request.

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. SCOs are able to give final approval and denial of service plans. 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.

The ASAPs contract with a Fiscal Management Service (FMS) also known as the Fiscal Intermediary (FI) entity that will be responsible for supporting the participant as the employer of self-directed services as outlined in Appendix E. The ASAPs will manage the performance of the FI via contract, including review of performance metrics and required monthly reports.

The agreements that outline the requirements for these contractors will be available to CMS upon request.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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:

EOEA contracts with nonprofit agencies called Aging Services Access Points (ASAPs) in the operation of the waiver. EOEA operates under the authority of M.G.L. c. 19A, which establishes EOEA as principal state agency to plan, develop, and implement programs to serve Older Adults in Massachusetts. M.G.L. c. 19A, § 4B authorizes EOEA to establish a coordinated system of care to be administered by Aging Service Access Points (ASAPs) as designated and contracted by EOEA. ASAPs are contracted in compliance with M.G.L. c. 7, §§ 4, 4A and 22; M.G.L. c. 30, §§ 51 and 52; and 801 CMR 21.00. The most recent contract was executed July 1, 2023 and EOEA evaluates ASAP performance every two years pursuant to a process of designation review. The contract is available upon request.

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. ASAPs are also responsible for recruitment and ongoing oversight of the waiver service provider network. ASAPs are able to give final approval and denial of service plans. In relation to self-directed waiver services, this includes contracting with and oversight of the Fiscal Management Service (FMS) also known as the Fiscal Intermediary (FI). 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.

Appendix A: Waiver Administration and Operation

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:

EOEA 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. EOEA evaluates ASAP performance every two years pursuant to a process of designation review, per Massachusetts General Laws c.19a § 4b and as outlined in Appendix A-4.

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.

Appendix A: Waiver Administration and Operation

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:

EOEA 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. Key informant interviews are conducted with ASAP leadership and staff, including Executive Directors, Chief Financial Officers, Chief Operating Officers, Nurse Managers, Program Managers, Quality Managers, Reporting Mangers, Contract Managers, and any ASAP staff whom EOEA views as vital to the process. 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 work 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.

Appendix A: Waiver Administration and Operation

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	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☐	☐
Waiver enrollment managed against approved limits	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☐	☐
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☐	☐
Utilization management	☒	☐	☐
Qualified provider enrollment	☒	☒	☒
Execution of Medicaid provider agreements	☒	☒	☒
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐	☒
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
AA 1. 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 the percentage of timely submissions of quality data reports. Numerator: Number of ASAP and SCO quality reports that were on time Denominator: Number of ASAP and SCO reports due

Data Source (Select one):
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**	☐ **Stratified** Describe Group:

ASAPs and SCOs		
	☐ **Continuously and Ongoing**	☐ **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:
AA 2. Percentage of Case Management staff supporting waiver participants who are competent and qualified, in accordance with state requirements. Numerator: Number of Case Managers that met qualification standards Denominator: Number of Case Managers

Data Source (Select one):
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	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*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 SCOs	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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**

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

Performance Measure:
AA 3. The percentage of annual redeterminations of level of care that were completed on a timely basis. Numerator: Number of waiver participants whose level of care evaluation was conducted Denominator: Number of waiver participants who were due for a level of care redetermination

Data Source (Select one):
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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
EOEA Designated cloud-based data enterprise system

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

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

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

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**

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

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 one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	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**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	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:

Not applicable

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

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:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

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

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

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount

that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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	20000
Year 2	20000
Year 3	20000
Year 4	20000
Year 5	20000

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

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

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

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: Participant Access and Eligibility

B-4: 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**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional state supplement recipients**
- [x] **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)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only 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 dollar amount:

☐ **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%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

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 period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). 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-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

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 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

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

Specify:

iii. 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:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

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.

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

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

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **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 formula:
- ○ **Other**

  Specify:

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

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

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

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

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

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.

Appendix B: Participant Access and Eligibility

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 services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

Waiver services must be scheduled on at least a monthly basis. The participant's case manager will be responsible for monitoring on at least a monthly basis when the participant does not receive scheduled services for longer than one month (for example when absent from the home due to hospitalization). Monitoring includes in person, telephone, video-conferencing, text messaging, email contacts, and/or other electronic modalities with the participant, guardian, or other family member designated by the participant and may also include collateral contact with service providers or informal supports. Guardians and other family members designated by the participant will be documented in their electronic record by the Case Manager. Contact requires a response from, and engagement with, the participant, guardian, or other specified family member in order to be considered monitoring. Every participant has an in-person visit at least twice annually. In-person visits are almost always conducted in the home. However, a participant may choose a different location that accommodates their needs. In addition, any time that any service provider is delivering services in the home, they are required to communicate any changes to the home environment that would impact a participant’s safety.

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

Aging Services Access Point (ASAPs) 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 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 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 EOEA designated cloud-based data enterprise system. In-person assessments are the default method for conducting evaluations and reevaluations. Alternative modalities may be permissible based on the participant's need and current status. The Registered Nurse will review in-person safety and requirements with the participant and document the reason for the use of an alternative modality in the participant's electronic record. Alternative modalities include video only, audio only, video and audio, or a hybrid approach which is any of the aforementioned modalities in addition to a short in-person visit. In cases where the participant elects an approach that does not include an in-person visit, the assessor is expected to draw on other sources of information about the participant, including the case manager, other providers, family members, or other individuals or organizations providing support. The allowance of a virtual option or component to the assessment process aligns with the person-centered nature of the Frail Elder waiver and is available as a way to accommodate the preferences of participants and potential participants. The inclusion of other sources of information by the assessor is the mechanism by which virtual assessment data can be supplemented. A telehealth option may be more convenient and comfortable for the potential participant or participant, and it is included in this waiver as a person-centered flexibility.

While assessments may be provided via telehealth, it is within the context of regular contact with the case manager including an in-person visit at least twice annually. Case managers maintain regular contact with providers of waiver services, which also serves to inform the case manager of any health and safety concerns. As described in Appendix G-1-b, 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.

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.

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 assessment of the applicant/participant for both initial as well as annual reevaluation of level of care, and completes the CDS assessment tool. The assessment is generally conducted in the elder's home, but may be conducted in an alternative location. In-person assessments are the default method for conducting evaluations and reevaluations. Alternative modalities may be permissible based on the participant's need and current status. Members may decline in-person assessment and request an assessment be performed via alternative modality. The Registered Nurse will review in-person safety and requirements with the participant and document the reason for the use of an alternative modality in the participant's electronic record. Alternative modalities include video only, audio only, video and audio, or a hybrid approach which is any of the aforementioned modalities in addition to a short in-person visit. Every participant has an in-person visit at least twice annually. In-person visits are almost always conducted in the home. However, a participant may choose a different location that accommodates their needs. In addition, any time that any service provider is delivering services in the home, they are required to communicate any changes to the home environment that would impact a participant's safety. In cases where the participant elects an approach that does not include an in-person visit, the assessor is expected to draw on other sources of information about the participant, including the case manager, other providers, family members, or other individuals or organizations providing support.

The ASAP RN enters these clinical determinations and supporting information into the participant's record in EOEA designated cloud-based data enterprise system.

For participants enrolled in a Senior Care Organization (SCO), the SCO RN conducts a reevaluation of the participant and completes the MDS-HC assessment tool. The assessment is generally conducted in the participant's home, but may be conducted in an alternative location. In-person assessments are the default method for conducting evaluations and reevaluations. Alternative modalities may be permissible based on the participant's need and current status. Members may decline in-person assessment and request an assessment be performed via alternative modality. The Registered Nurse will review in-person safety and requirements with the participant and document the reason for the use of an alternative modality in the participant's electronic record. Alternative modalities include video only, audio only, video and audio, or a hybrid approach which is any of the aforementioned modalities in addition to a short in-person visit. Every participant has an in-person visit at least twice annually. In-person visits are almost always conducted in the home. However, a participant may choose a different location that accommodates their needs. In addition, any time that any service provider is delivering services in the home, they are required to communicate any changes to the home environment that would impact a participant's safety. In cases where the participant elects an approach that does not include an in-person visit, the assessor is expected to draw on other sources of information about the participant, including the case manager, other providers, family members, or other individuals or organizations providing support. 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.

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.

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 EOEA designated cloud-based data enterprise system. 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 and then transferred to the MassHealth data warehouse. The reevaluation assessments uploaded by the SCO plans are maintained electronically in the MassHealth data warehouse indefinitely and the data is retrievable.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:
LOC a1. Percentage of applicants' initial clinical eligibility that was assessed by an RN within 10 business days of of their request for or having identification of their need for the waiver program. Num: Number of waiver applicants whose initial clinical eligibility was assessed within 10 business days of identifying their need for the waiver program Den: Total number of waiver applicants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
EOEA designated cloud-based data enterprise system

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

LOC c1. Percentage of applicants' initial level of care evaluation 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):
Other
If 'Other' is selected, specify:
EOEA designated cloud-based data enterprise system

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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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:
LOC c2. The percentage of redeterminations of level of care that were 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):
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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
EOEA designated cloud-based data enterprise system

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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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:
LOC c3. The percentage of determinations where 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):
Other
If 'Other' is selected, specify:
EOEA designated cloud-based data enterprise system

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

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

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: Participant Access and Eligibility

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) in person, by mail, or electronically. 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 their 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.

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 (RCF) is maintained in the client record at the ASAP office or RCF is maintained in the EOEA designated cloud-based enterprise system for a minimum of three years per 45 CFR § 92.42.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency 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.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Alzheimer's/Dementia Coaching**		
Statutory Service	**Home Health Aide**		
Statutory Service	**Homemaker**		
Statutory Service	**Personal Care**		
Statutory Service	**Respite**		
Other Service	**Assisted Transportation**		
Other Service	**Assistive Technology - Electronic Comfort Animals**		
Other Service	**Assistive Technology for Telehealth**		
Other Service	**Chore**		
Other Service	**Companion**		
Other Service	**Complex Care Training and Oversight**		
Other Service	**Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS)**		
Other Service	**Environmental Accessibility Adaptation**		
Other Service	**Evidence Based Education Programs**		
Other Service	**Goal Engagement Program**		
Other Service	**Grocery Shopping and Delivery**		
Other Service	**Home Based Wandering Response Systems**		
Other Service	**Home Delivered Meals**		
Other Service	**Home Delivery of Pre-packaged Medication**		
Other Service	**Home Safety/Independence Evaluations (formerly Occupational Therapy)**		
Other Service	**Laundry**		
Other Service	**Medication Dispensing System**		

Service Type	Service		
Other Service	Orientation and Mobility Services		
Other Service	Peer Support		
Other Service	Senior Care Options (SCO)		
Other Service	Supportive Day Program		
Other Service	Supportive Home Care Aide		
Other Service	Transitional Assistance		
Other Service	Transportation		
Other Service	Virtual Communication and Monitoring (VCAM)		

Appendix C: Participant Services

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 Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Alzheimer’s/Dementia Coaching

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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.

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

Additional information related to telehealth delivery of services in this waiver is provided in the Brief Waiver Description, B. Optional section of this waiver.

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	Provider Type Title
Individual	Qualified individual providers of Alzheimer's/Dementia Coaching
Agency	Home Health Agencies
Agency	Alzheimer's/Dementia Coaching agencies
Agency	Homemaker/Personal Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Alzheimer's/Dementia Coaching

Provider Category:
Individual
Provider Type:

Qualified individual providers of Alzheimer's/Dementia Coaching

Provider Qualifications

License *(specify):*

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 working with person with dementia/related illness
- Occupational Therapist
- Providers trained and certified by the Alzheimer's Association to provide this service

Certificate *(specify):*

Services must be performed by an individual trained in Habilitation Therapy by the Alzheimer's Association

Other Standard *(specify):*

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:
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).

Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 19A, Section 23(a), to protect the privacy and security of the participant's protected health information.
EOEA/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by EOEA and EOHHS officials.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Alzheimer's/Dementia Coaching

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

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 working with person with dementia/related illness
- Occupational Therapist
- Providers trained and certified by the Alzheimer's Association to provide this service.

Certificate *(specify):*

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.

Other Standard *(specify):*

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).

Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 19A, Section 23(a), to protect the privacy and security of the participant's protected health information.
EOEA/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by EOEA and EOHHS officials.

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Alzheimer's/Dementia Coaching

Provider Category:

Agency

Provider Type:

Alzheimer's/Dementia Coaching agencies

Provider Qualifications

License *(specify):*

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 working with person with dementia/related illness
- Occupational Therapist
- Providers trained and certified by the Alzheimer's Association to provide this service.

Certificate *(specify):*

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.

Other Standard *(specify):*

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).

Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 19A, Section 23(a), to protect the privacy and security of the participant's protected health information.
EOEA/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by EOEA and EOHHS officials.

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Alzheimer's/Dementia Coaching

Provider Category:

Agency

Provider Type:

Homemaker/Personal Care Agencies

Provider Qualifications

License *(specify):*

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 working with person with dementia/related illness
- Occupational Therapist
- Providers trained and certified by the Alzheimer's Association to provide this service

Certificate *(specify):*

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.

Other Standard *(specify):*

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).

Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 19A, Section 23(a), to protect the privacy and security of the participant's protected health information.
EOEA/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by EOEA and EOHHS officials.

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Statutory Service

Service:

Home Health Aide

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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.

Home Health Aide services are primarily delivered in the waiver participant's home. In circumstances where Home Health Aides accompany waiver participants into the community, they may deliver services outside of the home.

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.

Home Health Aide is not duplicative of Personal Care or Supportive Home Care Aide. These services differ by the type of assistance they provide and level of worker training, as described in their service definitions. Through the person-centered planning process, the participant's care needs and level of complexity are matched to the most appropriate waiver service, given those factors. This service may not be delivered at the same time as Personal Care or Supportive Home Care Aide, as each of those services provides a different level of assistance.

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	Provider Type Title
Agency	Homemaker/Personal Care Agencies
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Health Aide

Provider Category:

Agency

Provider Type:

Homemaker/Personal Care Agencies

Provider Qualifications

License *(specify):*

Supervision of Home Health Aides must be provided by a Registered Nurse with a valid Massachusetts license.

Certificate *(specify):*

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

Other Standard *(specify):*

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Health Aide

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

Supervision of Home Health Aides must be provided by a Registered Nurse with a valid Massachusetts license.

Certificate *(specify):*

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

Other Standard *(specify):*

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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 Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the approved waiver.**

Service Definition *(Scope):*

The Homemaker service includes assistance with: shopping, menu planning, laundry, and the performance of general household tasks such as 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.

The person-centered planning process assures that waiver services are meeting the waiver participant's goals and assessed needs. The process identifies all services and supports and ensures that there is no duplication among them, or with Medicaid state plan services.

This service may not be provided at the same time when other services that include incidental housekeeping tasks are being provided to complete the same task and address the same need.

This service does not provide 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.

When a waiver participant may be concurrently receiving two services that are nominally duplicative or overlapping, duplication of tasks is not allowable. The case manager is responsible to ensure that the documentation in the participant's electronic record supports the service delivery and illustrates that there is no duplication. When more than one provider is involved, the care plan must describe how services from multiple providers are coordinated.

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	Provider Type Title
Agency	Home Health Agencies
Individual	Individual Homemaker (self-directed only)
Agency	Homemaker/Personal Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Individual Homemaker (self-directed only)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals who provide Homemaker services must meet requirements for individuals in such roles, including, but not limited to: have been CORI checked, have life or work experience providing services to older adults or individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; and have ability to meet legal requirements in protecting confidential information.

Individuals must be provided with information regarding the applicable regulations related to the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

ASAPs for initial enrollment and FI every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Homemaker/Personal Care Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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 Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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 cueing 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.

The person-centered planning process assures that waiver services are meeting the waiver participant's goals and assessed needs. The process identifies all services and supports and ensures that there is no duplication among them, or with Medicaid state plan services.

Personal Care is not duplicative of Supportive Home Care Aide or Home Health Aide. These services differ by the type of assistance they provide and level of worker training, as described in their service definitions. Through the person-centered planning process, the participant's care needs and level of complexity are matched to the most appropriate waiver service, given those factors. This service may not be delivered at the same time as Supportive Home Care Aide or Home Health Aide, as each of those services provides a different level of assistance.

This service may not be provided at the same time when other services that include housekeeping tasks are being provided to complete the same task and address the same need.

Personal Care workers may assist or supervise the participant with tasks such as meal preparation and housekeeping chores when the tasks are incidental to the Personal Care service but may not perform these activities as discrete services.

When a waiver participant may be concurrently receiving two services that are nominally duplicative or overlapping, duplication of tasks is not allowable. The case manager is responsible to ensure that the documentation in the participant's electronic record supports the service delivery and illustrates that there is no duplication. When more than one provider is involved, the care plan must describe how services from multiple providers are coordinated.

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	Provider Type Title
Agency	Home Health Agencies
Agency	Homemaker/Personal Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Homemaker/Personal Care Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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 Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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 participants 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.

This service may not be provided at the same time as a waiver service that includes ADL supports (Personal Care, Home Health Aide, Supportive Home Care Aide).

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	Provider Type Title
Agency	Assisted Living Residence
Agency	Adult Foster Care
Agency	Hospital
Agency	Adult Day Health
Agency	Skilled Nursing Facility
Agency	Rest Home

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Assisted Living Residence

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by EOEA in accordance with 651 CMR 12.00 (EOEA regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

EOEA

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Foster Care

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

MassHealth

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Hospital

Provider Qualifications

License *(specify):*

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)

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Day Health

Provider Qualifications

License *(specify):*

Licensed by the Department of Public Health in accordance with 105 CMR 158.000 (Department of Public Health Licensure of Adult Day Health Programs)

Certificate *(specify):*

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Skilled Nursing Facility

Provider Qualifications

License *(specify):*

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)

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Rest Home

Provider Qualifications

License *(specify):*

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)

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assisted Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the approved waiver.**

Service Definition *(Scope):*

Provision of assistance, escort, and transportation to enable participants to access waiver services, and other community services, activities, and resources, as specified by the waiver participant's service plan. Assisted Transportation is a service designed to provide participants with the entire transportation service while maintaining functional independence and assurance from assistance providers while in the community.

This service is offered as a separate service, 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 at 130 CMR 407.000. This service differs from other existing State Plan and waiver transportation services in two key ways: (1) it includes assistance and escort to support the participant throughout the duration of the outing and (2) it allows for transportation to non-medical appointments and community outings. This service is provided only in circumstances when the waiver participant's needs align with these service elements. Assisted 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.

Participants may not receive duplicative services from Assisted Transportation, the MassHealth State Plan Medical Transportation, or the Transportation waiver service at time-of-service provision. The person-centered planning process assures that waiver services are meeting the waiver participant's goals, and that there is no duplication among them, or with Medicaid state plan services.

The cost of transportation is not included in Chore, Companion, Personal Care, and Homemaker services. This is a distinct service with a distinct cost.

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	Provider Type Title
Agency	Homemaker/Personal Care Agencies
Agency	Home Health Agencies
Agency	Companion Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assisted Transportation

Provider Category:

Agency

Provider Type:

Homemaker/Personal Care Agencies

Provider Qualifications

License *(specify):*

The worker providing transportation must have a valid Driver's License

Certificate *(specify):*

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
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.

Other Standard *(specify):*

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).

Driver and Vehicle Requirements: Verification of valid driver's license, liability insurance, age of vehicles; RMV inspection; seat belts; air conditioning and heating.
Assisting passengers on/off vehicles and from door to door
Tracking and scheduling trips

Providers must ensure that staff who transport must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; and communicate effectively with participants, families, other providers and agencies.

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assisted Transportation

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

Supervision of Home Health Aides must be provided by a Registered Nurse with a valid Massachusetts license.

The worker providing transportation must have a valid Driver's License

Certificate *(specify):*

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

Other Standard *(specify):*

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 services(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).
Driver and Vehicle Requirements: Verification of valid driver's license, liability insurance, valid registration, age of vehicles; RMV inspection; seat belts; air conditioning and heating;
Assisting passengers on/off vehicles and from door to door
Tracking and scheduling trips

Providers must ensure that staff who transport must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; and communicate effectively with participants, families, other providers and agencies.

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assisted Transportation

Provider Category:

Agency

Provider Type:

Companion Provider Agencies

Provider Qualifications

License *(specify):*

The worker providing transportation must have a valid Driver's License

Certificate *(specify):*

Other Standard *(specify):*

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).

Driver and Vehicle Requirements: Verification of valid driver's license, liability insurance, age of vehicles; RMV inspection; seat belts; air conditioning and heating.
Assisting passengers on/off vehicles and from door to door
Tracking and scheduling trips

Providers must ensure that staff who transport must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; and communicate effectively with participants, families, other providers and agencies.

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology - Electronic Comfort Animals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the approved waiver.**

Service Definition *(Scope):*

This service includes purchase or other acquisition costs of battery operated, life-like, interactive animals that facilitate companionship without assuming the responsibilities and expense of taking care of a real animal. This service helps combat the effects of loneliness and allows consumers to receive similar gratification and comfort that they would get from live animals.

This service includes device installation and set- up costs. This service does not include internet service installation, set-up costs, and ongoing service provision fees.

Electronic Comfort Animals are realistic, robotic comfort animals that simulate movements, sounds, and responses of the actual animal. With realistic fur and interactive sensors that respond to petting and hugs, Electronic Comfort Animals are calming, and provide a sense of purpose to consumers.

These types of products are highly effective in soothing a person with Alzheimer's disease and related dementias, keeping them engaged, and reducing anxiety. This service also provides similar benefits to participants with a wide range of other conditions. This service is used to support waiver participants who express feelings of loneliness, anxiety, or a desire for companionship, as identified through the person-centered planning process.

Case managers will discuss the need for assistance or training on how to use the service and will provide that help if needed.

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

2 animals per 3 year timeframe up to $600 [examples: lost ECA replacement, or 1 for home, 1 for alternative site (i.e., day program or family member home)]

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	Provider Type Title
Agency	Electronic Comfort Animal Suppliers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology - Electronic Comfort Animals

Provider Category:

Agency

Provider Type:

Electronic Comfort Animal Suppliers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

This service can be purchased from any provider in the community that provides electronic comfort animal products.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology for Telehealth

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the approved waiver.**

Service Definition *(Scope):*

This service includes purchase, lease, or other acquisition costs of cell phones, tablets, computers, and ancillary equipment necessary for the operation of the Assistive Technology devices that enable the participant to engage in telehealth. This service includes device installation and set-up costs. This services does not include internet service installation, set-up costs, and ongoing service provision fees.

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

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

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

$500 limit, every five years.

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

Participants who receive a device through the VCAM service that may be used for telehealth may not receive a duplicative device through 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	Provider Type Title
Agency	Assistive Technology/Telehealth Provider Agencies
Individual	Assistive Technology/Telehealth Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology for Telehealth

Provider Category:

Agency

Provider Type:

Assistive Technology/Telehealth Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any provider in the community that provides mobile devices or service, or related ancillary equipment.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology for Telehealth

Provider Category:

Individual

Provider Type:

Assistive Technology/Telehealth Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any provider in the community that provides mobile devices or service, or related ancillary equipment.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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.

The person-centered planning process assures that waiver services are meeting the waiver participant's goals and assessed needs. The process identifies all services and supports and ensures that there is no duplication among them, or with Medicaid state plan services.

This service does not provide routine, light housekeeping assistance; it is focused on heavy chores or repairs.

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	Provider Type Title
Agency	Chore Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:

Agency

Provider Type:

Chore Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not

specified in statute.

Service Title:

Companion

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the approved waiver.**

Service Definition *(Scope):*

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

This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a. Additional information related to telehealth delivery of services in this waiver is provided in the Brief Waiver Description, B. Optional section of this waiver.

The person-centered planning process assures that waiver services are meeting the waiver participant's goals and assessed needs. The process identifies all services and supports and ensures that there is no duplication among them, or with Medicaid state plan services.

This service may not be provided at the same time when other services that include incidental housekeeping tasks are being provided to complete the same task and address the same need. Companions may assist or supervise the participant with tasks such as meal preparation, laundry, and shopping when the tasks are incidental to the Companion service but may not perform these activities as discrete services.

When a waiver participant may be concurrently receiving two services that are nominally duplicative or overlapping, duplication of tasks is not allowable. The case manager is responsible to ensure that the documentation in the participant's electronic record supports the service delivery and illustrates that there is no duplication. When more than one provider is involved, the care plan must describe how services from multiple providers are coordinated.

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	Provider Type Title
Individual	Individual Companion (self-directed only)
Agency	Companion Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion

Provider Category:
Individual

Provider Type:

Individual Companion (self-directed only)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals who provide Individual Companion services must meet requirements for individuals in such roles, including, but not limited to: have been CORI checked, have life or work experience providing services to older adults or individuals with disabilities; can handle emergency situations; can set limits, and communicate effectively with participants, families, other providers and agencies; and have ability to meet legal requirements in protecting confidential information.

Individuals must be provided with information regarding the applicable regulations related to the Elder Abuse Reporting and Protective Services Program found at 651 CMR 5.00 et seq (The Executive Office of Elder Affairs' Elder Abuse Reporting and Protective Services Program regulations). Individuals must attest to having reviewed this information.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

ASAPs for initial enrollment and FI every 3 years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion

Provider Category:

Agency

Provider Type:

Companion Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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).

Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 19A, Section 23(a), to protect the privacy and security of the participant's protected health information.
EOEA/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by EOEA and EOHHS officials.

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 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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Complex Care Training and Oversight

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the approved waiver.**

Service Definition *(Scope):*

Complex Care Training and Oversight is a periodic, episodic service that includes medication management, 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 includes the provision of education and services requiring specialized skills related to the participants health conditions promoting health and welfare.

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	Provider Type Title
Agency	Home Health Agencies
Agency	Homemaker/Personal Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Complex Care Training and Oversight

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

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, as governed by Massachusetts General Laws Chapter 112, Sections 74 to 81C.

Certificate *(specify):*

Other Standard *(specify):*

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, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Complex Care Training and Oversight

Provider Category:

Agency

Provider Type:

Homemaker/Personal Care Agencies

Provider Qualifications

License *(specify):*

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, as governed by Massachusetts General Laws Chapter 112, Sections 74 to 81C.

Certificate *(specify):*

Other Standard *(specify):*

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, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the approved waiver.**

Service Definition *(Scope):*

Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS) provides personal emergency response service. ET/CPERS functionality includes:

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

ET/CPERS also includes fall detection technology, as needed.

Agencies that provide ET/CPERS under the waiver are not required to enroll with MassHealth as a provider of MassHealth State Plan PERS. This service does not duplicate services available through the State Plan.

Participants may not receive duplicative services from ET/CPERS and the MassHealth State Plan Personal Emergency Response System or the Virtual Communication and Monitoring waiver service.

The reimbursement rate includes the device and response center subscription, which pays for 24/7 access to staff at the response center.

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	Provider Type Title
Agency	Personal Emergency Response Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS)

Provider Category:

Agency

Provider Type:

Personal Emergency Response Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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).

ETC/CPERS providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 19A, Section 23(a), to protect the privacy and security of the participant's protected health information. EOEA/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by EOEA and EOHHS officials.

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.

Providers must have the capacity to supply and support ET/CPERS devices with a 2-way audio connection.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

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.

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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).

Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

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

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Accessibility Adaptation Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptation

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptation Agencies

Provider Qualifications

License *(specify):*

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)

Certificate *(specify):*

Other Standard *(specify):*

Any not-for-profit or proprietary organization that contracts with the ASAP as such and successfully demonstrates, at a minimum, the following: Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities.

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Evidence Based Education Programs

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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.

The person-centered planning process assures that waiver services are meeting the waiver participant's goals and assessed needs, and that there is no duplication among them, or with Medicaid state plan services.

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.

This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process and reviewed by the Case Manager during each scheduled reassessment as outlined in Appendix D-2-a. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D-2-a. Additional information related to telehealth delivery of services in this waiver is provided in the Brief Waiver Description, B. Optional section of this waiver.

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	Provider Type Title
Agency	Evidence Based Education Program provider agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Evidence Based Education Programs

Provider Category:

Agency

Provider Type:

Evidence Based Education Program provider agencies

Provider Qualifications

License *(specify):*

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 *(specify):*

Certificate of good standing from the Healthy Living Center of Excellence

Other Standard *(specify):*

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).

Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 19A, Section 23(a), to protect the privacy and security of the participant's protected health information.
EOEA/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by EOEA and EOHHS officials.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Goal Engagement Program

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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 their 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. The person-centered planning process assures that waiver services are meeting the waiver participant's goals and assessed needs, and that there is no duplication among them, or with Medicaid state plan services.

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, 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	Provider Type Title
Agency	Goal Engagement Program agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Goal Engagement Program

Provider Category:

Agency

Provider Type:

Goal Engagement Program agencies

Provider Qualifications

License *(specify):*

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. All occupational therapists must have a valid Massachusetts license, as governed by Massachusetts General Laws Chapter 112, Sections 23B to 23E.

Skilled nursing elements of the service must be performed by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license. All nurses must have a valid Massachusetts license, as governed by Massachusetts General Laws Chapter 112, Sections 74 to 81C.

If the scope of work involves minor home repairs, agencies and individuals employed by the agencies must possess any licenses/ certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc). The Massachusetts Division of Occupational Licensure governs the licensure and certification requirements for trades involved in minor home repairs.

Certificate *(specify):*

Staff providing OT and nursing must be CAPABLE certified.

Other Standard *(specify):*

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 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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Grocery Shopping and Delivery

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the approved waiver.**

Service Definition *(Scope):*

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

The person-centered planning process assures that waiver services are meeting the waiver participant's goals and assessed needs. The process identifies all services and supports and ensures that there is no duplication among them, or with Medicaid state plan services.

This service may not be provided at the same time when other services that include the tasks of grocery shopping and delivery are being provided to complete the same task and address the same need.

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	Provider Type Title
Agency	Grocery Shopping and Delivery Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Grocery Shopping and Delivery

Provider Category:

Agency

Provider Type:

Grocery Shopping and Delivery Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Based Wandering Response Systems

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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. Using GPS technology, Home Based Wandering Response Systems are programmed to provide an alert signal when a person goes outside a designated perimeter. This differs from the ET/CPERS service, where the participant proactively presses the help button in order to request assistance. 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	Provider Type Title
Agency	Home Based Wandering Response Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Based Wandering Response Systems

Provider Category:

Agency

Provider Type:

Home Based Wandering Response Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

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.

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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.

The person-centered planning process assures that waiver services are meeting the waiver participant's goals and assessed needs. The process identifies all services and supports and ensures that there is no duplication among them, or with Medicaid state plan services.

This service may not be provided at the same time when other services that include the task of meal preparation for the same meal are being provided.

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	Provider Type Title
Agency	Home Delivered Meal Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meal Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The nutrition provider's central kitchen, meal sites, and caterers must meet the requirements regarding food handling and sanitation as stipulated within the Massachusetts Department of Public Health 105 CMR 590.000, State Sanitary Code for Food Establishments Chapter X and Vending Machines. Food preparation kitchens and meal service sites must have local Board of Health certificates and other applicable licenses. Each nutrition provider should have a Local Board of Health Variance on file for each city and town (Satellite Feeding and Food Manager Certification, 105 CMR 590.003(A))

Other Standard *(specify):*

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivery of Pre-packaged Medication

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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.

Waiver participants may have access to home delivery of prescription medications through their MassHealth State Plan pharmacy benefit, Medicare Part D plan, or other prescription drug coverage. This waiver service includes features above and beyond what those plans would provide: customized packaging for the recipient to assist them in taking their medications properly and coordination with waiver case managers. If a participant's assessed needs indicate that these features would be helpful to the participant, then this waiver service is discussed. The waiver case manager would ensure that this service does not duplicate home delivery of the same medications by the waiver participant's prescription drug 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	Provider Type Title
Agency	Pharmacy

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivery of Pre-packaged Medication

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

Pharmacist must meet licensing requirements of the Massachusetts Board of Registration in Pharmacy

The licensing requirements of the Massachusetts Board of Registration in Pharmacy are governed by Massachusetts General Law Chapter 112, Sections 24 to 42A.

Certificate *(specify):*

Other Standard *(specify):*

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

Entity Responsible for Verification:

ASAP

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Safety/Independence Evaluations (formerly Occupational Therapy)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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	Provider Type Title
Agency	Health Care Agencies
Agency	Home Health Agencies
Agency	Homemaker/Personal Care agencies
Individual	Individual Occupational Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Safety/Independence Evaluations (formerly Occupational Therapy)

Provider Category:

Agency

Provider Type:

Health Care Agencies

Provider Qualifications

License *(specify):*

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).

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

Certificate *(specify):*

Other Standard *(specify):*

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 by105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Safety/Independence Evaluations (formerly Occupational Therapy)

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

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 supervision of a licensed Occupational Therapist

Certificate *(specify):*

Other Standard *(specify):*

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 by105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Safety/Independence Evaluations (formerly Occupational Therapy)

Provider Category:

Agency

Provider Type:

Homemaker/Personal Care agencies

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Safety/Independence Evaluations (formerly Occupational Therapy)

Provider Category:

Individual

Provider Type:

Individual Occupational Therapist

Provider Qualifications

License *(specify):*

Home Safety/Independence Evaluation services must be performed by an Occupational Therapist with a valid Massachusetts license.

All occupational therapists must have a valid Massachusetts license, as governed by Massachusetts General Laws Chapter 112, Sections 23B to 23E.

Certificate *(specify):*

Other Standard *(specify):*

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).

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Laundry

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the approved waiver.**

Service Definition *(Scope):*

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

The person-centered planning process assures that waiver services are meeting the waiver participant's goals and assessed needs. The process identifies all services and supports and ensures that there is no duplication among them, or with Medicaid state plan services.

This service may not be provided at the same time when Homemaker or Companion services are being provided for the specific need of laundry assistance.

When a waiver participant may be concurrently receiving two services that are nominally duplicative or overlapping, duplication of tasks is not allowable. The case manager is responsible to ensure that the documentation in the participant's electronic record supports the service delivery and illustrates that there is no duplication. When more than one provider is involved, the care plan must describe how services from multiple providers are coordinated.

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	Provider Type Title
Agency	Laundry Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Laundry

Provider Category:

Agency

Provider Type:

Laundry Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Medication Dispensing System

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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 a signed, written agreement between the provider and the caregiver clearly delineating the responsibilities of each party.

The formal/informal caregiver is responsible for system monitoring, making sure that the system is functioning appropriately. The formal/informal caregiver is also responsible for dispensing medications at appropriate intervals.

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.

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	Provider Type Title
Agency	Specialized Medical Equipment Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Dispensing System

Provider Category:

Agency

Provider Type:

Specialized Medical Equipment Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years.

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Orientation and Mobility Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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	Provider Type Title
Individual	Certified Orientation and Mobility Specialists (COMS)
Agency	Human Service Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Orientation and Mobility Services

Provider Category:

Individual

Provider Type:

Certified Orientation and Mobility Specialists (COMS)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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.

Other Standard *(specify):*

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Orientation and Mobility Services

Provider Category:

Agency

Provider Type:

Human Service Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Individual providers and individuals employed by the agency providing Orientation and Mobility Services must have a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from an ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals)- certified university program.

Other Standard *(specify):*

Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:
- Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities.

Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies.

Staff providing services must have:
- Master's degree in special education with a specialty in orientation and mobility; or - bachelor's degree with a certificate in orientation and mobility from an ACVREP certified university program Individuals providing services must also have:
- Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual's customary environment.
- Knowledge and/or experience in educating caregivers or direct care staff, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with vision impairment or legal blindness, in sensitivity to low vision/blindness.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Peer Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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.

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

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

Not to exceed 16 hours per week.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Peer Support Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Peer Support

Provider Category:

Agency

Provider Type:

Peer Support Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Individuals providing Peer Support must have a Certificate of successful completion of Certified Older Adults Peer Specialist (COAPS) training.

Other Standard *(specify):*

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).

Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 19A, Section 23(a), to protect the privacy and security of the participant's protected health information. EOEA/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by EOEA and EOHHS officials.

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Senior Care Options (SCO)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **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 the 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.

Enrollment in SCO does not substitute for the requirement included in Appendix B-6-a that a participant must receive at least one waiver service per month in order to maintain waiver eligibility.

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	Provider Type Title
Agency	Senior Care Organization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Senior Care Options (SCO)

Provider Category:

Agency

Provider Type:

Senior Care Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Senior Care Organizations enrolled under 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

Entity Responsible for Verification:

MassHealth Office of Long Term Services and Supports

Frequency of Verification:

Annually

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supportive Day Program

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **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 the 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	Provider Type Title
Agency	Supportive Day Program Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supportive Day Program

Provider Category:

Agency

Provider Type:

Supportive Day Program Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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:
-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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supportive Home Care Aide

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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.

Supportive home care aide services are provided to participants with Alzheimer's Disease/Dementia or behavioral health needs, where the complexity of their needs requires the additional training and skills of a worker with training beyond that required for a homemaker, companion, personal care worker or home health aide.

The person-centered planning process assures that waiver services are meeting the waiver participant's goals and assessed needs. The process identifies all services and supports and ensures that there is no duplication among them, or with Medicaid state plan services.

Supportive Home Care Aide is not duplicative of Personal Care or Home Health Aide. These services differ by the type of assistance they provide and level of worker training, as described in their service definitions. Through the person-centered planning process, the participant's care needs and level of complexity are matched to the most appropriate waiver service, given those factors. This service may not be delivered at the same time as Personal Care or Home Health Aide, as each of those services provides a different level of assistance.

This service may not be provided at the same time when other services that include housekeeping tasks are being provided to complete the same task and address the same need. Supportive Home Care Aides may assist or supervise the participant with homemaking tasks when the tasks are incidental to the Supportive Home Care Aide service but may not perform these activities as discrete services.

When a waiver participant may be concurrently receiving two services that are nominally duplicative or overlapping, duplication of tasks is not allowable. The case manager is responsible to ensure that the documentation in the participant's electronic record supports the service delivery and illustrates that there is no duplication. When more than one provider is involved, the care plan must describe how services from multiple providers are coordinated.

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	Provider Type Title
Agency	Home Health Agencies
Agency	Homemaker/Personal Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supportive Home Care Aide

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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.

Other Standard *(specify):*

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).

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. For MH SHCA, the Home Care Aide Council Mental Health Supportive Home Care Aide training curriculum or equivalent is required. 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. For ADRD SHCA, 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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supportive Home Care Aide

Provider Category:

Agency

Provider Type:

Homemaker/Personal Care Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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.

Other Standard *(specify):*

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).

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. For MH SHCA, the Home Care Aide Council Mental Health Supportive Home Care Aide training curriculum or equivalent is required. 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. For ADRD SHCA, 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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional Assistance

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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 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; (i) activities to assess need, arrange for and procure need resources related to personal household expenses, specialized medical equipment, or community services; and (j) cell phones, tablets, computers, and ancillary equipment necessary for the operation of the devices that enable the participant to participate in telehealth. 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.)

This service includes device installation and set up costs but excludes installation and set-up and ongoing provision fees related to internet service.

This service may be provided remotely via telehealth based on the participant's needs, preferences, and goals as determined during the person-centered planning process as outlined in Appendix D. This service may be delivered remotely via telehealth 100% of the time. The methods and minimum frequency with which participants will receive face-to-face contact to ensure health and welfare are described in Appendix D. Additional information related to telehealth delivery of services in this waiver is provided in the Brief Waiver Description, B. Optional section of this waiver.

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

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

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Any agency or vendor providing goods and services in accordance with the service description.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Assistance

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Will meet applicable State regulations and industry standards for type of goods/services provided.

Telehealth providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their applicable regulations, as well applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 19A, Section 23(a), to protect the privacy and security of the participant's protected health information.
EOEA/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by EOEA and EOHHS officials.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the 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.

Participants may not receive duplicative services from Assisted Transportation, the MassHealth State Plan Medical Transportation, or the Transportation waiver service at time-of-service provision. The person-centered planning process assures that waiver services are meeting the waiver participant's goals, and that there is no duplication among them, or with Medicaid state plan 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	Provider Type Title
Agency	Transportation Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Transportation Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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.

Driver and Vehicle Requirements:
-Verification of valid driver's license, liability insurance, written certification of vehicle maintenance, age of vehicles; passenger capacity of vehicles; RMV inspection; seat belts; list of safety equipment; air conditioning and heating; first aid kits; snow tires in winter; and two-way communication.
-Assisting passengers on/off vehicles and from door to door
-Tracking and scheduling trips

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).

Providers must ensure that staff who transport must: have been CORI checked; experience providing services to individuals with disabilities; can handle emergency situations; and communicate effectively with participants, families, other providers and agencies.

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

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Virtual Communication and Monitoring (VCAM)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **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 the approved waiver.**

Service Definition *(Scope):*

Virtual Communication and Monitoring (VCAM) provides personal emergency and non-emergency response service. VCAM functionality includes:

- A response device that enables a 2-way audio and video connection and provides 24/7 access to a response center.
- The capacity for participant-initiated requests for emergency and non-emergency response from a response center.
- The capacity for scheduled assistance by response center staff as established through the person-centered planning process.

VCAM includes a personal emergency and non-emergency response service through an interactive, non-intrusive monitoring system and 2-way audio and video device. Devices are placed in an agreed upon location within the home, based on the participant's person-centered care planning and desire for location of a device. The participant always has the option to relocate or transport a device within the home to their desired location. These devices are activated at pre-determined times or as needed by the participant. The participant has control over the device at all times, including where to locate the device in the home and whether the camera is turned on or off. The system must have visual or other indicators that inform the participant when the VCAM system is activated. Placement of VCAM devices will be considered based on assessed need, privacy and right considerations, and the agreement of the participant and others who live in the home. Consents from the participant and others in the home will be documented in the participant's record.

VCAM video monitoring devices are not installed in a fixed location in the home and are under the control of the waiver participant at all times. Participants will be informed and educated about appropriate locations on where to locate their device.

This service supports participants' independence in their home and communities while minimizing the need for onsite staff presence and intervention. The use of VCAM supports the goal of maintaining independence in the least restrictive environment. Participants will be able to independently manage tasks like taking their medications with the additional support and supervision from the response center. This will increase the participants' health, welfare, and safety, and will enhance participants' independence in their homes, while decreasing their dependence on others to provide physical assistance with some tasks. VCAM empowers participants to be more active in their daily care needs.
The inclusion of VCAM as part of the person-centered care planning process will include education on participant roles, utilization of the device, and identification of the participant's choices regarding when the device should be active and/or frequency of engagement. Participants can reach out to their Case Managers at any time to request assistance and/or re-education on VCAM devices. The provider of VCAM service is responsible for troubleshooting, re-education, and correction of any technology issues or failures.

A backup plan is part of the development of the person-centered care planning process, authorization of the VCAM service, and part of the contract with the provider of the VCAM service. In the event of an equipment failure or a power outage, the response center will notify the ASAP/SCO that the device has been turned offline. ASAP/SCO staff will respond to the notification and follow up as needed.

Non-emergency and scheduled VCAM services are limited to cost effective, incidental remote supports that are not duplicative of other Medicaid services.

Participants may not receive duplicative services from VCAM and the MassHealth State Plan Personal Emergency Response System or the Enhanced Technology/Cellular Personal Emergency Response System waiver service.

The reimbursement rate includes the device and response center subscription, which pays for 24/7 access to staff at the response center.

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	Provider Type Title
Agency	Personal Emergency Response Providers
Agency	Virtual Communication and Monitoring Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Virtual Communication and Monitoring (VCAM)

Provider Category:

Agency

Provider Type:

Personal Emergency Response Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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, including non-emergency response and scheduled assistance; 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.

Providers must have the capacity to supply and support devices with a 2-way audio and video connection.

PERS providers have the capacity to provide both the waiver ET/CPERS service and VCAM.

PERS providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their application regulations, as well as applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 19A, Section 23(a), to protect the privacy and security of the participant's protected health information. EOEA/EOHHS relies on the providers' independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by EOEA and EOHHS officials.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Virtual Communication and Monitoring (VCAM)

Provider Category:

Agency

Provider Type:

Virtual Communication and Monitoring Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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, including non-emergency response and scheduled assistance; 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.

Providers must have the capacity to supply and support devices with a 2-way audio and video connection.

VCAM providers may not be providers of the waiver ET/CPERS service.

VCAM providers must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, and their application regulations, as well as applicable state law, M.G.L. Ch. 66A and M.G.L. Ch. 19A, Section 23(a), to protect the privacy and security of the participant’s protected health information. EOEA/EOHHS relies on the providers’ independent legal obligation as covered entities and contractual obligations to comply with these requirements. There is not a single state HIPAA compliance officer. This methodology is accepted by EOEA and EOHHS officials.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

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.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☒ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Case management is provided as an administrative activity by Aging Services Access Points (ASAPs) under contract with the Executive Office of Elder Affairs (EOEA). 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.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **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.

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):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements) establishes a registry to be maintained by the Massachusetts Department of Public Health which contains: 1) the names of individuals who are certified as nurse aides, and (2) sanctions, findings and adjudicated findings of abuse, neglect, and mistreatment of patients or residents and misappropriation of patient or resident property imposed upon or made against nurse aides, home health aides and homemakers for the abuse, neglect, mistreatment of patients or residents or misappropriation of patient or resident property. ASAPs are required to verify provider agency compliance with 105 CMR 155.000 as part of on-site reviews.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

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

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

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-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

  ☐ **Self-directed**

  ☐ **Agency-operated**

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:

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 Aging Services Access Points (ASAPs). 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, 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 blind.

ASAPs must contract with any qualified provider who is willing to accept the terms and conditions. The enrollment period for Frail Elder Waiver service providers is a continuous open enrollment period.

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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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.***

Performance Measures

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

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

Performance Measure:
QPa1.The % of all contracted waiver service providers required to maintain licensure/cert in accordance with waiver/state requirements, who adhered to the specifications. Num:# of waiver service providers required to maintain licensure/cert that adhered to these specifications Den:# of waiver service providers required to maintain licensure/cert that were due for review during the reporting period

Data Source (Select one):
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: ASAPs and Senior Care Organizations (SCO)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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:

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

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

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

Performance Measure:
QPb1.The % of non-licensed/non-certified waiver service providers who adhered to provider qualification specifications, in accordance with state requirements. Num: # of non-licensed/non-certified waiver service providers that demonstrated compliance

with qualification requirements Den: # of non-licensed/non-certified waiver service providers that were due for review during the reporting period

Data Source (Select one):
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: ASAPs and Senior Care Organizations (SCO)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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**

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

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

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

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

Performance Measure:
QP c1. The percentage of waiver waiver service providers who has an audit completed who 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 that were due for review during the reporting period.

Data Source (Select one):
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: ASAPs and Senior Care Organizations (SCO)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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:

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

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 States 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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **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; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **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: Participant Services

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 Executive Office of Elder Affairs (EOEA), an agency within EOHHS that has primary responsibility for day-to-day operation of the Frail Elder Waiver, undertook a review of all their regulations, standards, policies, service descriptions, and other provider requirements to ensure compliance of settings with all applicable HCBS Community Rule 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 are presumed to be fully compliant with the HCBS Community Rule settings requirements. 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.

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.

All settings receive ongoing monitoring for all service requirements as part of the existing waiver case management monitoring process, to ensure continued compliance with all applicable HCBS Community Rule requirements.

This monitoring occurs as part of the annual person-centered planning process and during regular contacts with the ASAP or SCO case manager or RN. The case manager or RN meets with the participant at least every six months. In addition, the case manager maintains regular contact with the participant through a variety of means (e.g., in person, telephone, video-conferencing, text messaging, e-mail contacts, and/or other electronic modalities) and in the ways the participant prefers between visits. Every participant has direct in-person contact at least twice annually. The frequency of contact with a participant is based on the participant's individual needs. Participants with changing needs experience more frequent contact based on their individual needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

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 *(select 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:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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 Service 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.

Case Management in this waiver is an administrative activity and not a waiver service, so the case manager is never the waiver service provider. The Executive Office of Elder Affairs conducts ongoing on-site reviews and desk audits of each ASAP, as described in Appendix A-6. EOEA evaluates ASAP performance every two years pursuant to a process of designation review. M.G.L. c. 19A, § 4B authorizes EOEA to establish a coordinated system of care to be administered by ASAPs as designated and contracted by EOEA. As part of the contract between EOEA and the ASAPs, EOEA conducts designation reviews every two years to evaluate ASAP performance. The most recent contract between EOEA and the ASAPs was effective July 1, 2023.

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.

The ASAPs are prohibited from providing waiver services except for nutrition services. In the instance where there are no available waiver service providers for other waiver services, the ASAP can request a direct service waiver from the Secretary of Elder Affairs to be able to provide the service. The Secretary issues an approval of that waiver, in accordance with M.G.L. 19A. These requests are approved in cases where there would be a gap or inequity in access to waiver services unless the ASAP is approved to provide the service. These direct service waivers are typically approved for no more than two years at a time. Per the ASAP contract, waivers are issued for a finite period, in order to ensure that the conditions for granting such a waiver remain applicable.

A Senior Care Organization does not provide direct waiver services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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.

TThe 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 RN Case Managers utilizing a person-centered planning approach and assessment tool designed to assist 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 their 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 RN Case Manager meets with the participant or authorized representative prior to any Comprehensive Service Plan meeting to ensure the participant has the information their 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 CSP 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 CSP development. This is documented in the member's record in the EOEA Designated Cloud-Based Data Enterprise System.

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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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, ASAP/SCO Case Managers and Registered Nurses follow standard procedures and time frames in performing the intake, service needs 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). Timeframes are outlined in 651 CMR 3.00, Sub-regulatory guidance, and the ASAP contract.

Waiver participants' needs are identified throughout the referral, service 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 service 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 CSP development processes follow EOEA-mandated procedures in 651 CMR 3.05 and in Program Instructions 09-12 and 09-20.

The initial assessment for service needs and development of the Comprehensive Service Plan (CSP) is conducted by a Case Manager or an ASAP RN. Service needs 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 CSP. The Case Manager or RN explains programs and services to the participant and assists them with clarifying their 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 CSPs 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 person-centered planning process assures that waiver services are meeting the waiver participant's goals and assessed needs, and that there is no duplication among them, or with Medicaid state plan services.

The case manager, along with the Interdisciplinary Care Planning Team, is responsible for ensuring that waiver services are meeting the waiver participant's goals and assessed needs, and that there is no duplication among them, or with Medicaid state plan services. This is accomplished through the comprehensive assessment and person-centered planning processes, which require the case manager to have extensive and detailed knowledge of all the services and supports available to the participant in order to avoid duplication and inappropriate use of services in the CSP.

The CSP is the authorization mechanism for all waiver services; there are no additional prior authorization requirements imposed on any waiver services.

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. EOEA Program Instruction 11-06 governs this process. A risk level assessment worksheet is used to determine an individual's level of risk. Risk level is determined through a review of both the risk factors that are present and the level and quality of informal support available to the individual.

The participant/representative may choose to identify other people or other members of the Interdisciplinary Case Management Team to be present for the assessment visit and subsequent service planning meetings. The waiver participant/representative may also choose to exclude individuals from the CSP 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 their representative, is not English, the information in service plans must be translated into their 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 their understanding of the service plan, and they do 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 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. Case Managers are responsible for service plan development. The RN plays a supporting role as a member of the interdisciplinary team to ensure that all the participants' needs are met.

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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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.

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.

EOEA Program Instruction 11-06 sets the requirements for the identification of management and risks. ASAPs utilize a risk level assessment worksheet in order to determine an individual's level of risk. Risk level is determined through a review of both the risk factors that are present and the level and quality of informal supports available to the individual. The risk assessment worksheet is used as a tool, where the identified risks are listed out, and an evaluation is conducted in order to identify preventive measures and supports to minimize risks, as well as those identified to help or support.

After risk is initially assessed, it is reassessed at least once annually and as necessary when an individual's circumstances change.

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. Back-up plans may include identification of other formal or informal supports. 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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 will provide a list of available providers on an ongoing basis. 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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.

EOHHS is the single state agency for administration of the Medicaid program in Massachusetts. EOEA, a state agency within and subject to the oversight authority of EOHHS conducts the review of a sample of service plans. The ASAPs and SCOs are responsible for the day-to-day operations, and they are the ones who approve the service plans. ASAPs are acting in accordance with their contracts with EOEA, and SCOs are acting in accordance with their contracts with EOHHS.

Service Plans are reviewed for content, quality, and required components. The sample size is intended to meet requirements of a 95% confidence level and a +/-5% margin of error 95/5 response distribution.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

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 EOEA Designated Cloud-Based Data Enterprise System. 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, at the ASAP offices.

Similarly, SCOs maintain electronic and paper records on all waiver participants. Electronic records are maintained in the SCO electronic health record and paper records are maintained at the SCO offices.

All records are maintained for seven years after the date the case is closed.

Appendix D: Participant-Centered Planning and Service Delivery

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, their representatives and members of the Interdisciplinary Case Management team. The RN plays a supporting role as a member of the interdisciplinary team to ensure that all the participants' needs are met.

Every participant has an in-person meeting at least twice annually; this may include the ASAP or SCO case manager visit and an annual Level of Care assessment by an ASAP or SCO RN. The case manager or RN may determine that additional contact would be necessary in response to changes in the participant's health condition, formal or informal supports or other changes. Assessment and contacts 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 (e.g., in person, telephone, video-conferencing, text messaging, e-mail contacts, and/or other electronic modalities) and in the ways the participant prefers between the in-person meetings. The frequency and method used to engage with participants based on their preferences will be documented in the participants' electronic record. Contact requires a response from, and engagement with, the participant, guardian, or other specified family member in order to be considered monitoring. Case managers and nurses conduct assessments in the home but, when necessary or based on participant choice, they may be completed at another location. In cases where the participant elects an approach that does not include an in-person visit, the assessor is expected to draw on other sources of information about the participant, including the case manager, other providers, family members, or other individuals or organizations providing support to confirm safety in the home. 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 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. Documentation is in a progress note in the member's electronic record. Part of the supervisory review is to ensure that this is completed.

The person-centered planning process assures that waiver services are meeting the waiver participant's goals and assessed needs, and that there is no duplication among them, or with Medicaid state plan services.

Case managers or RN monitor services to ensure they are delivered in accordance with the CSP and that they are meeting the participant's needs and preferences. Case managers are in continuous contact with waiver participants and with their informal supports. This contact happens primarily via phone calls between scheduled visits. Case managers also communicate regularly with waiver and non-waiver service providers for the purposes of coordinating care and services for the waiver participants. This communication is meant to ensure that the waiver participant is accessing services in accordance with their service plan, and that services are continuing to meet participants' needs. Policies are outlined in the ASAP contract and monitoring by EOEA is done through the designation review process. 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 their 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, as well as in other sections of Appendix D:

a) Assessment of health and welfare concerns such as abuse, neglect, poor hygiene, environmental safety, falls risk, and medication management needs (Appendix G performance measures)
b) incident reporting and management (described in Appendix G)
c) investigations process (described in Appendix G)
d) risk assessment and mitigation system (Appendix D-1-e)
e) periodic progress and update meetings (Appendix D-1-d)
f) ongoing contact with the participant and service providers (Appendix D-1-d).

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.

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' CSPs have all needs identified and addressed through either waiver or non-waiver services, the State reviews a statistically significant sample of participant records.

SCOs do not provide direct waiver services to their enrollees.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

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.***

Performance Measures

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

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

Performance Measure:
SP a1. The percentage of waiver participants who have received the required assessment, which includes a health and safety assessment, using the proper tool. Numerator: Number of waiver participants with a completed assessment on the required tool Denominator: Number of waiver participants

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

	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
EOEA designated cloud-based data enterprise system

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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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:
SP a2. The percentage of service plans that have been developed in accordance with waiver requirements. Numerator: Number of waiver participants with a service plan developed in accordance with waiver requirements Denominator: Number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
EOEA review of data in EOEA designated cloud-based data enterprise system

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 =

		95% confidence interval, +/-5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☒ **Annually**	☒ **Stratified** Describe Group:

Senior Care Organizations (SCOs)		By SCO: 95% confidence interval, +/-5% margin of error
	☐ **Continuously and Ongoing**	☐ **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:
SPa3. The percentage service plans that address personal goals through waiver services or through other means. Numerator: Number of consumers whose person-centered goals are addressed during service plan development Denominator: Number of waiver participants with an active service plan

Data Source (Select one):
Other
If 'Other' is selected, specify:

EOEA review of data in EOEA designated cloud-based data enterprise system

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 = 95% confidence interval, +/-5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
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**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Senior Care Organizations (SCO)	☒ **Annually**	☒ **Stratified** Describe Group: By SCO: 95% confidence interval, +/-5% margin of error
	☐ **Continuously and Ongoing**	☐ **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**

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
SP c1. The percent of participants who had a review of their service plan documented by their Case Manager 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):
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**	☐ **Weekly**	☐ **100% Review**

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
EOEA designated cloud-based data enterprise system

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

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.

Performance Measures

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

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

Performance Measure:
SP d1. The percentage of services that were delivered according to the type, scope, amount, duration, and frequency identified in the service plan. Numerator: Number of service units delivered for all waiver participants Denominator: Number of service units authorized in the service plan for all waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service plan data and service delivery data from EOEA designated cloud-based data enterprise system

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

	☐ **Other** Specify:	

Data Source (Select one):
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: SCOs	☒ **Annually**	☒ **Stratified** Describe Group: By SCO: 95% confidence interval, +/-5% margin of error
	☐ **Continuously and Ongoing**	☐ **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:

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

Performance Measures

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

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

Performance Measure:
SP e1. The percentage of waiver participants who 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):
Other
If 'Other' is selected, specify:
EOEA review of data in EOEA designated cloud-based data enterprise system

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 = 95% confidence interval, +/-5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
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: Senior Care Organizations (SCO)	☒ **Annually**	☒ **Stratified** Describe Group: By SCO: 95% confidence interval, +/-5% margin of error
	☐ **Continuously and Ongoing**	☐ **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 States 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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

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

Each year at the time of the Comprehensive Service Plan development process, participants will be given the opportunity to self-direct certain services as specified in this application. The Case Manager will assess, based on established criteria, the participant's ability to self-direct and what supports may be needed to ensure success. Self-direction opportunities will be available to all participants enrolled in the waiver.

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

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

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

The case management entity conducts the Criminal Offender Record Information (CORI) check.

The worker has the option to enroll with the FI into a direct deposit payment system into the worker's bank account in which case, the participant will notify the FI to do so. The worker may choose to apply for a payroll debit card to receive payment or has the option to receive payment by check.

The FI is responsible for tracking time worked to enable MassHealth to calculate payments to be made in accordance with FLSA requirements, including but not limited to payments for overtime. In addition, the FI will track the accumulation of earned paid time to enable MassHealth to make earned paid time payments and which satisfies the requirements of the Massachusetts sick time law at Massachusetts General Law chapter 149, section 148C.

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individuals' family or guardian has domain and control.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Self-direction opportunities will be available to all participants enrolled in the waiver. Participants must express their desire to self-direct services and may be assessed for their need for a surrogate to assist them to self-direct. The need for surrogacy will be assessed during the service planning process by the care planning team and reviewed annually. If it is determined the participant needs a surrogate, the participant will seek a voluntary surrogate from family, friends, or other sources.

The state does not exclude participants from self-direction solely on the basis of an assessment that the individual, in isolation, is unable to carry out some of the responsibilities associated with participant direction.

The Case Manager will provide or arrange for skills training to the participant or participant's unpaid surrogate and assist the participant/surrogate in on-going management of the self-directed supports. Should evidence arise that a participant who is self-directing their services is no longer able to do so, they will be offered the option to have a surrogate, as described above, to assist with their self-direction decisions. If a participant who has been assessed to require surrogacy does not wish to use or continue to use a surrogate they will not be able to self-direct and will transition to receiving supports through a traditional provider. Appeal rights will be granted.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

As part of the intake and waiver eligibility process, information about the waiver and opportunities for self-direction will be provided to each waiver participant. The range of options will be discussed as part of the person-centered planning process and throughout the implementation of the POC by the Case Manager. The Case Manager will provide written materials to the participant describing both the benefits and potential liabilities of self-direction, and the role of the Fiscal Intermediary in managing these services. When a participant elects to self-direct some of their services, additional information and a handbook about the Fiscal Intermediary (FI) and the requirements for self-directing will be provided, including information about the Consumer Directed Care ASAP-Consumer Agreement.

Case Managers provide waiver participants with information about the opportunity to self-direct. This education is done primarily in person, with supplemental information provided per the participant's preferences – either by email, mail, or phone. Case Managers use a consumer handbook to assist with these education efforts and engage with waiver participants to address any additional concerns or learning that may need to occur. Case Managers are required to document all interactions with waiver participants and their families in the participant's electronic record.

The FI has the responsibility for providing fiscal services related to income tax and social security tax withholding, and state worker compensation taxes.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The state's practice is to allow waiver participants the opportunity to self-direct their waiver services independently if they are able to do so, or with assistance if needed from a non-legal representative chosen by the waiver participant.

For non-legal representatives, the extent of the decision-making authority is determined by the participant and outlined in the Consumer-Directed Care ASAP-Consumer Agreement. In addition, the representative may not be paid to provide waiver services to the participant.

The case manager will provide support as needed to the waiver participant to ensure that proper safeguards are in place to ensure effective oversight and implementation of the POC.

The waiver participant and the participant's non-legal representative delineate agreed upon responsibilities of the representative in the Consumer Directed Care ASAP-Consumer Agreement. The case manager will address any concerns they have about self-directed services through regular meetings with the waiver participant and their representative. In addition, meetings can occur anytime an issue or concern arises.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Homemaker	☒	☐
Companion	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Fiscal Intermediary (FI) will be provided through a financial management service entity. These services are procured in accordance with state procurement laws. The FMS procurement results in the selection of a single vendor.

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

The FI will be furnished as an administrative activity. The administrative fee is contracted by each case management entity and is required to use the MassHealth established rate paid on a per person per day basis for each participant who chooses to self-direct. Monthly and on an annual basis the case management entity and FI review monthly expenditures of self-directed service and the administrative task fee for the purpose of reconciliation activities.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

☐ **Maintain a separate account for each participant's participant-directed budget**

☐ **Track and report participant funds, disbursements and the balance of participant funds**

☐ **Process and pay invoices for goods and services approved in the service plan**

☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The case management entity will manage the performance of the FI via contract. The case management entity will establish performance metrics as part of the FI contract and will require that its FI meet them and have an established process of remediation if they do not achieve them. Monthly FI reports will reconcile expenditures for a participant with that participant's approved comprehensive service plan. The FI is also required to maintain a log of complaints.

The ASAPs, in conjunction with the SCOs, establish performance metrics that are specific to the self-direction model, focusing on financial processes including invoicing and payment. The state supports the development of these metrics. Monitoring of these metrics and remediation efforts are ongoing. Official monitoring of the FI contract is done every three years by the ASAPs.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Each participant who desires to self-direct their services will be assessed to determine their capacity to do so and the types of supports that will be required to assist them. Each Participant will have a Case Manager to provide information and assistance to support self-direction. The Case Manager will monitor the implementation of the support plan and provide coordination and oversight of supports. The role of the Case Manager in individual planning is to support the person and other team members to develop and implement a plan that addresses the participant's needs and preferences. Case Managers support participants to be actively involved in the planning process, share information about choice of qualified providers and self-directed options, and assist with arranging supports and services as described in the plan. They also support the participant to monitor services and make changes as needed. The Case Manager may also support participants to:

- hire, train and manage their employees;
- develop emergency back up plans; and
- access and develop self-advocacy skills.

Information and assistance to support self-direction is included as an Administrative Activity as part of the Administrative Case Management functions. As noted in Appendix C-1-b, case managers are employed by ASAPs and SCO programs. Case managers review a Consumer Directed Care Employer Service Agreement with waiver participants. This document educates the waiver participant on aspects of self-direction, including what is involved with employing workers and consumer/surrogate responsibilities. Case Managers are responsible for ensuring that participants understand their responsibilities under self-direction and that the participant has signed the Consumer Directed Care ASAP-Consumer Agreement. As case managers provide all information and assistance in support of self-direction, there is no duplication. The assessment tool used is contained in the Consumer Directed Care Employer Service Agreement.

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Assistive Technology for Telehealth	☐
Home Delivery of Pre-packaged Medication	☐
Senior Care Options (SCO)	☐
Transitional Assistance	☐
Home Delivered Meals	☐
Home Health Aide	☐
Supportive Home Care Aide	☐
Personal Care	☐
Chore	☐
Homemaker	☐
Laundry	☐
Complex Care Training and Oversight	☐
Supportive Day Program	☐
Companion	☐
Peer Support	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Alzheimer's/Dementia Coaching	☐
Grocery Shopping and Delivery	☐
Virtual Communication and Monitoring (VCAM)	☐
Evidence Based Education Programs	☐
Home Based Wandering Response Systems	☐
Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS)	☐
Environmental Accessibility Adaptation	☐
Respite	☐
Assisted Transportation	☐
Medication Dispensing System	☐
Goal Engagement Program	☐
Home Safety/Independence Evaluations (formerly Occupational Therapy)	☐
Transportation	☐
Assistive Technology - Electronic Comfort Animals	☐
Orientation and Mobility Services	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Each participant who desires to self-direct their services will be assessed by their case manager to determine their capacity to do so and the types of supports that will be required to assist them. Each Participant will have a Case Manager to provide information and assistance to support self-direction.

The Case Manager supports the participant, their representative, or their surrogate in arranging for, directing, and managing waiver services. Assistance is provided in identifying immediate and long-term needs, developing options to meet those needs and accessing identified waiver supports and waiver services. Participants or their representatives may also receive information on recruiting and hiring direct service workers, managing workers and providing information on effective problem solving and communication. The Case Manager function includes providing information to ensure that the participant or representative understands the responsibilities of directing their own services; the extent of assistance needed by the participant is discussed by the team and specified in the service plan. The Case Manager will assist in developing the self-direction specifics of the POC to ensure that the needs and preferences are clearly understood and reflected in the plan and will ensure the participant receives skills training, if needed, to enable them to arrange for, direct and manage waiver services.
The Case Manager will focus on the following sets of activities in support of participant-directed services:

- Support the individual to recruit, train and hire staff;
- Facilitate community access and inclusion opportunities;
- Monitor and assist the individual participant when revisions to the POC are needed; and
- Support the participant in working with the Fiscal Intermediary to recruit, screen, hire, train, schedule, monitor and pay support workers.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

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

The case manager is responsible for establishing a transition of services that ensures the participant's health and welfare. There is no set transition period as the process is person-centered and based on the transition plan established by the case manager through an interdisciplinary care management team meeting with the participant. The waiver participant signs a form to indicate their decision to terminate self-directed services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

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

The Case Manager is responsible for establishing a transition of services that ensures the participant's health and welfare. There is no set transition period as the process is person-centered and based on the transition plan established by the Case Manager through an interdisciplinary care management team meeting with the participant. The termination action is appealable.

Although the State will work to prevent situations of involuntary termination of self-direction, they may be necessary. Reasons for involuntary termination of self-direction will include (but not be limited to) such things as refusal on the part of the participant to be involved in the development and implementation of the person-centered care Planning Process, the participant authorizing payment for services or supports that are not in accordance with the plan of care, the participants commission of fraudulent or criminal activity associated with self-direction, demonstration that the participant requires a surrogate to ensure adequate management of workers, but declines such surrogate when informed one is necessary in order to self-direct, on-going inability to locate, supervise, and retain employees, and/or to submit time-sheets in a timely manner, and other individual circumstances that may preclude continued self-direction.

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	44	
Year 2	87	
Year 3	131	
Year 4	174	
Year 5	174	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

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

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

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Criminal background checks are conducted in accordance with processes outlined in Appendix C-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☐ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☐ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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. The Fair Hearing request form includes contact information should individuals need a verbal explanation. 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 in accordance with 42 CFR §431.211. 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 which is rendered within 60 days of the hearing. Individuals are notified in writing 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 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.).

Copies of notices of adverse actions and the notices regarding Fair Hearings are maintained in the participant's paper or electronic record.

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.

Appendix F: Participant-Rights

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: Participant-Rights

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 or through the secure Critical Incident Report portal 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, reporting is required for critical incidents involving abuse, neglect, exploitation, or unexplained death involving an unpaid caregiver, family member, or other informal support to Protective Services. Reporting of critical incidents involving abuse, neglect, exploitation, or unexplained death by a paid caregiver would be to the Department of Public Health (DPH). Reports of critical incidents of abuse, neglect, exploitation, or unexplained death are made in accordance with Mandated Reporting requirements outlines in 651 CMR 5.00 and 105 CMR 155.

All ASAP/SCO case managers and RN's are Mandated Reporters and are required to report incidents of abuse, neglect, exploitation, and unexplained death.

The Executive Office of Elder Affairs administers a statewide system for receiving and investigating reports of elder abuse, neglect and unexplained death, 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, self-neglect, and unexplained death, 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 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, mistreatment, misappropriation of patients' property/financial exploitation, and unexplained death by paid caregivers such as home health aides and homemakers. DPH is required to immediately notify the Attorney General after receiving the oral or written report. DPH must then conduct an investigation into the allegations contained in the report within 24 hours after receipt of the oral report and within 7 days after receipt of the written report. DPH also must maintain a registry which contains any findings which conclude that the individual about whom the complaint was registered, did, in fact, commit the acts. In accordance with 105 CMR 155.008 if DPH finds that a patient has died as a result of abuse, neglect, or mistreatment DPH must immediately report such death to the Attorney General and the District Attorney for the county in which such death occurred, and the medical examiner for said county. 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 they have 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 reviewing 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 they have a concern related to abuse, neglect or financial exploitation.

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

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, financial exploitation, and unexplained death in accordance with 105 CMR 155.00: PATIENT AND RESIDENT ABUSE PREVENTION, REPORTING, INVESTIGATION, PENALTIES AND REGISTRY (the state's mandated reporter regulation). In the instance where the participants (and their families/legal representatives) are the complainant, they are informed of investigation results at the conclusion of the investigation, consistent with the timing for mandated reporters. Investigation reports are also available upon request. 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.

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, financial exploitation, and unexplained death 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.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

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, mistreatment, and unexplained death, 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.

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

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **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, mistreatment, and unexplained death, 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.

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:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

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, mistreatment, and unexplained death, 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.

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 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: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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. The scope, frequency, and methods of monitoring of participant medication regimens are governed by the licensure for the setting. Waiver participants are treated the same as other residents of these settings.

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).

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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

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

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

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.

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. The state licensure/certification agency is responsible for the trending in the aggregate for all individuals in the setting, including waiver participants.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 instancesof 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.)*

Performance Measures

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

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

Performance Measure:
H&W a1. Percentage of waiver participants who were assessed to identify concerns of abuse and neglect. Numerator: Number of waiver participants with a documented assessment of abuse and neglect Denominator: Total number of waiver participants

Data Source (Select one):
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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
EOEA designated cloud-based data enterprise system

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**	☐ **Weekly**	☒ **100% Review**

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

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

Performance Measure:
H&W a2. Percentage of case management entity staff who 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):
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: ASAPs and Senior Care Organizations (SCO)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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 a3. Percentage of waiver service provider staff who 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):
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: ASAPs and Senior Care Organizations (SCO)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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:

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

Performance Measure:
H&W a4. Percentage of case management entity staff who received training on their responsibilities as mandated reporters of abuse, neglect, exploitation, and unexplained death. Numerator: Number of case management entity staff that were trained on abuse, neglect, exploitation, unexplained death, and mandated reporter requirements Denominator: Number of case management entity staff

Data Source (Select one):
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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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&Wa5. % of provider performance monitoring that ensured waiver service providers were trained on responsibilities as mandated reporters of abuse, neglect, exploitation & unexplained death. Num:# waiver service provider agencies audited with documented staff training on abuse, neglect, exploitation, unexplained death & mandated reporter requirements Denom:# waiver service provider agencies audited

Data Source (Select one):
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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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:

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

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 Measures

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

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

Performance Measure:
H&Wb1. The percentage of reported critical incidents affecting waiver participants that had action/safety plans implemented, according to applicable EOEA requirements. Num: Number of reported critical incidents affecting waiver participants that had action/safety plans implemented, according to applicable EOEA requirements Den: Number of reported critical incidents affecting waiver participants

Data Source (Select one):
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**	☐ **Annually**	☐ **Stratified**

Specify: ASAPSs and Senior Care Organizations		Describe Group:
	☒ **Continuously and Ongoing**	☐ **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:

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

Performance Measures

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

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

Performance Measure:
H&W c1. % of reported incidents of the unauthorized use of restraints/restrictive interventions that had follow-up, according to EOEA requirements. Num: Number of reported incidents of the unauthorized use of restraints/restrictive interventions that had follow-up, according to EOEA requirements Den: Number of reported incidents of the unauthorized use of restraints/restrictive interventions

Data Source (Select one):
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: ASAPs and Senior Care Organizations (SCO)	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **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&Wc.2.% of risk mitigation & prevention measures implemented in response to reported incidents of the unauthorized use of restraints/restrictive interventions N:# of reported incidents of unauthorized use of restraints/restrictive interventions for which risk mitigation & prevention measures are implemented D:# of reported incidents of unauthorized use of restraints/restrictive interventions

Data Source (Select one):
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: Responsible Party for data aggregation and analysis	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **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:

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

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 Measures

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

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

Performance Measure:
H&W d1. Percentage of waiver participants who 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):
Other
If 'Other' is selected, specify:
EOEA designated cloud-based data enterprise system

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**	☐ **Stratified** Describe Group:

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

Data Source (Select one):
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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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 d2. Percentage of waiver participants who 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):
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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
EOEA designated cloud-based data enterprise system

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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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 d3. Percentage of waiver participants who 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):

Other
If 'Other' is selected, specify:
EOEA designated cloud-based data enterprise system

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

Data Source (Select one):
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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **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:

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

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 States 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

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 Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* 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 QIS 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.

Appendix H: Quality Improvement Strategy (2 of 3)

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, Assistant 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
Quality oversight at the participant level include ASAP and State level reviews of person-centered care plans, timely investigation and resolution of complaints, critical incidents, on-going review of consumer goals, and redetermination of level of care.

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 and monitored waiver service providers. SCOs are responsible for conducting monitoring activities for each provider with whom they hold a direct contract. The following activities apply to all waiver providers; unless variations are noted below.
-Providers receive onsite audits by ASAPs and/or SCOs 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 EOEA's designated cloud-based data enterprise system 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 EOEA's designated cloud-based data enterprise system. 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 regularly 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 and Lean Six Sigma principles including identification and removal of 8 process wastes to improve efficiency and outcomes.

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 strategizes to shift quality improvement with ongoing training, support, and coaching to ASAPs to enhance processes and outcomes.in alignment with the following steps in the quality improvement process.

•Create a problem opportunity statement to define the problem
•Identify team roles, stakeholders and communication strategies
•Produce an AIM Statement that is specific, measurable, attainable, realistic and timebound
•Identify process and establish measures (process, outcome and balance)
•Use root cause analysis to select and prioritize change ideas
•Implement and test changes through the Plan, Do, Study, Act (PDSA) cycle

Utilize various tools, such as run and 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.
•Build Storyboards to share and spread results and lessons learned from quality improvement initiatives. Storyboards are an effective way to visually capture and share prior work and plan for future work.

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 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 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 regularly meets with ASAPs confirming QIS waiver measures, improvement strategies, outcomes and sustainment efforts. EOEA periodically surveys ASAPs.

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.

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

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

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

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

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

Appendix I: Financial Accountability

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 EOEA designated cloud-based data enterprise system and the Medicaid Management Information System (MMIS). ASAP staff utilize EOEA designated cloud-based data enterprise system to confirm the delivery of services, the units of delivered services and the cost of all services prior to submitting claims to Medicaid. The EOEA designated cloud-based data enterprise system 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 EOEA designated cloud-based data enterprise system 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 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. SCO plans submit quarterly reports of progress toward compliance metrics to MassHealth. MassHealth's Program Integrity Unit conduct audits on an ad hoc basis. They review paid claims and encounter data in order to identify any overpayment, fraud, waste, or abuse. 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.

(d) 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) 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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
FA a1. Percentage of services that were billed in accordance with established waiver service payment rates and the rate methodology specified in the approved waiver.
Numerator: The total dollar value of processed MMIS claims for waiver participants
Denominator: The total dollar value of service claims submitted for waiver participants

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:
Reports from EOEA designated cloud-based data enterprise system and MMIS data

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

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
FA b1. Percentage of provider payment rates that 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):*
Financial records (including expenditures)
If 'Other' is selected, specify:
Reports from EOEA designated cloud-based data enterprise system and MMIS data

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

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: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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.

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 and PI #22-01 (Provider Service 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 EOEA designated cloud-based data enterprise system and are available for EOEA review. This approach

applies to the following waiver services:
- *Alzheimer's/Dementia Coaching*
- *Assisted Transportation*
- *Chore*
- *Companion*
- *Enhanced Technology/Cellular PERS*
- *Evidence Based Education Programs*
- *Goal Engagement Program*
- *Grocery Shopping and Delivery*
- *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 (partial and full day)*
- *Supportive Home Care Aide*
- *Transportation*
- *Virtual Communication and Monitoring (VCAM)*

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 set at the rate for this service established in 101 CMR 359.00: Rates for Home and Community Based Services Waivers, which set the rate for services in the Acquired Brain Injury and Moving Forward Plan HCBS waivers.

4. 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*
- *Assistive Technology for Telehealth*

- *Assistive Technology - Electronic Comfort Animals*

6. Self-directed services are paid through the Fiscal Management Service Agency (FMS), also known as Fiscal Intermediary (FI) are set at the rate for these services, provided as self-directed services, established in 101 CMR 359.00: Rates for Home and Community Based Services Waivers, which sets the rate for services in the Acquired Brain Injury and Moving Forward Plan HCBS waivers. This applies to self-directed Companion and self-directed Homemaker services. The waiver case manager will inform the participant of the availability of information about self-directed waiver services payment rates, as well as all other waiver service payment rates.

7. 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 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, EOEA Designated cloud-based data enterprise system. The ASAP submits claims to the state's MMIS via EOEA designated cloud-based data enterprise system. On a routine/monthly basis, the claim data is electronically submitted to MMIS for claim editing and processing. Providers may bill the state directly.

When a participant chooses one of the Participant Directed Services listed in Appendix E-1, the Participant Directed Service will be included in the participant's Plan of Care (POC). The POC will include the frequency and duration of the authorized Participant Directed Service. The participant will submit their timesheet weekly to the Fiscal Intermediary (FI) for each worker who provided Participant Directed Services. The FI will pay the worker and bill the ASAP for these services. The ASAP will then follow the process outlined above, utilizing the Data Enterprise System to submit claims to the state's MMIS. Providers may bill Medicaid directly. Direct billing instructions are provided upon request.

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

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

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.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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 eligibility data to ensure that a client is enrolled in a Medicaid waiver program prior to payment of claims. The EOEA designated cloud-based data enterprise system 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. These MMIS and EOEA designated cloud-based data enterprise system checks occur in the billing validation process, and result in the removal of any inappropriate billings, prior to the calculation of FFP.

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.

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: Financial Accountability

I-3: Payment (1 of 7)

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) and 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:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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. The Fiscal Intermediary is also reimbursed by the ASAP on a monthly basis subsequent to the direct care worker's submission of a timesheet following the provision of services, the confirmation that services are consistent with the self-directed services authorized in the Comprehensive Service Plan and upon receipt of an invoice.

EOEA designated cloud-based data enterprise system maintains the audit trail for services provided and claimed for Federal Financial Participation.

Direct billing instructions are provided upon request.

As outlined in Appendix A-2-a, MassHealth and EOEA have an Interagency Service Agreement that specifies the functions of MassHealth and EOEA related to operation of the waiver.

ASAPs are responsible for recruitment and ongoing oversight of the waiver service provider network. In relation to self-directed waiver services, ASAPs are responsible for contracting with and oversight of the Fiscal Management Service (FMS) also known as the Fiscal Intermediary (FI). The Executive Office of Elder Affairs is responsible for oversight of all ASAP activities, including ensuring that remediation strategies are implemented within appropriate timelines if/when any issues are discovered related to ASAPs' operation of the FI contract.

Monitoring and oversight of the FI billing processes happen continuously, as case management entities (ASAPs and SCOs) must address issues as they arise. The state supports the ASAPs and SCOs in remediation efforts. Official monitoring of the FI contract is done by the ASAPs every three years.

☒ ***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.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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.

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

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.

- ○ ***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 ?1115 waiver specifies the types of health plans that are used and how payments to these***

plans are made.

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

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:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

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:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

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: Financial Accountability

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: Financial Accountability

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: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

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.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

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

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-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: 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 (Col 7 less Column4)
1	24995.80	14146.00	39141.80	72301.68	2898.43	75200.11	36058.31
2	25488.83	14533.57	40022.40	74282.60	2977.84	77260.44	37238.04
3	25965.15	14932.29	40897.44	76320.49	3059.53	79380.02	38482.58
4	26439.72	15343.03	41782.75	78419.85	3143.69	81563.54	39780.79
5	26903.11	15765.62	42668.73	80579.78	3230.28	83810.06	41141.33

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	20000	20000
Year 2	20000	20000
Year 3	20000	20000
Year 4	20000	20000
Year 5	20000	20000

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

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) 2021 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 2021. 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: 279.47 (WY1); 279.66 (WY2); 279.86 (WY3); 280.08 (WY4); 280.31 (WY5).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D costs are based on the following:

-Number of Users:
The estimated number of users for each 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 average number of users in Waiver Year 2019, 2021, and 2022. For services with no utilization in WY 2019, estimates were based on average utilization in WY 2021 and 2022. This applies to the following services: Respite, Assistive Technology for Telehealth, Enhanced Technology/Cellular PERS (monthly), Supportive Day Program – Full Day, Transitional Assistance, and Transportation – per mile.

For services with no utilization in 2019, 2021, and 2022, prior estimates were carried forward for the current renewal cycle. This applies to the following services: Home Based Wandering Response System (install and monthly fee), Home Delivery of Pre-Packaged Medication, and Orientation and Mobility Services. The original estimates are detailed below:

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 described below for these services. The Home Care Program serves approximately 60,000 elders in the Commonwealth, and as such is a valuable indicator of need and uptake of services in the FEW. The state agency staff consulted in the development of these estimates are staff within the Executive Office of Elder Affairs Home Care Unit, with extensive knowledge of and access to data on utilization and expenditures in the Home Care Program.

Home Delivery of Pre-Packaged Medication: estimated number of users is based on the actual number of users in Waiver Year 2016.

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. (As noted, the state used utilization data from its MFP-CL waiver reference point for WY1, but increased the estimate to account for the somewhat greater anticipated need in the FEW, inherent to the older population. As a result, we estimated 10 users in WY1, 20 users in WY2, 30 users in WY3, 40 users in WY4, and 50 users in WY5. The modest projected growth reflects EOEA's programmatic goals in serving elders who experience vision loss as they age.)

Virtual Communication and Monitoring (VCAM): utilization was estimated at 1.2% of participants in WY1, 1.5% in WY2, 1.8% in WY3, 2.1% in WY4, and 2.4% in WY5 based on pilot data, anticipated need based on expected uptake and EOEA programmatic goals.

Assisted Transportation (for each of the 4 levels) and Goal Engagement: Utilization was estimated at 0.5% of the population in WY1, 0.75% of the population in WY2, 1% of the population in WY3, 1.25% of the population in WY4, and 1.5% of the population in WY5 based on consultation with state agency program staff and anticipated need based on expected uptake and EOEA programmatic goals.

Assistive Technology - Electronic Comfort Animals: Utilization was estimated at 0.5% of the population each year. Utilization of this service was based on utilization in the analogous state-funded program that serves a similar, non-waiver population.

SCO: 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 2021 and trended forward based on average SCO-FEW enrollment growth in Waiver Years 2016 – 2021.

-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 in Waiver Year 2019, 2021, and 2022. For services with no utilization in WY 2019, estimates were based on average utilization in WY 2021 and 2022. This applies to the following services: Respite, Assistive Technology for Telehealth, Enhanced Technology/Cellular PERS (monthly), Supportive Day Program – Full Day, Transitional Assistance, and Transportation – per mile.

For services with no utilization in 2019, 2021, and 2022, prior estimates were carried forward for the current renewal cycle. This applies to the following services: Orientation and Mobility Services, and Virtual Communication and Monitoring. The original estimates are detailed below:

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. (The state referenced utilization experienced in the MFP-CL waiver starting point to estimate units per user and adjusted for the average length of stay in the FEW. The estimate of fifteen 15-minute units per user per year represents 1-2 visits for assessment and training, totaling 3.75 hours.)

Virtual Communication and Monitoring (VCAM): For the new VCAM service, units per user were set based on the ALOS, accounting for one unit per month of enrollment.

Home Based Wandering Response System, of which there was no utilization in 2019, 2021, or 2022 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.

Home Delivery of Pre-Packaged Medication, of which there was no utilization in 2019, 2021, or 2022 average units per user is estimated as one per month based on the average length of stay for the waiver population.

Assisted Transportation (for each of the 4 levels): estimated at eight 15-minute units per week based on the average length of stay for the waiver population.

Assistive Technology - Electronic Comfort Animals: estimated at one unit per user.

Enhanced Technology /Cellular PERS: estimated at one installation per user.

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). (Where this is a comprehensive service, and the unit type (per episode) encompasses up to 10 in-home visits by the OT or RN and up to $1,800 in purchases related to home safety, minor home repairs, and related items and services, the state set a service limit of one episode per participant per year. The average units per user reflects this service limit as described in Appendix C-1/C-3.)

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 2022.

Home Health Aide and Complex Care Training and Oversight: Based on the proposed MassHealth state plan rate for these services.

Assisted Transportation: the rate for each level is based on the rate for the worker type plus $3.13 per 15-minute unit which is based on the average cost per one-way trip for transportation providers.

Assistive Technology - Electronic Comfort Animals: based on current rates in the state-funded Home Care program.

Goal Engagement Program: There is currently no comparable service in the Commonwealth; however this service will be implemented concurrently in the state-funded Home Care Program. The cost per unit for this service reflects the anticipated rate for this service in the Home Care Program. The negotiated rate is based on the rate for the nursing and occupational therapy visits (up to 10 visits) plus the cost of the home repair which is limited to $1,800.

Home Delivery of Pre-Packaged Medication: based on current rates in the state-funded Home Care program. The negotiated rate is inclusive of the filling of the medication cassette and delivery to the home of the consumer.

Orientation and Mobility Services: This service is currently available in the Massachusetts MFP-CL Waiver (MA.1027). The average cost per unit is based on the actual average per unit rate for Orientation and Mobility Services as reflected in claims data in the WY 2020 CMS-372 report for the MFP-CL Waiver, which was the most recent utilization data available.

Virtual Communication and Monitoring (VCAM) (monthly fee): The estimated average cost per unit was based on pilot program data.

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 2021 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 2024, as well as for subsequent waiver years, by 2.67 %, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 24-mos. ended May 2023).

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

Factor D' costs are based on WY 2021 utilization of all other Medicaid services (D') by MA.0059 Waiver participants as reported on the 2021 CMS-372. The Factor D' reflected on the WY 2021 372 is comprised of both the FFS and SCO Average Per Capita Other Medicaid Expenditures. The annualized value of Factor D' is adjusted by the average length of stay used for Factor D to make the period of comparison comparable as follows: the annualized value of Factor D' was multiplied by the average length of stay and divided by 365.

In addition, WY 2021 costs were trended forward annually 2.67%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 24-mos. ended May 2023) to estimate Factor D' for WY 2024 (WY 1), as well as for subsequent waiver years.

The calculation for Factor D' in WY1, therefore, is as follows:
Step1: Annualize the WY 2021 Factor D'
WY 2021 Annualized D' = WY 2021 Factor D' x (365 ÷ WY 2021 ALOS)

Step 2: Trend forward and de-annualize to estimate Factor D' for WY1
WY1 D' = [WY 2021 Annualized D' x (WY1 ALOS ÷ 365)] x 1.021^3

As Factor D' costs are based on WY 2021 data, the cost and utilization of prescription drugs in the base data reflects the full implementation of Medicare Part D. Therefore no Medicare Part D drug costs or utilization are included in the Factor D' estimate.

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 current average MassHealth nursing facility per diem rate.

The annualized value of Factor G is adjusted by the average length of stay used for Factor D to make the period of comparison comparable as follows: the per diem was multiplied by the average length of stay.

The current per diem was used to calculate Factor G for WY1. For subsequent years costs were trended forward annually by 2.67%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 24-mos. ended May 2023) to estimate Factor G.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these*

estimates is as follows:

Factor G' costs are based on the utilization of all Medicaid services (G') in WY 2021 for MassHealth members 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 as follows: the annualized value of Factor G' was multiplied by the average length of stay and divided by 365.

In addition, WY 2021 costs were trended forward annually by 2.67%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 24-mos. ended May 2023) to estimate Factor G' for WY 2021 (WY 1), as well as for subsequent waiver years.

The calculation for Factor G' in WY1, therefore, is as follows:
Step1: Annualize the WY 2021 Factor G'
WY 2021 Annualized G' = WY 2021 Factor G' x (365 ÷ WY 2021 ALOS)

Step 2: Trend forward and de-annualize to estimate Factor G' for WY1
WY1 G' = [WY 2021 Annualized G' x (WY1 ALOS ÷ 365)] x 1.0267^3

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Alzheimer's/Dementia Coaching	
Home Health Aide	
Homemaker	
Personal Care	
Respite	
Assisted Transportation	
Assistive Technology - Electronic Comfort Animals	
Assistive Technology for Telehealth	
Chore	
Companion	
Complex Care Training and Oversight	
Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS)	
Environmental Accessibility Adaptation	
Evidence Based Education Programs	
Goal Engagement Program	
Grocery Shopping and Delivery	
Home Based Wandering Response Systems	
Home Delivered Meals	
Home Delivery of Pre-packaged Medication	
Home Safety/Independence Evaluations (formerly Occupational Therapy)	
Laundry	
Medication Dispensing System	
Orientation and Mobility Services	
Peer Support	
Senior Care Options (SCO)	

Waiver Services	
Supportive Day Program	
Supportive Home Care Aide	
Transitional Assistance	
Transportation	
Virtual Communication and Monitoring (VCAM)	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Alzheimer's/Dementia Coaching Total:							**17578.00**
Alzheimer's/Dementia Coaching	☐	Visit	50	2.00	175.78	**17578.00**	
Home Health Aide Total:							**212169625.80**
Home Health Aide	☐	15 min	4521	4610.00	10.18	**212169625.80**	
Homemaker Total:							**77191810.84**
Homemaker	☐	15 min	9923	886.00	8.78	**77191810.84**	
Personal Care Total:							**106731424.80**
Personal Care	☐	15 min	6024	1947.00	9.10	**106731424.80**	
Respite Total:							**22408.10**
Respite	☐	Per Diem	5	13.00	344.74	**22408.10**	
Assisted Transportation Total:							**1355082.75**
Assisted Transportation - companion	☐	15 min	85	315.00	10.43	**279263.25**	
Assisted Transportation - personal care	☐	15 min	85	315.00	12.23	**327458.25**	

GRAND TOTAL:	**499916004.16**
Total: Services included in capitation:	16811432.37
Total: Services not included in capitation:	483104571.79
Total Estimated Unduplicated Participants:	**20000**
Factor D (Divide total by number of participants):	**24995.80**
Services included in capitation:	840.57
Services not included in capitation:	24155.23
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Transportation - home health aide	☐	15 min	85	315.00	13.30	356107.50	
Assisted Transportation - supportive home care aide	☐	15 min	85	315.00	14.65	392253.75	
Assistive Technology - Electronic Comfort Animals Total:							10115.00
Assistive Technology - Electronic Comfort Animals	☐	Item	85	1.00	119.00	10115.00	
Assistive Technology for Telehealth Total:							5071.00
Assistive Technology	☐	Item	22	1.00	230.50	5071.00	
Chore Total:							1992842.25
Chore	☐	15 min	1055	147.00	12.85	1992842.25	
Companion Total:							18965662.80
Companion	☐	15 min	2758	942.00	7.30	18965662.80	
Complex Care Training and Oversight Total:							2547694.08
Complex Care Training and Oversight	☐	Visit	3936	6.00	107.88	2547694.08	
Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS) Total:							905807.31
Cellular PERS - Install	☐	Install	281	1.00	41.31	11608.11	
Cellular PERS - Monthly	☐	Monthly	3254	8.00	34.35	894199.20	
Environmental Accessibility Adaptation Total:							1549247.40
Environmental Accessibility Adaptation	☐	Item	2364	3.00	218.45	1549247.40	
Evidence Based Education Programs Total:							347.84
Evidence Based Education Programs	☐	Class	2	2.00	86.96	347.84	
Goal Engagement Program Total:							314591.80

GRAND TOTAL:	499916004.16
Total: Services included in capitation:	16811432.37
Total: Services not included in capitation:	483104571.79
Total Estimated Unduplicated Participants:	20000
Factor D (Divide total by number of participants):	24995.80
Services included in capitation:	840.57
Services not included in capitation:	24155.23
Average Length of Stay on the Waiver:	279

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goal Engagement Program	☐	Episode	85	1.00	3701.08	**314591.80**	
Grocery Shopping and Delivery Total:							**294938.70**
Grocery Shopping and Delivery	☐	Order	334	21.00	42.05	**294938.70**	
Home Based Wandering Response Systems Total:							**18072.00**
Home Based Wandering Response Systems - Monthly	☐	Monthly	50	9.00	39.21	**17644.50**	
Home Based Wandering Response Systems - Install	☐	Install	10	1.00	42.75	**427.50**	
Home Delivered Meals Total:							**12684465.36**
Home Delivered Meals	☐	Meal	8344	171.00	8.89	**12684465.36**	
Home Delivery of Pre-packaged Medication Total:							**11340.00**
Home Delivery of Pre-packaged Medication	☐	Monthly	45	9.00	28.00	**11340.00**	
Home Safety/Independence Evaluations (formerly Occupational Therapy) Total:							**11596.50**
Home Safety/Independence Evaluations (formerly Occupational Therapy)	☐	Visit	150	1.00	77.31	**11596.50**	
Laundry Total:							**3152862.40**
Laundry	☐	Order	2965	32.00	33.23	**3152862.40**	
Medication Dispensing System Total:							**254039.80**
Medication Dispensing System - Install	☐	Install	77	1.00	43.48	**3347.96**	
Medication Dispensing System - Monthly	☐	Monthly	784	7.00	45.68	**250691.84**	
Orientation and Mobility Services Total:							**28327.50**
Orientation and Mobility Services	☐	15 min	50	15.00	37.77	**28327.50**	
Peer Support Total:							**21185.40**

GRAND TOTAL:	***499916004.16***
Total: Services included in capitation:	*16811432.37*
Total: Services not included in capitation:	*483104571.79*
Total Estimated Unduplicated Participants:	***20000***
Factor D (Divide total by number of participants):	***24995.80***
Services included in capitation:	*840.57*
Services not included in capitation:	*24155.23*
Average Length of Stay on the Waiver:	*279*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Peer Support	☐	15 min	30	67.00	10.54	21185.40	
Senior Care Options (SCO) Total:							16811432.37
Senior Care Options (SCO)	☒	PMPM	3079	9.00	606.67	16811432.37	
Supportive Day Program Total:							61137.65
Supportive Day Program (half day)	☐	Half Day	11	49.00	25.75	13879.25	
Supportive Day Program (full day)	☐	Per diem	28	29.00	58.20	47258.40	
Supportive Home Care Aide Total:							41459696.64
Supportive Home Care Aide	☐	15 min	677	5316.00	11.52	41459696.64	
Transitional Assistance Total:							9648.08
Transitional Assistance	☐	Episode	4	2.00	1206.01	9648.08	
Transportation Total:							768299.04
Transportation - one-way trip	☐	One-Way Trip	783	14.00	59.44	651581.28	
Transportation - per mile	☐	Mile	316	152.00	2.43	116717.76	
Virtual Communication and Monitoring (VCAM) Total:							549652.95
Virtual Communication and Monitoring (VCAM)	☐	Monthly	203	9.00	300.85	549652.95	

GRAND TOTAL:	**499916004.16**
Total: Services included in capitation:	16811432.37
Total: Services not included in capitation:	483104571.79
Total Estimated Unduplicated Participants:	**20000**
Factor D (Divide total by number of participants):	**24995.80**
Services included in capitation:	840.57
Services not included in capitation:	24155.23
Average Length of Stay on the Waiver:	279

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Alzheimer's/Dementia Coaching Total:							**18053.00**
Alzheimer's/Dementia Coaching	☐	Visit	50	2.00	180.53	**18053.00**	
Home Health Aide Total:							**215291840.50**
Home Health Aide	☐	15 min	4469	4610.00	10.45	**215291840.50**	
Homemaker Total:							**78374798.04**
Homemaker	☐	15 min	9807	886.00	9.02	**78374798.04**	
Personal Care Total:							**108389295.30**
Personal Care	☐	15 min	5954	1947.00	9.35	**108389295.30**	
Respite Total:							**23013.25**
Respite	☐	Per diem	5	13.00	354.05	**23013.25**	
Assisted Transportation Total:							**2046712.50**
Assisted Transportation - companion	☐	15 min	125	315.00	10.71	**421706.25**	
Assisted Transportation - personal care	☐	15 min	125	315.00	12.56	**494550.00**	
Assisted Transportation - home health aide	☐	15 min	125	315.00	13.66	**537862.50**	
Assisted Transportation - supportive home care aide	☐	15 min	125	315.00	15.05	**592593.75**	
Assistive Technology - Electronic Comfort Animals Total:							**10265.64**
Assistive Technology - Electronic Comfort Animals	☐	Item	84	1.00	122.21	**10265.64**	
Assistive Technology for Telehealth Total:							**4971.12**
Assistive Technology	☐	Item	21	1.00	236.72	**4971.12**	
Chore Total:							**2023837.20**
Chore	☐	15 min	1043	147.00	13.20	**2023837.20**	
Companion Total:							**19259190.00**

GRAND TOTAL:	**509776537.65**
Total: Services included in capitation:	18370006.20
Total: Services not included in capitation:	491406531.45
Total Estimated Unduplicated Participants:	**20000**
Factor D (Divide total by number of participants):	**25488.83**
Services included in capitation:	918.50
Services not included in capitation:	24570.33
Average Length of Stay on the Waiver:	280

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Companion	☐	15 min	2726	942.00	7.50	19259190.00	
Complex Care Training and Oversight Total:							2585838.60
Complex Care Training and Oversight	☐	Visit	3890	6.00	110.79	2585838.60	
Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS) Total:							919761.62
Cellular PERS - Install	☐	Install	278	1.00	42.43	11795.54	
Cellular PERS - Monthly	☐	Monthly	3217	8.00	35.28	907966.08	
Environmental Accessibility Adaptation Total:							1572917.85
Environmental Accessibility Adaptation	☐	Item	2337	3.00	224.35	1572917.85	
Evidence Based Education Programs Total:							357.24
Evidence Based Education Programs	☐	Class	2	2.00	89.31	357.24	
Goal Engagement Program Total:							475126.25
Goal Engagement Program	☐	Episode	125	1.00	3801.01	475126.25	
Grocery Shopping and Delivery Total:							299306.70
Grocery Shopping and Delivery	☐	Order	330	21.00	43.19	299306.70	
Home Based Wandering Response Systems Total:							18560.50
Home Based Wandering Response Systems - Monthly	☐	Monthly	50	9.00	40.27	18121.50	
Home Based Wandering Response Systems - Install	☐	Install	10	1.00	43.90	439.00	
Home Delivered Meals Total:							12875463.81
Home Delivered Meals	☐	Meal	8247	171.00	9.13	12875463.81	
Home Delivery of Pre-packaged Medication Total:							11647.80
Home Delivery of	☐					11647.80	

GRAND TOTAL:	509776537.65
Total: Services included in capitation:	18370006.20
Total: Services not included in capitation:	491406531.45
Total Estimated Unduplicated Participants:	20000
Factor D (Divide total by number of participants):	25488.83
Services included in capitation:	918.50
Services not included in capitation:	24570.33
Average Length of Stay on the Waiver:	280

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Pre-packaged Medication		*Monthly*	*45*	*9.00*	*28.76*		
Home Safety/Independence Evaluations (formerly Occupational Therapy) Total:							***11751.20***
Home Safety/Independence Evaluations (formerly Occupational Therapy)	☐	*Visit*	*148*	*1.00*	*79.40*	***11751.20***	
Laundry Total:							***3200028.80***
Laundry	☐	*Order*	*2930*	*32.00*	*34.13*	***3200028.80***	
Medication Dispensing System Total:							***257880.15***
Medication Dispensing System - Install	☐	*Install*	*76*	*1.00*	*44.65*	***3393.40***	
Medication Dispensing System - Monthly	☐	*Monthly*	*775*	*7.00*	*46.91*	***254486.75***	
Orientation and Mobility Services Total:							***29092.50***
Orientation and Mobility Services	☐	*15 min*	*50*	*15.00*	*38.79*	***29092.50***	
Peer Support Total:							***21023.26***
Peer Support	☐	*15 min*	*29*	*67.00*	*10.82*	***21023.26***	
Senior Care Options (SCO) Total:							***18370006.20***
Senior Care Options (SCO)	☒	*PMPM*	*3276*	*9.00*	*623.05*	***18370006.20***	
Supportive Day Program Total:							***62789.79***
Supportive Day Program (half day)	☐	*15 min*	*11*	*49.00*	*26.45*	***14256.55***	
Supportive Day Program (full day)	☐	*Per diem*	*28*	*29.00*	*59.77*	***48533.24***	
Supportive Home Care Aide Total:							***42135147.60***
Supportive Home Care Aide	☐	*15 min*	*670*	*5316.00*	*11.83*	***42135147.60***	
Transitional Assistance Total:							***9908.56***
Transitional Assistance	☐	*Episode*	*4*	*2.00*	*1238.57*	***9908.56***	

GRAND TOTAL:	***509776537.65***
Total: Services included in capitation:	*18370006.20*
Total: Services not included in capitation:	*491406531.45*
Total Estimated Unduplicated Participants:	***20000***
Factor D (Divide total by number of participants):	***25488.83***
Services included in capitation:	*918.50*
Services not included in capitation:	*24570.33*
Average Length of Stay on the Waiver:	*280*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:							**779989.44**
Transportation - one-way trip	☐	One-Way Trip	774	14.00	61.04	**661429.44**	
Transportation - per mile	☐	Mile	312	152.00	2.50	**118560.00**	
Virtual Communication and Monitoring (VCAM) Total:							**697963.23**
Virtual Communication and Monitoring (VCAM)	☐	Monthly	251	9.00	308.97	**697963.23**	

GRAND TOTAL:	**509776537.65**
Total: Services included in capitation:	18370006.20
Total: Services not included in capitation:	491406531.45
Total Estimated Unduplicated Participants:	**20000**
Factor D (Divide total by number of participants):	**25488.83**
Services included in capitation:	918.50
Services not included in capitation:	24570.33
Average Length of Stay on the Waiver:	280

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Alzheimer's/Dementia Coaching Total:							**18169.20**
Alzheimer's/Dementia Coaching	☐	Visit	49	2.00	185.40	**18169.20**	
Home Health Aide Total:							**218290368.90**
Home Health Aide	☐	15 min	4413	4610.00	10.73	**218290368.90**	
Homemaker Total:							**79459226.60**
Homemaker	☐	15 min	9685	886.00	9.26	**79459226.60**	
Personal Care Total:							**109904256.00**

GRAND TOTAL:	**519303095.31**
Total: Services included in capitation:	20069522.55
Total: Services not included in capitation:	499233572.76
Total Estimated Unduplicated Participants:	**20000**
Factor D (Divide total by number of participants):	**25965.15**
Services included in capitation:	1003.48
Services not included in capitation:	24961.68
Average Length of Stay on the Waiver:	280

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care	☐	15 min	5880	1947.00	9.60	109904256.00	
Respite Total:							23634.65
Respite	☐	Per diem	5	13.00	363.61	23634.65	
Assisted Transportation Total:							2774945.25
Assisted Transportation - companion	☐	15 min	165	315.00	11.00	571725.00	
Assisted Transportation - personal care	☐	15 min	165	315.00	12.90	670477.50	
Assisted Transportation - home health aide	☐	15 min	165	315.00	14.03	729209.25	
Assisted Transportation - supportive home care aide	☐	15 min	165	315.00	15.46	803533.50	
Assistive Technology - Electronic Comfort Animals Total:							10417.33
Assistive Technology - Electronic Comfort Animals	☐	Item	83	1.00	125.51	10417.33	
Assistive Technology for Telehealth Total:							5105.31
Assistive Technology	☐	Item	21	1.00	243.11	5105.31	
Chore Total:							2053119.60
Chore	☐	15 min	1030	147.00	13.56	2053119.60	
Companion Total:							19526152.80
Companion	☐	15 min	2692	942.00	7.70	19526152.80	
Complex Care Training and Oversight Total:							2622856.56
Complex Care Training and Oversight	☐	Visit	3842	6.00	113.78	2622856.56	
Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS) Total:							932516.34
Cellular PERS - Install	☐	Install	275	1.00	43.58	11984.50	
Cellular PERS -	☐					920531.84	

GRAND TOTAL:	**519303095.31**
Total: Services included in capitation:	20069522.55
Total: Services not included in capitation:	499233572.76
Total Estimated Unduplicated Participants:	**20000**
Factor D (Divide total by number of participants):	**25965.15**
Services included in capitation:	1003.48
Services not included in capitation:	24961.68
Average Length of Stay on the Waiver:	280

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Monthly		Monthly	3176	8.00	36.23		
Environmental Accessibility Adaptation Total:							**1595358.84**
Environmental Accessibility Adaptation	☐	Item	2308	3.00	230.41	**1595358.84**	
Evidence Based Education Programs Total:							**366.88**
Evidence Based Education Programs	☐	Class	2	2.00	91.72	**366.88**	
Goal Engagement Program Total:							**644100.60**
Goal Engagement Program	☐	Episode	165	1.00	3903.64	**644100.60**	
Grocery Shopping and Delivery Total:							**303688.56**
Grocery Shopping and Delivery	☐	Order	326	21.00	44.36	**303688.56**	
Home Based Wandering Response Systems Total:							**19062.90**
Home Based Wandering Response Systems - Monthly	☐	Monthly	50	9.00	41.36	**18612.00**	
Home Based Wandering Response Systems - Install	☐	Install	10	1.00	45.09	**450.90**	
Home Delivered Meals Total:							**13062813.12**
Home Delivered Meals	☐	Meal	8144	171.00	9.38	**13062813.12**	
Home Delivery of Pre-packaged Medication Total:							**11963.70**
Home Delivery of Pre-packaged Medication	☐	Monthly	45	9.00	29.54	**11963.70**	
Home Safety/Independence Evaluations (formerly Occupational Therapy) Total:							**11904.84**
Home Safety/Independence Evaluations (formerly Occupational Therapy)	☐	Visit	146	1.00	81.54	**11904.84**	
Laundry Total:							**3245910.40**
Laundry	☐	Order	2894	32.00	35.05	**3245910.40**	

GRAND TOTAL:	**519303095.31**
Total: Services included in capitation:	20069522.55
Total: Services not included in capitation:	499233572.76
Total Estimated Unduplicated Participants:	**20000**
Factor D (Divide total by number of participants):	**25965.15**
Services included in capitation:	1003.48
Services not included in capitation:	24961.68
Average Length of Stay on the Waiver:	280

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medication Dispensing System Total:							**261443.40**
Medication Dispensing System - Install	☐	Install	75	1.00	45.86	**3439.50**	
Medication Dispensing System - Monthly	☐	Monthly	765	7.00	48.18	**258003.90**	
Orientation and Mobility Services Total:							**29880.00**
Orientation and Mobility Services	☐	15 min	50	15.00	39.84	**29880.00**	
Peer Support Total:							**21586.73**
Peer Support	☐	15 min	29	67.00	11.11	**21586.73**	
Senior Care Options (SCO) Total:							**20069522.55**
Senior Care Options (SCO)	☒	PMPM	3485	9.00	639.87	**20069522.55**	
Supportive Day Program Total:							**64479.80**
Supportive Day Program (half day)	☐	half day	11	49.00	27.16	**14639.24**	
Supportive Day Program (full day)	☐	Per diem	28	29.00	61.38	**49840.56**	
Supportive Home Care Aide Total:							**42693593.40**
Supportive Home Care Aide	☐	15 min	661	5316.00	12.15	**42693593.40**	
Transitional Assistance Total:							**7632.06**
Transitional Assistance	☐	Episode	3	2.00	1272.01	**7632.06**	
Transportation Total:							**790849.36**
Transportation - one-way trip	☐	One-Way Trip	764	14.00	62.69	**670532.24**	
Transportation - per mile	☐	Mile	308	152.00	2.57	**120317.12**	
Virtual Communication and Monitoring (VCAM) Total:							**848169.63**
Virtual Communication and Monitoring (VCAM)	☐	Monthly	297	9.00	317.31	**848169.63**	

GRAND TOTAL:	**519303095.31**
Total: Services included in capitation:	20069522.55
Total: Services not included in capitation:	499233572.76
Total Estimated Unduplicated Participants:	**20000**
Factor D (Divide total by number of participants):	**25965.15**
Services included in capitation:	1003.48
Services not included in capitation:	24961.68
Average Length of Stay on the Waiver:	280

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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 4

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Alzheimer's/Dementia Coaching Total:							***18279.36***
Alzheimer's/Dementia Coaching	☐	Visit	48	2.00	190.41	***18279.36***	
Home Health Aide Total:							***221192778.80***
Home Health Aide	☐	15 min	4354	4610.00	11.02	***221192778.80***	
Homemaker Total:							***80500666.44***
Homemaker	☐	15 min	9554	886.00	9.51	***80500666.44***	
Personal Care Total:							***111364233.42***
Personal Care	☐	Per diem	5801	1947.00	9.86	***111364233.42***	
Respite Total:							***24272.95***
Respite	☐	15 min	5	13.00	373.43	***24272.95***	
Assisted Transportation Total:							***3524018.40***
Assisted Transportation - companion	☐	15 min	204	315.00	11.30	***726138.00***	
Assisted Transportation - personal care	☐	15 min	204	315.00	13.25	***851445.00***	
Assisted Transportation - home health aide	☐	15 min	204	315.00	14.41	***925986.60***	
Assisted Transportation - supportive home care aide	☐	15 min	204	315.00	15.88	***1020448.80***	
Assistive Technology - Electronic Comfort Animals Total:							***10440.90***
Assistive Technology	☐					***10440.90***	

GRAND TOTAL:	***528794492.27***
Total: Services included in capitation:	*21924495.45*
Total: Services not included in capitation:	*506869996.82*
Total Estimated Unduplicated Participants:	***20000***
Factor D (Divide total by number of participants):	***26439.72***
Services included in capitation:	*1096.22*
Services not included in capitation:	*25343.50*
Average Length of Stay on the Waiver:	*280*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
- Electronic Comfort Animals		Item	81	1.00	128.90		
Assistive Technology for Telehealth Total:							**5243.07**
Assistive Technology	☐	Item	21	1.00	249.67	**5243.07**	
Chore Total:							**2080473.36**
Chore	☐	15 min	1016	147.00	13.93	**2080473.36**	
Companion Total:							**19790440.32**
Companion	☐	15 min	2656	942.00	7.91	**19790440.32**	
Complex Care Training and Oversight Total:							**2657169.00**
Complex Care Training and Oversight	☐	Visit	3790	6.00	116.85	**2657169.00**	
Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS) Total:							**945059.08**
Cellular PERS - Install	☐	Install	271	1.00	44.76	**12129.96**	
Cellular PERS - Monthly	☐	Monthly	3134	8.00	37.21	**932929.12**	
Environmental Accessibility Adaptation Total:							**1616419.53**
Environmental Accessibility Adaptation	☐	Item	2277	3.00	236.63	**1616419.53**	
Evidence Based Education Programs Total:							**376.80**
Evidence Based Education Programs	☐	Class	2	2.00	94.20	**376.80**	
Goal Engagement Program Total:							**817844.16**
Goal Engagement Program	☐	Episode	204	1.00	4009.04	**817844.16**	
Grocery Shopping and Delivery Total:							**307119.96**
Grocery Shopping and Delivery	☐	Order	321	21.00	45.56	**307119.96**	
Home Based Wandering Response Systems Total:							**19579.10**
Home Based Wandering Response	☐					**19116.00**	

GRAND TOTAL:	***528794492.27***
Total: Services included in capitation:	*21924495.45*
Total: Services not included in capitation:	*506869996.82*
Total Estimated Unduplicated Participants:	***20000***
Factor D (Divide total by number of participants):	***26439.72***
Services included in capitation:	*1096.22*
Services not included in capitation:	*25343.50*
Average Length of Stay on the Waiver:	*280*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Systems - Monthly		Monthly	50	9.00	42.48		
Home Based Wandering Response Systems - Install	☐	Install	10	1.00	46.31	463.10	
Home Delivered Meals Total:							13231475.55
Home Delivered Meals	☐	Meal	8035	171.00	9.63	13231475.55	
Home Delivery of Pre-packaged Medication Total:							12287.70
Home Delivery of Pre-packaged Medication	☐	Monthly	45	9.00	30.34	12287.70	
Home Safety/Independence Evaluations (formerly Occupational Therapy) Total:							12058.56
Home Safety/Independence Evaluations (formerly Occupational Therapy)	☐	Visit	144	1.00	83.74	12058.56	
Laundry Total:							3288960.00
Laundry	☐	Order	2855	32.00	36.00	3288960.00	
Medication Dispensing System Total:							264987.20
Medication Dispensing System - Install	☐	Install	74	1.00	47.10	3485.40	
Medication Dispensing System - Monthly	☐	Monthly	755	7.00	49.48	261501.80	
Orientation and Mobility Services Total:							30690.00
Orientation and Mobility Services	☐	15 min	50	15.00	40.92	30690.00	
Peer Support Total:							22169.63
Peer Support	☐	15 min	29	67.00	11.41	22169.63	
Senior Care Options (SCO) Total:							21924495.45
Senior Care Options (SCO)	☒	PMPM	3707	9.00	657.15	21924495.45	
Supportive Day Program Total:							64393.03
Supportive Day Program (half day)	☐					15032.71	

GRAND TOTAL:	528794492.27
Total: Services included in capitation:	21924495.45
Total: Services not included in capitation:	506869996.82
Total Estimated Unduplicated Participants:	20000
Factor D (Divide total by number of participants):	26439.72
Services included in capitation:	1096.22
Services not included in capitation:	25343.50
Average Length of Stay on the Waiver:	280

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		half day	11	49.00	27.89		
Supportive Day Program (full day)	☐	Per diem	27	29.00	63.04	49360.32	
Supportive Home Care Aide Total:							43256079.36
Supportive Home Care Aide	☐	15 min	652	5316.00	12.48	43256079.36	
Transitional Assistance Total:							7838.10
Transitional Assistance	☐	Episode	3	2.00	1306.35	7838.10	
Transportation Total:							801584.40
Transportation - one-way trip	☐	One-Way Trip	754	14.00	64.38	679595.28	
Transportation - per mile	☐	Mile	304	152.00	2.64	121989.12	
Virtual Communication and Monitoring (VCAM) Total:							1003058.64
Virtual Communication and Monitoring (VCAM)	☐	Monthly	342	9.00	325.88	1003058.64	

GRAND TOTAL:	528794492.27
Total: Services included in capitation:	21924495.45
Total: Services not included in capitation:	506869996.82
Total Estimated Unduplicated Participants:	20000
Factor D (Divide total by number of participants):	26439.72
Services included in capitation:	1096.22
Services not included in capitation:	25343.50
Average Length of Stay on the Waiver:	280

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Alzheimer's/Dementia							18772.80

GRAND TOTAL:	538062240.02
Total: Services included in capitation:	23955895.44
Total: Services not included in capitation:	514106344.58
Total Estimated Unduplicated Participants:	20000
Factor D (Divide total by number of participants):	26903.11
Services included in capitation:	1197.79
Services not included in capitation:	25705.32
Average Length of Stay on the Waiver:	280

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coaching Total:							
Alzheimer's/Dementia Coaching	☐	Visit	48	2.00	195.55	**18772.80**	
Home Health Aide Total:							**223874508.00**
Home Health Aide	☐	15 min	4290	4610.00	11.32	**223874508.00**	
Homemaker Total:							**81498311.30**
Homemaker	☐	15 min	9415	886.00	9.77	**81498311.30**	
Personal Care Total:							**112737296.76**
Personal Care	☐	15 min	5716	1947.00	10.13	**112737296.76**	
Respite Total:							**24928.15**
Respite	☐	Per diem	5	13.00	383.51	**24928.15**	
Assisted Transportation Total:							**4276291.95**
Assisted Transportation - companion	☐	15 min	241	315.00	11.61	**881373.15**	
Assisted Transportation - personal care	☐	15 min	241	315.00	13.61	**1033203.15**	
Assisted Transportation - home health aide	☐	15 min	241	315.00	14.80	**1123542.00**	
Assisted Transportation - supportive home care aide	☐	15 min	241	315.00	16.31	**1238173.65**	
Assistive Technology - Electronic Comfort Animals Total:							**10590.40**
Assistive Technology - Electronic Comfort Animals	☐	Item	80	1.00	132.38	**10590.40**	
Assistive Technology for Telehealth Total:							**5128.20**
Assistive Technology	☐	Item	20	1.00	256.41	**5128.20**	
Chore Total:							**2105673.57**
Chore	☐	15 min	1001	147.00	14.31	**2105673.57**	
Companion Total:							**20017537.68**
Companion	☐					**20017537.68**	

GRAND TOTAL:	**538062240.02**
Total: Services included in capitation:	23955895.44
Total: Services not included in capitation:	514106344.58
Total Estimated Unduplicated Participants:	**20000**
Factor D (Divide total by number of participants):	**26903.11**
Services included in capitation:	1197.79
Services not included in capitation:	25705.32
Average Length of Stay on the Waiver:	280

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 min	2617	942.00	8.12		
Complex Care Training and Oversight Total:							**2689200.00**
Complex Care Training and Oversight	☐	Visit	3735	6.00	120.00	**2689200.00**	
Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS) Total:							**956213.83**
Cellular PERS - Install	☐	Install	267	1.00	45.97	**12273.99**	
Cellular PERS - Monthly	☐	Monthly	3088	8.00	38.21	**943939.84**	
Environmental Accessibility Adaptation Total:							**1636010.64**
Environmental Accessibility Adaptation	☐	Item	2244	3.00	243.02	**1636010.64**	
Evidence Based Education Programs Total:							**386.96**
Evidence Based Education Programs	☐	Class	2	2.00	96.74	**386.96**	
Goal Engagement Program Total:							**992264.48**
Goal Engagement Program	☐	Episode	241	1.00	4117.28	**992264.48**	
Grocery Shopping and Delivery Total:							**311481.03**
Grocery Shopping and Delivery	☐	Order	317	21.00	46.79	**311481.03**	
Home Based Wandering Response Systems Total:							**20109.10**
Home Based Wandering Response Systems - Monthly	☐	Monthly	50	9.00	43.63	**19633.50**	
Home Based Wandering Response Systems - Install	☐	Install	10	1.00	47.56	**475.60**	
Home Delivered Meals Total:							**13390842.42**
Home Delivered Meals	☐	Meal	7918	171.00	9.89	**13390842.42**	
Home Delivery of Pre-packaged Medication Total:							**12619.80**
Home Delivery of Pre-packaged	☐					**12619.80**	

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medication		Monthly	45	9.00	31.16		
Home Safety/Independence Evaluations (formerly Occupational Therapy) Total:							**12212.00**
Home Safety/Independence Evaluations (formerly Occupational Therapy)	☐	Visit	142	1.00	86.00	**12212.00**	
Laundry Total:							**3327891.52**
Laundry	☐	Order	2813	32.00	36.97	**3327891.52**	
Medication Dispensing System Total:							**268201.57**
Medication Dispensing System - Install	☐	Install	73	1.00	48.37	**3531.01**	
Medication Dispensing System - Monthly	☐	Monthly	744	7.00	50.82	**264670.56**	
Orientation and Mobility Services Total:							**31515.00**
Orientation and Mobility Services	☐	15 min	50	15.00	42.02	**31515.00**	
Peer Support Total:							**21986.72**
Peer Support	☐	15 min	28	67.00	11.72	**21986.72**	
Senior Care Options (SCO) Total:							**23955895.44**
Senior Care Options (SCO)	☒	PMPM	3944	9.00	674.89	**23955895.44**	
Supportive Day Program Total:							**66128.38**
Supportive Day Program (half day)	☐	half day	11	49.00	28.64	**15436.96**	
Supportive Day Program (full day)	☐	Per diem	27	29.00	64.74	**50691.42**	
Supportive Home Care Aide Total:							**43821170.16**
Supportive Home Care Aide	☐	15 min	643	5316.00	12.82	**43821170.16**	
Transitional Assistance Total:							**8049.72**
Transitional Assistance	☐	Episode	3	2.00	1341.62	**8049.72**	
Transportation Total:							**811356.24**

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation - one-way trip	☐	One-Way Trip	743	14.00	66.12	**687780.24**	
Transportation - per mile	☐	Mile	300	152.00	2.71	**123576.00**	
Virtual Communication and Monitoring (VCAM) Total:							**1159666.20**
Virtual Communication and Monitoring (VCAM)	☐	Monthly	385	9.00	334.68	**1159666.20**	

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