MASSACHUSETTS DEPARTMENT OF DEVELOPMENTAL SERVICES

Home & Community Based Services

Adult Waiver Programs Guide

Department of Developmental Services
500 Harrison Ave.
Boston, MA 02118

This Guide provides interpretive guidelines to Department of Developmental Services (DDS) staff with information regarding how to comply with the Centers for Medicare and Medicaid (CMS) and DDS regulations, policies, and practice regarding the three Adult Waivers administered by DDS. The Guide details the rules and responsibilities of staff in enrolling individuals in the Programs and delivering and monitoring their support and services.

This Guide is not meant to substitute for legal counsel or advice or a thorough understanding of the governing regulations and statutes. In the event that the provisions of the contents of this Guide conflict with any provision of law or regulation, such laws or regulations shall take precedent over the provisions in the Guide that are in conflict.

This Guide is effective as of ***January 1, 2016*** *and* ***supersedes all previous Guides and guidance materials****. Governing law, regulations, practice, and policy may be amended from time to time; notification of changes will be provided to DDS staff by the Waiver Management Unit. If you have any questions regarding the contents of this Guide or the three Adult Waivers, contact the Waiver Management Unit (contact information is available at the end of this guide).*

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Chapter

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Chapter 1

Introduction and Overview

In 1985, the Massachusetts Department of Developmental Services (the Department or DDS) received its original approval to operate a Home and Community-Based (HCBS) Waiver Program from the Federal Centers for Medicare and Medicaid Services (CMS).[1.] Since its inception in 1985, the Department's single comprehensive Waiver Program has grown from an initial enrollment of a few hundred individuals to an enrollment of over 13,000 participants in three Waiver Programs who receive community-based supports funded through a combination of state funds and federal Medicaid funds.

DDS now administers three separate Adult Waiver Programs for individuals with intellectual disability that reflect the principles of choice, portability, and self-direction.

Every State that operates a Waiver Program must comply with certain federal statutes and regulations. These statues and regulations govern participant eligibility criteria and establish certain requirements for the way the Waiver Program operates. A state must submit an application to CMS for approval for each Waiver Program it wishes to operate.

The application describes:

- How the Waiver Program will operate;
- The maximum limit on the number of unduplicated participants for each year the Program will operate;
- Any specific target groups for whom the state will reserve capacity;
- The process for evaluation and re-evaluation of level of care;
- A summary of the services covered and their specifications including any limits;

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1 In 1981, Congress authorized the ability for States to apply to the federal government the opportunity to waive some provisions of the Social Security Act which allows a state to provide home and community services (other than room and board) to individuals who would otherwise require SNF, ICF, or ICF-ID services reimbursable by Medicaid.

- The qualifications of providers of services;
- The person centered service planning, development and monitoring process;
- Opportunities for participant direction;
- Participant safeguards;
- Participant rights, including fair hearings; and,
- The financial accountability systems and processes in place.

The State must also assure through the CMS application several operating principles, to include:

- There is an evaluation and annual re-evaluation of level of care;
- Individuals have chosen to receive these services within the community rather than an Intermediate Care Facility for individuals with Intellectual Disability (ICF-ID);
- Service plans are person centered and address participants' needs, are monitored and updated at least annually, and services are delivered in accordance with the service plan, including the specified type, scope, amount, frequency and duration;
- Participants are afforded choice among Waiver services, providers and service delivery methods;
- Safeguards exist to protect the health and welfare of participants;
- Service providers are qualified and meet applicable standards;
- On an on-going basis, the state identifies, addresses and seeks to prevent the occurrence of abuse, neglect, and exploitation; and
- State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved Waivers.

Compliance with these assurances is imbedded in the activities at every level of DDS. Waiver requirements undergird the structure of the DDS service system from the initial efforts taken when an individual applies for DDS eligibility, to determining his/her eligibility for a Waiver Program, to operating a service planning process that identifies assessed needs and provides choice, to service delivery and on-going monitoring and documentation. Each of these activities is designed not only to comply with required federal assurances but also to meet the goals of the DDS Waiver Programs, which is to provide support to individuals in their communities that will obviate the need for more restrictive institutional care.

Massachusetts Waiver Programs Overview

The State Medicaid agency submits to CMS for review and approval the application for a Home and Community Based Services (HCBS) Waiver. In Massachusetts, the Executive Office of Health and Human Services, Office of Medicaid, administers the Medicaid (Title XIX) Program and the State Children's Health Insurance Program (SCHIP) (Title XXI). Massachusetts combines Medicaid and SCHIP into one Program called MassHealth.

CMS requires that the State Medicaid agency have the ultimate responsibility for all the HCBS Waiver Programs it operates. The State Medicaid agency may delegate the day-to-day operation of the Program to

another entity. MassHealth designated DDS the lead agency responsible for the day-to-day operation of these three Adult Waiver Programs.

MassHealth monitors compliance with all of the HCBS Waivers that operate in the Commonwealth and verifies applicants' financial eligibility to participate in a Waiver Program, i.e., applicant/participant is in the correct MassHealth Waiver category (coverage type).

The Commonwealth, through its various agencies, operates 10 Waiver Programs[2]. They include:

- The three ID Adult DDS Waivers discussed in this document;
- The Autism Waiver (for children) also operated by DDS;
- The Frail Elder Waiver operated by Aging Service Access Points (ASAPs) through the Office of Elder Affairs;
- The two Money Follows the Person Waivers,
  - The Residential Services Waiver operated by DDS,
  - The Community Living Waiver operated by the Massachusetts Rehabilitation Commission (MRC);
- The two Acquired Brain Injury Waivers,
  - The Residential Habilitation Waiver operated by DDS,
  - The Non-Residential Habilitation Waiver operated by MRC; and
- The Traumatic Brain Injury Waiver operated by MRC.

It is important to note that an individual can only be enrolled in one Waiver Program at a time.

CMS approves Waivers initially for three years and every five years thereafter. Eighteen (18) months prior to the renewal of a Waiver, CMS will review Waiver Programs using an Evidence Package submitted by the state's operating agency to verify that the Waiver Programs operate in accordance with the approved CMS application. An integral part of DDS participation in the HCBS Waiver Programs is the assurances provided to CMS that participants in the Waiver are healthy and safe and are receiving required services by qualified providers. The primary mechanism by which DDS reports its adherence to the required assurances is through the submission of this Evidence Package.

The Evidence Package is required for all Waivers and includes specific data on how DDS meets each of the six assurances required by each Waiver Program. They are:

- Level of Care;
- Service Plans;
- Qualified Providers;
- Health and Welfare;

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2 As of January 2016.

- Administrative Authority; and
- Financial Accountability

The Evidence Package forms the framework for continued participation and receipt of Federal reimbursement under the Waiver Program. MassHealth submits this evidence package to CMS on behalf of DDS because it is the oversight agency for all Waivers in the Commonwealth of Massachusetts.

The Three Waiver Programs

On July 1, 2010, DDS began operating three Adult Waiver Programs that replaced the single comprehensive Waiver. On July 1, 2013, the three Adult Waivers were amended and renewed for an additional five-year operating cycle.

These Waivers are the centerpiece of the DDS ID Adult service system.

They are the:

- Intensive Supports Waiver Program (formally known as the Residential Supports Waiver)
- Community Living Waiver Program
- Adult Supports Waiver Program

Each of the Waiver Programs has a unique configuration of eligibility requirements and services available for participants who need different levels of service intensity as determined by the Department.

Definitions for the services listed in the following tables are located in Chapter 4.

Intensive Supports Waiver

The purpose of this Waiver is to provide 24/7 community-based services to adults with intellectual disabilities, age 22 or older, who have been determined through an assessment process to need a comprehensive level of support. Individuals in this Waiver have a high level of support due to significant behavioral, medical, and/or physical support needs. Individuals in this Waiver need 24/7 support either in an out of home placement or with additional supports and supervision in the family home. For individuals who reside in the family home although natural supports and state plan supports are available, they are insufficient to meet the needs of the individual. For individuals who cannot or do not have family to provide care for them, the Waiver services in combination with MassHealth services, and generic community resources make it possible for them to successfully live in the community.

The population served in the Intensive Supports Waiver include individuals moving from ICFs-ID or nursing facilities, young adults aging out of special education, and individuals whose needs and caregiver circumstances have become more complex, requiring 24-hour care. Additionally, the individual's prospective Waiver service budget must be over $70,000 per year. However, if someone lives in a group home (residential habilitation) or shared living and the budget is less than $70,000 they still must be

enrolled in the Intensive Supports Waiver, as those services are not available in the other DDS Adult Waivers.

INTENSIVE SUPPORTS WAIVER SERVICES	
Adult Companion	Live-In Caregiver
Assistive Technology	Occupational Therapy
Behavioral Supports and Consultation	Peer Supports
Center Based Day Supports	Physical Therapy
Chore	Residential Habilitation
Community Based Day Supports	Respite
Day Habilitation Supplement	Specialized Medical Equipment and Supplies
Family Training	Speech Therapy
Group Supported Employment	Stabilization
Home Modification and Adaptations	Transitional Assistance Services
Individual Goods and Services	Transportation
Individualized Day Supports	Vehicle Modification
Individualized Home Supports	24 Hour Self-Directed Home Sharing
Individual Supported Employment	

Table 1 – Intensive Supports Waiver Services

Community Living Waiver

The purpose of the Community Living Waiver is to provide services to adults with intellectual disabilities, age 22 or older, who require a moderate level of assistance and who live in their own home or in their family's home and who meet the level of care for an ICF-ID. These individuals require less than 24 hours a day of support and may have challenging behaviors or have returned home from a placement, or the family member/caregiver may need significant help to provide direct physical assistance to assure the health and safety of the individual. The individual may have a moderate level of functional limitations resulting in the need for more regular support and supervision, or the individual may have medical issues requiring close monitoring and/or treatment.

Without the Community Living Waiver services, individuals would be at moderate risk for residential habilitation or institutionalization in an ICF-ID. For individuals who live outside the family home, these services are necessary due to a lack of adequate natural supports or a sufficient array of community services to support their health and welfare in the community. For individuals who reside with their families, the Waiver will provide a level of support to assist the individual to acquire the skills necessary to work and access the community or to provide substantial assistance to the family/caregiver to allow the individual to remain at home. Through the coordination of natural supports, MassHealth services, generic community resources and the services available in this Waiver, individuals are able to live successfully in the community. Additionally, the individual's prospective Waiver service budget must be $70,000 or less per year.

COMMUNITY LIVING WAIVER SERVICES	
Adult Companion	Individualized Home Supports
Assistive Technology	Individual Supported Employment
Behavioral Supports and Consultation	Live-In Caregiver
Center Based Day Supports	Occupational Therapy
Chore	Peer Supports
Community Based Day Supports	Physical Therapy
Day Habilitation Supplement	Respite
Family Training	Specialized Medical Equipment and Supplies
Group Supported Employment	Speech Therapy
Home Modification and Adaptations	Stabilization
Individual Goods and Services	Transportation
Individualized Day Supports	Vehicle Modification

Table 2 - Community Living Waiver Services

Adult Supports Waiver

The purpose of the Adult Supports Waiver is to provide community-based services to adults with intellectual disabilities age 22 and over, who have been determined through an assessment to require supports to reside successfully in the community. Included in this Waiver are individuals who live with family or in their own homes who meet the level of care for an ICF-ID but who have a strong natural or informal support system. Some participants may live in a home they manage and some may live with family and have significant behavioral, medical and/or physical supports. Through the coordination of natural supports, MassHealth services, generic community resources and the services available in this Waiver, individuals are able to live successfully in the community.

Without the Waiver services individuals would be at risk for more intensive supports or institutional care at an ICF-ID. For individuals who live outside of the family home, these services are necessary due to a lack of adequate natural supports or a sufficient array of community services to support their health and welfare in the community. For individuals who reside with their families, the Waiver provides a level of support to assist the individual to develop and acquire work skills or provides assistance to the family/caregiver to coordinate natural supports, MassHealth services, generic community resources and the services available in this Waiver so that individuals are able to live successfully in the community. Additionally, the individual's prospective Waiver service budget must be $40,000 or less per year.

ADULT SUPPORTS WAIVER SERVICES	
Adult Companion	Individualized Home Supports
Assistive Technology	Individual Supported Employment
Behavioral Supports and Consultation	Occupational Therapy
Center Based Day Supports	Peer Supports
Chore	Physical Therapy
Community Based Day Supports	Respite
Day Habilitation Supplement	Specialized Medical Equipment and Supplies
Family Training	Speech Therapy
Group Supported Employment	Stabilization
Home Modification and Adaptations	Transportation
Individual Goods and Services	Vehicle Modification
Individualized Day Supports	

Table 3 - Adult Supports Waiver Services

Restrictions and Limits

The following statements provide general information about the Waiver Programs:

- Certain services within Waivers have utilization and funding limits[3];
- An individual can only be enrolled in one Waiver Program at a time;
- Participants are eligible only for the services within the Waiver Program that s/he has been assessed to need;
- Waiver Program services are not "portable" to other states, so participants moving out of or into Massachusetts cannot take their Waiver Program benefit with them;
- If a participant's needs change and cannot be met by his/her current Waiver Program, s/he can no longer receive services in that Waiver Program. A change of need form must be submitted to the Waiver Management Unit in order for the participant to be enrolled into an appropriate Waiver Program (Please refer to Chapter 10);
- Waiver Program services cannot supplant services available under the Vocational Rehabilitation Act (VRA),the Individuals with Disabilities Educational Act (IDEA), the MassHealth State Plan or Private Insurance; and
- An individual cannot be in a Waiver Program and also be enrolled in OneCare, Senior Care Option (SCO) or Programs of All-Inclusive Care for the Elderly (PACE).

Services Not Allowable in the Waiver Programs

Below is a list of individual expenses not allowed under any circumstances for DDS Waiver Participants whether self-directed, through agency with choice or through provider services and programs[4]

3 See service definitions in Chapter 4 for additional information.

Medical

- Payment for experimental and/or non-approved FDA (U.S. Food and Drug Administration) treatments or medications unless it is part of an approved clinical trial.
- Money to supplement MassHealth rates for medically necessary services.
- Costs associated with CommonHealth premiums and other private health insurance premiums (excluding prescription co-payments).

Housing

- Payment for housing supports such as the principal on a mortgage, the down payment on a residence, or tax or other municipal bills on property.
- Room and board costs. All individuals who receive room and board assistance from DDS are required to make a financial contribution towards their monthly room and board costs.
- Capital Improvements. (E.g. new roof[5] etc.)

Personal Expenses

- Items or activities that have limited benefit to the individual with a disability. Examples include big screen television for a family room that is inaccessible to the individual with a disability; home modifications/additions which have no direct impact on the functional limitations of the individual with a disability.
- Luxury items that are fixed capital improvements to the home, (spa, pool, etc.).
- Share of cost of family vacation, including family travel and transportation costs, and/ or housing rental.[6]

Legal

- Payment of an attorney or legal fees for any purpose. Examples include fees related to trusts, guardianship, citizenship, rep-payee or educational appeals.
- Any expenses or fees related to obtaining guardianship for the individual with a disability, including but not limited to attorney and legal fees or any other fees or costs associated with the guardianship process.

Miscellaneous

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4 Information about Self-direction and agency with choice are located in chapter 6.

5 Based upon assessed needs, some windows may be allowable.

6 Reasonable individual vacation costs, including personal travel, are permissible.

- The provision of services that are normally covered by other DDS service codes.
- Any purpose that may directly or indirectly jeopardize the integrity of the program, for example, support for criminal conduct or any activity that places the individual at physical or medical risk.

- Use of public monies for the purchase of private items or services that are not allowed by state regulation or statute, including the regulations of the Division of Purchased Services 808 CMR1.00 and the State Anti-Aid Amendment
- Use of public monies for the purpose of lobbying or for litigation against the Commonwealth including Division of Purchased Service regulations found in 808 CMR 1.00 and state statutes.

Chapter

2

Chapter 2

Waiver Application and Eligibility Process

In order for individuals to be eligible for an Adult DDS Waiver Program, they must meet the following requirements:

- Apply to become a Waiver participant;
- Be a person with Intellectual Disability as determined by DDS;
- Be eligible for and enrolled in MassHealth Standard (see Financial Eligibility section in this chapter for further guidance);
- Be at least 22 years of age or older;
- Reside in Massachusetts;
- Be eligible for admission to an Intermediate Care Facility for Individuals with Intellectual Disability (ICF-ID);
- Choose to receive services in the community rather than in an institutional setting; and
- Be assessed by DDS to need one or more Waiver services monthly.

In addition to meeting the above requirements, in order to be enrolled there must be sufficient capacity in the appropriate Waiver Program to which the individual is applying.

Assessment and Prioritization for Services

Eligibility for a Waiver Program begins with the DDS Adult eligibility process. Individuals apply for eligibility for DDS services through Regional Eligibility Teams (RET). These teams collect assessment information, administer the Inventory for Client and Agency Planning (ICAP), and make a determination of eligibility for DDS Adult intellectual disability services. If an individual is determined eligible for DDS

Adult intellectual disability services, the RET assigns the individual to an Area office and shares that information with that Area Office.

The Department employs a clinical assessment tool called the Massachusetts Comprehensive Assessment Profile (*MASSCAP*) that determines the need for residential and/or intensive level of service. The ICAP, a nationally used adaptive behavior assessment, along with the Consumer and Caregiver Assessment (CCA) developed by the Department together constitutes the *MASSCAP*. These assessment tools are used together to determine the eligibility and prioritization for adult services. The *MASSCAP* process requires the exercise of professional judgment in measuring and assessing the domains of the *MASSCAP* and the need for services.

The administration of the *ICAP* most often occurs at the time of Adult Eligibility. In addition, the Area *MASSCAP* Team may administer the *MASSCAP* when an individual or guardian requests a new service and when an individual experiences significant changing needs.

Following the administration of the *MASSCAP*, the Area *MASSCAP* Team, along with the Area Director, determines the individual's prioritization for the requested service(s). It is at this time that the Area Office will determine whether the identified need can be met with a DDS State funded[7] service.

Enrollment Activities and Individual Discussions

Waiver enrollment begins with the individual completing a Waiver application. The receipt of a Waiver application begins a series of activities by the Area that includes discussions with the individual and guardians, assessing the individual's need for services and the urgency of that need, and discussing the Department's Waivers. Individuals and their families or guardians can apply for the Department's Waiver Programs at any time; however, DDS ID eligibility is a core criteria for Waiver eligibility.

An Individual may choose which Waiver Program(s) he or she is applying for; the Intensive Supports Waiver, the Community Living Waiver, the Adult Supports Waiver, or all of the Adult Waiver Programs. It is recommended that the applicant and/or his or her family check "ANY" in order for the Waiver Management Unit (WMU) to appropriately determine which Waiver to enroll the applicant into as well as to allow for future change of need requests to be processed quickly and without the need for an another application.

There are many opportunities for Service Coordinators to provide information and guidance about the Department's three Adult Waivers. When discussing the three Adult Waivers, Service Coordinators should offer the written materials developed to inform individuals about the Waiver Programs and make available a Waiver Application Form to aid in discussions regarding service planning. Service Coordinators must also inform the individual/guardian that in order to be on an Adult Waiver, the individual must also apply for and be enrolled in MassHealth if they are not already receiving MassHealth benefits. MassHealth applications should be made available to the individual to complete.

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7 DDS State funded services are distinct and separate services from MassHealth State Plan Services.

Individuals New to DDS

After DDS has determined that an individual is eligible for DDS services pursuant to 115 CMR 6.00 et seq., DDS Area Office staff will share information about the three Adult Waiver Programs. Individuals are provided written information about the Waiver Programs and a Waiver application form. In addition to a completed Waiver Application, each individual must:

- have a completed Level of Care Determination (LOC),
- have a Statement of Need determination,
- be in a Waiver eligible MassHealth category, and
- be prioritized for a Waiver service.

Individuals and Guardians need to be aware that these processes must be completed with the Area Office before they may become eligible for enrollment in a Waiver Program.

Individuals receiving Services but not Enrolled in a Waiver Program

If a person receiving services that are available in a Waiver is not enrolled in a Waiver Program and could meet the eligibility standards for a Waiver Program, the Service Coordinator should use the ISP meeting or the next contact as an opportunity to discuss the Waiver Programs and to provide the individual with a Waiver Program application form.

If the individual is not likely to meet the eligibility criteria for a Waiver Program, the Service Coordinator should use the next ISP meeting or the next contact as an opportunity to discuss the Waiver Programs, explain why the person is not eligible, and provide information regarding how the person can become eligible for a Waiver Program, if appropriate. It is the Area Office's responsibility to assist individuals enrolled in a Waiver to maintain their financial eligibility for the Waiver Program.

Every year at the ISP meeting, the Service Coordinator should remind the individual/guardian about the Waiver Programs, answer questions, and provide documentation as appropriate.

Individuals Transitioning from an ICF-ID

For individuals living in ICFs-ID who are transitioning to community placements, the Area Office should provide an explanation of the Waiver Programs and a Waiver Program application form as part of the Individualized Transition Planning (ITP) process. The Area Director should complete the LOC and Statement of Need determinations in MEDITECH at the time of discharge from the ICF-ID.

Individuals in Crisis Situations who are not enrolled in a Waiver Program

For individuals in crisis who are not enrolled in a Waiver Program, after the crisis has been stabilized, during service planning, the Service Coordinator should describe the Waiver Programs and provide a brochure and a Waiver Program application form to the individual/guardian. The Area Director is required to complete the LOC and Statement of Need determinations in MEDITECH prior to enrollment in the Waiver Program. MEDITECH is the official electronic system of record for DDS individuals.

MassHealth Financial Eligibility Requirements

Because the DDS Adult Waivers are MassHealth programs, individuals who participate in a Waiver, must be eligible for and receive MassHealth Standard benefits. MassHealth determines an individual's financial eligibility for the Waivers. MassHealth has different financial eligibility rules for people in different categories. People in long term care facilities, community residents under age 65, community residents over age 65 and HCBS Waiver participants each have different financial eligibility rules. In order for the MassHealth Enrollment Centers (MEC) to know which set of rules to use, it must know to which group the applicant belongs. DDS, through a UMASS Benefit Coordinator, provides the documentation needed by the MEC to determine which rules apply. This documentation includes a current Level of Care determination and either a Waiver enrollment or a pending application with the projected Waiver indicated. The MEC will not process a determination or redetermination without this documentation.

MassHealth Financial Eligibility Determination Rules

Individuals who are clinically eligible to participate in any Massachusetts Waiver benefit from MassHealth expanded financial eligibility rules. Individuals can earn up to 300% of the Federal Benefit Rate (FBR) as opposed to the 133% of the Federal Poverty Level (FPL) for MassHealth recipients who are not participating in a Waiver[8] and his/her countable assets must be less than $2,000. The individual's spouse's income (if applicable) is not included in the income calculation. The FBR is subject to change on an annual basis.

These expanded financial eligibility rules allow for individuals who might otherwise be ineligible to receive MassHealth benefits to become eligible for MassHealth if they are part of a Waiver. *It is very important to maintain the MassHealth financial eligibility for Waiver participants or an individual could lose their health insurance.*

UMASS Medical School Coordination of Benefits

DDS utilizes UMASS Medical School's Benefit Coordinators to assist Area Offices with both the conversion of an individual into the correct Waiver billable category and to assist with MassHealth financial eligibility redeterminations. These benefit coordinators are also involved directly with Waiver claims to ensure that the State receives the appropriate Federal Financial Participation (FFP) from the Federal Government.

Applicants not known to MassHealth

Applicants who are currently not receiving MassHealth benefits will have to apply for MassHealth in order to be enrolled in a Waiver. Upon receipt of a Waiver application, the WMU will determine if the individual is receiving MassHealth benefits: either in a correct Waiver category or in a Waiver category that will need to be converted. (UMASS Medical School's Benefit Coordinators will assist with the MassHealth conversions as stated above). If the applicant is not receiving MassHealth benefits, the WMU will notify the Area Office that the applicant must apply for MassHealth. The Area Office should assist the individual with applying for MassHealth. If no application for financial eligibility has been submitted to MassHealth after 90 days from receipt of a Waiver application, the WMU will issue a denial letter to the applicant informing him or her that he or she does not meet the financial eligibility requirements. The denial notice

8 Please contact the Waiver Management Unit to find out the current income dollar amount.

will contain a notice of appeal rights. The individual can re-apply to one of the Waivers at any time, but it is recommended s/he access his/her MassHealth benefit prior to re-applying.

Submitting Waiver Application

Service Coordinators and Area Office staff can assist individuals/guardians in completing and mailing application forms to the Waiver Management Unit (WMU). Applications cannot be faxed or hand-delivered. This is because an original signature on the Choice of Community form and a date stamp on the envelope for time tracking the processing of the application are required. The application ***must be sent*** to the WMU at Central Office.

Department of Developmental Services
Waiver Management Unit
500 Harrison Ave.
Boston, MA 02118

Processing Waiver Applications

When Application Forms arrive at the WMU they are date stamped in the order received. Applicants will NOT receive a letter or other notification indicating receipt of their Application Form by the WMU.

Service Coordinators, Area/Regional Management can view information for existing DDS individual's Waiver application status by viewing the Waiver CDS (Waiver Application and Details in the CDS Menu) in MEDITECH. Reports are available to view application, new applications received and status by caseload and Area Office.

There are several places during the Waiver application and enrollment process where an applicant could be rejected for enrollment because they do not meet a particular eligibility criterion for a Waiver Program (listed at beginning of chapter). Should an individual fail to meet one of the criteria for participation, s/he will be notified of the reason s/he is being denied eligibility for a particular Waiver Program and his/her right to appeal this decision. In all cases, the notification is in writing, and appeal rights are described. (See Appeals below)

Target Groups

As part of its approved Waivers, the Department has identified specific target groups of individuals for whom it has prioritized its resources. Each year the Waiver capacity is increased[9] and target group members are given priority for these new Waiver slots.

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9 Waiver year for the DDS Adult Waivers is the same as DDS' fiscal year: July 1st to June 30th.

If an individual is determined to meet the criteria for a target group enrollment, an application for Waiver Program participation must be completed by the individual or guardian and sent to the WMU to determine eligibility for the Waiver Program for which s/he has applied before s/he will be enrolled. The table below lists the specified target groups for whom DDS has prioritized its resources and has reserved capacity each year in the Waiver Programs.

TARGET GROUP	INT	CLS	ADS
Individuals transitioning from ICFs-ID to the community;	X		
Individuals transitioning from a skilled nursing facility into the community;	X		
Individuals determined through assessment to be the highest priority (Priority One) for services; and	X	X	X
Individuals who are turning age 22 and are part of the C.688 process;	X	X	X
Individuals enrolled in a Waiver Program who have changing needs	X	X	X

Table 4: Target Groups by Waiver

Waiver Eligibility Determination

Waiver Determination Notice to Applicants

Within 90 days of receipt of an application, the WMU makes a determination regarding the applicant's clinical and financial eligibility for the Waiver Program to which s/he has applied.

If the applicant meets the eligibility criteria and there is sufficient capacity within that Waiver Program, the WMU will enroll the individual in that Waiver. If all necessary documentation has not been submitted within 90 days of the WMUs receipt of the Waiver application, the application will be denied and the applicant is notified or his/her appeal. The applicant may re-apply at any time.

Individuals with Changing Needs who may need to change from one Waiver Program to Another

Individuals whose needs have changed resulting in his/her prospective budget exceeding the specific limitations for the Waiver s/he is currently enrolled in will require a change of need form to be submitted to the WMU. The Service Coordinator should explain to the participant the need for the Waiver change. The Area Office informs the WMU using the Waiver Change in Need form as soon as the individual begins receiving the additional service(s) requiring a change to a new Waiver Program. At that time, the WMU will check to make sure there is an application on file stating the individual had applied for "ANY" Waiver. If not, the WMU will request that the Service Coordinator obtain an appropriate application. After all correct documentation is in place and a slot is available in the requested Waiver change, the WMU will dis-enroll the individual from their current Waiver Program under which s/he previously received services and enroll them into the appropriate Waiver. Enrollment into the new Waiver will be dated the

same date as the new service enrollment. The individual will be notified of both the dis-enrollment and subsequent enrollment and be provided with the appeal rights.

Appeal from Denial of Eligibility for a Waiver Program or an Adverse Determination by DDS[10]

An individual is entitled to a hearing to contest certain determinations made by DDS with respect to Waiver enrollment and Waiver services. Waiver appeals are governed by federal regulations, including the content of notices about the right to a hearing that are issued by DDS. 42 CFR 431, subpart E (42 CFR 431.200-431.250.)

An Individual has the right to request a fair hearing when:

(a) the WMU issues a determination denying enrollment in the Waiver program that the individual applied for;
(b) he or she is not provided a choice of home and community-based services as an alternative to institutional (ICF/ID) care;
(c) he or she is denied his or her choice of Waiver service or a qualified and willing provider; or
(d) a Waiver service(s) is denied, suspended, reduced or terminated.

The WMU will send a written notice to an individual or his or her guardian, if applicable, informing him or her of the method by which he or she may obtain a hearing. In cases that the Notice of Appeal Rights pertains to a suspension, reduction, or termination of a Waiver service(s) it shall inform the individual that DDS will not terminate or reduce services unless and until a decision authorizing such action is rendered after the hearing. Among other things, federal regulations provide that an individual may appeal DDS decisions regarding "changes in the type or amount of services."

The notice of appeal rights also informs the individual that the procedures governing Waiver Program appeals may be found at 115 CMR 6.33-6.34 (DDS appeals regulations) and 801 CMR 1.02 (the Informal Rules of the Standard Adjudicatory Rules of Practice and Procedure).

10 The Office of Medicaid (MassHealth) determines financial eligibility for Waivers subsequently, appeals for financial eligibility are submitted directly to MassHealth and the MassHealth Board of Hearings.

Chapter

3

Chapter 3

Level of Care

Waiver applicants must be assessed to meet the eligibility requirements for admission to an ICF-ID and require at least one Waiver service on a monthly or more frequent basis to be eligible to participate in a Waiver Program. Individuals who do not meet this Level of Care are generally fairly independent and able to function with little supervision.

What Constitutes Level of Care

Meeting Level of Care requires that all of the following criteria be met. They are:

- The individual is determined by the Regional Eligibility Team (RET) to be DDS eligible on the basis of ID;
- The individual meets the clinical eligibility for a Waiver Program, based on the Department's needs assessment process (MASSCAP, HCBW tool, and other available information); and
- The individual needs at least one Waiver Program service monthly.

Table 5: Level of Care Criteria

Level of Care Determination

Each applicant for the Waiver Program must have his/her Level of Care evaluated in order to determine his/her eligibility for the Waiver Program. Individuals already participating in a Waiver Program must have their Level of Care re-evaluated at least annually or upon a significant change in their functioning. DDS

determines Level of Care (LOC) for Waiver Program applicants and participants through the DDS needs assessment process (*ICAP and/or the HCBW Tool*[11]) and the process occurs as follows:

For new applicants for DDS services. Within 60 days the RET administers the Inventory of Client Agency Planning (ICAP) in order to assess the initial Level of Care for ID individuals. An applicant must have and ICAP score of 85 or lower to meet the Level of Care for a Waiver Program.

For individuals who are already DDS eligible who apply for a Waiver Program or for individuals who are transitioning from an ICF-ID to the Community. The HCBW Tool (a shortened version of the *MASSCAP*) is administered if there is not already a current HCBW Tool on file (meaning less than 365 days). A LOC determination must be made within 90 days of the Department's receipt of a Waiver application.

For individuals already enrolled in a Waiver Program. The Service Coordinator, as part of the participant's annual support planning process, determines if the participant continues to meet LOC and must review the HCBW Tool each year. If during that review, there has been a significant change in the individual's condition or functioning and the individual receives a score of 8 or below on the HCBW Tool, a *MASSCAP* or components of the *MASSCAP,* based upon professional judgement, must be administered to determine if s/he continues to meet LOC.

HCBW Scoring Guidelines: An HCBW score of 5 means the individual does not meet LOC; scores 9 or higher on the HCBW Tool means that the individual meets the LOC. Scores between 6 and 8 require that the Area Director use professional judgment to determine whether the individual meets the LOC.

The following chart summarizes the required assessments and process for initial and annual re-evaluations of Level of Care.

GROUP	Initial	Ongoing
New applicants for DDS services	*ICAP*	HCBW Tool Administered
DDS Consumer not in a Waiver Program	HCBW Tool Administered	HCBW Tool Administered
Existing Waiver Participants		HCBW Tool Reviewed
Changing Needs	*MASSCAP (if 8 or below)*	HCBW Tool Reviewed

Table 6: LOC assessment process (see above for more detail)

11 Home and Community Base Wavier Tool (HCBW) is a modified tool that assures the continued meeting of level of care.

Documenting Level of Care and Statement of Need

For each year the Area Director documents in the MEDITECH Customer Defined Screen (CDS) "LOC Determination Screen" that s/he has determined through an annual needs assessment process that the individual is clinically eligible for DDS services, meets the Level of Care criteria for ICF-ID care and needs at least one Waiver service monthly.

Area Directors must generate a new CDS each year to document that the determination is completed. An existing CDS should never be overwritten as it is date specific and is required for claiming and auditing purposes.

Documenting Level of Care

Documenting Level of Care begins with the administration of either the *MASSCAP* or HCBW. If this is the initial assessment, then the Regional Eligibility Team (RET) enters the ICAP score in MEDITECH (PCS) or the Participant's Service Coordinator completes the HCBW Tool and enters those scores in (PCS). In subsequent years, the HCBW Tool is reviewed using the "recall values" function in MEDITECH.

The Area Director must review the appropriate scores (ICAP or HCBW when appropriate) recorded in MEDITECH to make his or her determination. To indicate that the applicant meets or the participant continues to meet the Level of Care criteria; the Area Director places a "Y" in the field "Meets Level of Care" and selects his/her name from the adjacent "Determined by" drop-down menu.

Documenting Statement of Need

The Department assures that applicant/participant is in need of at least one Waiver service monthly. This is referred to as the **Statement of Need**. The MEDITECH Customer Defined Screen (CDS) is where the Area Director documents that s/he has determined through a needs assessment process that the individual is clinically eligible for DDS services, meets the criteria for ICF-ID institutional care and needs at least one service available in a Waiver Program monthly. The Area Director should indicate with a "Y" in the field on the CDS after the statement, "There is reasonable indication that the individual needs a waiver service in the near future (one month or less)," that the person meets the Statement of Need criteria.

Applicants Who Don't Meet the Level of Care for the Waiver Program

If the Level of Care evaluation process indicates that an individual does not meet the ICF-ID Level of Care, s/he is not eligible to participate in a Waiver Program. Meeting the LOC requires either an ICAP or HCBW score within the correct range AND the need for at least one Waiver service monthly. Both conditions must be present to meet Level of Care.

The Area Director enters an "N" in the field after "Meets Level of Care" statement on the screen, selects his/her name in the "Determined by" field and chooses from a drop-down list the appropriate reason why an individual does not meet the Level of Care. The reasons for not meeting Level of Care are as follows:

- DDSINELIG – DDS Ineligible
- NOTMEETNAP – Doesn't meet Needs Assessment Process
- NOWAIVSVC – No Waiver service required monthly.

Waiver Management Unit and LOC and Statement of Need

Upon receipt of an application, the Waiver Management Unit (WMU) reviews the "LOC Determination Screen" for the applicant to determine if the applicant meets the Level of Care and Statement of Need criteria for Waiver enrollment. The WMU issues a Notice of Ineligibility along with an explanation of appeal rights to applicants who do not meet the Level of Care for a Waiver Program. Individuals may appeal their LOC determination.

Chapter 4

Chapter 4

Waiver Services

The goal of the Waiver Program is to assist participants to live in the community and avoid institutionalization. Waiver services address a participant's health and welfare needs and complement services furnished through the MassHealth State Plan and other formal or informal supports. Each participant must have a need for the Waiver Program service they are receiving, as determined through on-going person centered service planning, using assessments and available information. Individuals who are self-directing their services may only use their individual allocation to purchase services for which they have an assessed need.

Services that are recreational in nature are not allowable Waiver Program services. Waiver funds cannot be used to pay for room and board expenses or to acquire goods and services such as a cable television service that a household, which does not include a person with a disability, would be expected to pay for as a normal household expense. If an individual has an assessed need for a service not available in a Waiver Program depending on circumstances, it sometimes may be funded by DDS as "Non-Waiver Financial Assistance." Decisions regarding such services are made through the service planning process and are subject to appropriation.

CMS HCBS Community Rule

All Services defined in the section must meet CMS' requirements for a home and community-based setting (known as the HCBS Community Rule). The basic requirements involve making sure that all Waiver participants have access to and are integrated in the greater community, are treated with dignity and respect and have choice and control over all aspects of their lives. Modifications or restrictions to these requirements must be documented through the person-centered planning process involving the Waiver participant/guardian, DDS, and providers.

DDS is working with all providers to ensure that they meet these requirements. There are specific requirements for provider-owned and controlled settings, such as Residential Habilitation and Day and Employment Supports.

For more information on the Community Rule, go to: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services.html.

Service Delivery Methods

There are three types of **SERVICE DELIVERY METHODS** available for Waiver Program services. They are:

1) Provider Managed: A Provider Managed service is one where employees of an agency contracted by DDS deliver services to a participant. The provider has a written contract with DDS awarded through the Purchase of Service process. Providers are licensed by DDS to deliver the specific service. The provider is responsible for managing all elements of service provision in accordance with the service plan. In this model, the provider receives direction and supervision by DDS.

2) Participant-Directed: Participant-directed means that the participant has the authority to manage some or all aspects of service provision. The participant hires and supervises "individual providers" who deliver the service. Public Partnership Limited (PPL), the fiscal intermediary, completes all financial and some administrative functions. (See Chapter 5 for more information related to Participant-Directed Services).

3) Agency With Choice: Agency With Choice is a form of participant-direction and is known as a co-employment model. This means that the duties are split between the Agency, which serves as the employer, and the participant who serves as the managing employer. A person becomes an employee of the agency and the agency agrees to help the participant train and manage the staff.

An Individual can receive services through any combination of these service delivery methods. For example s/he could be enrolled in Residential Habilitation (3153) and use Agency with Choice Peer Supports (6716) along with Participant-Directed Transportation (5196).

Provider Types

Three **PROVIDER TYPES** can be employed to deliver Waiver Program services. They are:

1) Agency Providers: These are traditional providers licensed by DDS to deliver particular services. The Provider Managed model calls for the agency to directly employ staff and deliver a service in accordance with DDS regulations. The agency is paid based upon the Chapter 257 rates if applicable or at the rate negotiated in the contract.

2) Individual Providers: Participants who self-direct their services may do so by directly employing an individual or an agency if applicable (Vehicle Modification, Individual Goods and Services, etc.) to deliver their supports. This Individual Provider must meet a specific

set of qualifications. An individual provider is a person who is not employed by a provider agency and works independently. Any person employed directly by a participant is considered an individual provider. Rates of payment for individual providers are negotiated between the participant and the provider (subject to minimum wage regulations and Chapter 257 rate caps) and are paid by the fiscal intermediary.

3) Support Services Qualified Providers (SSQUAL): There is a standard set of qualifications for non-licensed providers of support services.

In many cases, the qualifications for Agency Providers are the DDS licensing requirements for the particular service.

Standard Qualifications

The **standard qualifications** for an Agency Provider, Individual Provider or SSQUAL are:

AGENCY PROVIDER QUALIFICATIONS

License: Licensed in accordance with 115 CMR 7.00, 8.00
Certificate: High School diploma, GED or relevant equivalencies or competencies
Other Standards:

- Possess appropriate qualifications as evidenced by interview(s) and two personal references,
- complete a Criminal Offense Records Inquiry (CORI),
- be age 18 years or older,
- be knowledgeable about what to do in an emergency;
- be knowledgeable about how to report abuse and neglect;
- have the ability to communicate effectively in the language and communication style of the participant,
- maintain confidentiality and privacy of the individual, and
- respect and accept different values, nationalities, races, religions, cultures and standards of living.

ENTITY RESPONSIBLE FOR VERIFYING PROVIDER QUALIFICATIONS: DDS Office of Quality Enhancement, Survey and Certification staff

FREQUENCY OF VERIFICATIONS: Annually or every two years, depending on level of licensure.

Table 7: Agency Provider Standard Qualifications

INDIVIDUAL PROVIDER QUALIFICATIONS

Certificate: High School diploma, GED or relevant equivalencies or competencies
Other Standards:

- Possess appropriate qualifications as evidenced by interview(s) and two personal references,
- complete a Criminal Offense Records Inquiry (CORI),
- be age 18 years or older,
- be knowledgeable about what to do in an emergency;
- be knowledgeable about how to report abuse and neglect;
- have the ability to communicate effectively in the language and communication style of the participant,
- maintain confidentiality and privacy of the individual, and
- respect and accept different values, nationalities, races, religions, cultures and standards of living.

ENTITY RESPONSIBLE FOR VERIFYING PROVIDER QUALIFICATIONS: DDS Waiver Management Unit

FREQUENCY OF VERIFICATION: Prior to utilization

Table8: Individual Provider Standard Qualifications

SSQUAL PROVIDER QUALIFICATIONS

If the agency is providing activities where licensure or certification is necessary, the applicant will have the necessary licensure/certification. The agency is responsible to ensure that staff has the specific competencies needed to meet the unique support needs of the individual receiving services.

Certificate: High School diploma, GED or relevant equivalencies or competencies
Other Standards:

- Possess appropriate qualifications as evidenced by interview(s) and two personal references,
- complete a Criminal Offense Records Inquiry (CORI),
- be age 18 years or older,
- be knowledgeable about what to do in an emergency;
- be knowledgeable about how to report abuse and neglect;
- have the ability to communicate effectively in the language and communication style of the participant,
- maintain confidentiality and privacy of the individual, and
- respect and accept different values, nationalities, races, religions, cultures and standards of living.

ENTITY RESPONSIBLE FOR VERIFYING PROVIDER QUALIFICATIONS: DDS Office of Quality Enhancement, Survey and Certification staff

FREQUENCY OF VERIFICATION: Administrative Desk Review every two years

Table 9: SSQUAL Provider Standard Qualifications

For services where the standard qualifications do not apply or there are additional requirements, the specific qualifications are listed within the service definitions below.

Living Arrangements

A specific service enrollment may not be allowable based upon an individual's living arrangement. Service Coordinators must enroll an individual into one of three living arrangements in MEDITECH:

1) zLivInd: Living independently in own home (may be with caregiver in own home) where the individual holds the lease or mortgage; or for individuals in 3798, the lease may be in the provider's name and the individual contributes to the rent.

2) zLivCare: Living independently in a caregiver home (may be caregiver home for home sharing) where the lease or mortgage is in the provider's name.

3) zLivFam: Living with the individual's family.

Exception to the Living Arrangement rule: The only individuals not to require a living arrangement are those enrolled in a Residential Habilitation or Placement Service code (3150, 3153, 3161, 4157, 9150, or 9153). These codes are considered the living arrangement.

Waiver Service Definitions and Guidance

The following pages contain the Waiver Program services in the three adult Waivers. Note that the initial digit in an activity code signifies the following:

3XXX	Provider Service
4XXX	State-Operated Service
5XXX	Self-Directed Service
6XXX	Agency with Choice Provider Service
9XXX	Massachusetts Commission for the Blind

Adult Companion

SERVICE CODE(S):
3707 Adult Companion
5707 Adult Companion
6707 Adult Companion

SERVICE DEFINITION: Non-medical care, supervision and socialization provided to an adult. Services may include assistance with meals and basic activities of daily living such as shopping, laundry, meal preparation, and routine household care incidental to the support and supervision of the individual. The service is provided to carry out personal outcomes identified in the individual plan that support the individual to successfully reside in his/her home or in the family home. Adult companion may also be provided when the caregiver regularly responsible for

these activities is temporarily absent or unable to manage the home and care. Adult companion services are also available for an individual in his/her own residence who require assistance with general household tasks.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- This service may not be provided at the same time as:
  - Chore (5725),
  - Individualized Home Support (3703, 5703, 6703, 3798, or 3287);
  - Respite (3701, 5701, 6701, 3702, 5702, 3721, or 3759);
  - Group Supported Employment (3181);
  - Individual Supported Employment (3168, 3197, 5168, 3180 or 5180);
  - Individualized Day Supports (5704 or 6704);
  - Center Based Day Supports (3166, 3169, 4169, or 9168);
  - Community Based Day (3163 or 9163); or
  - When other services that include care and supervision are provided.
- This service is 23 hours or less per day.
- This service does not entail hands on nursing care.
- It is available to individuals who live in their family home or in a home of their own.
- This service is not permitted when an individual has a service enrollment in either Residential Habilitation or Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam

SERVICE DELIVERY METHOD:

- Provider Managed
- Participant Directed
- Agency with Choice

PROVIDER TYPE AND SPECIFICATIONS:

- Qualified SSQUAL Adult Companion Agency Provider
- Qualified Adult Companion Individual Provider
- Qualified Adult Companion Agency with Choice Provider

Assistive Technology

SERVICE CODE(S):
5283 Assistive Technology

SERVICE DEFINITION: Assistive technology is defined as an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, including the design and fabrication that is used to develop, increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, rental, or customization or use of an assistive technology device. This service also covers maintenance, repairs of devices and rental of assistive technology during periods of repair. Assistive technology service includes:

- The evaluation of the assistive technology needs of the participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
- Services consisting of purchasing, leasing or otherwise providing for the acquisition of assistive technology devices for participants;
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
- Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
- Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- Assistive technology must be purchased through a self-directed budget.
- Assistive Technology must be authorized by the Service Coordinator as part of the Individual Service Plan.
- Waiver funding shall only be used for assistive technology that is specifically related to the functional limitation(s) caused by the individual's disability.
- Adaptive Aids must meet the Underwriter's Laboratory and/or Federal Communications Commission requirements where applicable for design, safety, and utility.
- There must be documentation that the item purchased is appropriate to the participant's needs.
- Any Assistive Technology item that is available through the MassHealth State Plan must be purchased through the MassHealth State Plan; only items not covered by the MassHealth State Plan may be purchased through the Waiver. The Service Coordinator will explore with the individual/legal guardian the use of the MassHealth State Plan.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified Assistive Technology Individual Provider
- Qualified SSQUAL Assistive Technology Agency Provider

Behavioral Supports and Consultation

SERVICE CODE(S):

3710 Behavioral Supports and Consultation
5710 Behavioral Supports and Consultation

SERVICE DEFINITION: Behavioral supports and consultative services are clinical and therapeutic services that are necessary to improve the individual's independence and integration in their home or in their community. This service is available to waiver participants and is designed to remediate identified challenging behaviors or to acquire socially appropriate behaviors. Professionals in the fields of psychology, mental health, or special education provide behavioral supports and consultation. The service may include:

- A functional assessment by a trained clinician;
- The development of a positive behavior support plan which includes the teaching of new skills for increasing new adaptive replacement behaviors, decreasing challenging behavior(s) in the individual's natural environments;
- Intervention strategies;
- Implementation of the positive behavior support plan and associated documentation and data analysis, and/or
- Monitoring of the effectiveness of the plan.

Monitoring of the plan will occur at least monthly or more frequently as needed. The service will include any change to the positive behavior support plan when necessary and the professional(s) shall be available to provide recommendations to the ISP team and the Service Coordinator including making referral recommendations to community physicians and other clinical professionals that support the assessment findings. In order to carry out supports to Waiver Participants, training, consultation and technical assistance to paid and unpaid caregivers can be provided to enable them to understand and implement the positive behavioral plan at home.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- This service does not provide direct services to either paid or unpaid caregivers.

- The behavioral supports and consultation must be consistent with the DDS regulations.
- Access to this service is only permissible by prior authorization through the Area Office Psychologist or the Area Director.
- This service is available in the waiver participant's home or in the community.
- Behavioral Supports and Consultation does not include any service covered by the MassHealth State Plan including individual, group, or family counseling or under private insurance including benefits under An Act Relative to Insurance Coverage for Autism (ARICA).
- If the waiver participant has a co-occurring mental health diagnosis those mental health services must be accessed through the MassHealth State Plan.
- Providers must first access behavioral supports and consultation through their own agency.
- This service may be self-directed through the Fiscal Intermediary.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified Behavioral Supports and Consultation Individual Provider:
  - Additional Qualifications Include:
    - Doctoral degree in psychology, education, medicine or a related discipline and any state licensure required for that discipline.
    - For mental health professionals such as family therapists and rehabilitation counselors, necessary certification requirements must be met for those disciplines.
    - 1500 hours of relevant training, including course work in principles of development, learning theory, behavior analysis, and positive behavioral supports. Knowledge and experience in a range of interventions for adults with intellectual disabilities. The relevant training may be part of an advanced degree program. Two years of relevant experience in assuming the lead role in designing and implementing behavioral supports and consultation.
- Qualified SSQUAL Behavioral Supports and Consultation Agency Provider:
  - Additional Qualifications Include:
    - If the agency employs individuals to provide behavioral support and consultation, staff must meet all relevant state and federal licensure requirements in their discipline. Doctoral degrees in psychology, education, medicine, or related discipline and any related state licensure required for the discipline.
    - For mental health professionals such as family therapists and rehabilitation counselors, necessary certification requirements must be met for those disciplines.
    - 1500 hours of relevant training, including course work in principles of development, learning theory, behavior analysis, and positive behavioral supports. Knowledge and experience in a range of interventions for adults with intellectual disabilities. The relevant training may be part of an advanced degree program. Two years of relevant

experience in assuming the lead role in designing and implementing behavioral supports and consultation.

- Individuals with less than the highest advanced degree for the discipline can offer the service under the supervision of a licensed individual per state requirements.

Center Based Day Supports

SERVICE CODE(S):
3166 Day Services LUSA
3169 Center Based Day Supports
4169 Center Based Day Supports
9168 MCB Work

SERVICE DEFINITION: Center Based Day Supports are services and supports that lead to the acquisition, improvement, and/or retention of skills and abilities to prepare an individual for paid employment in integrated community settings. Services are not predominantly job-oriented, but are intended to develop and teach general habilitative skills such as increasing an individual's attention span, completing assigned tasks, following directions, learning effective communication skills with supervisors, co-workers, and customers, learning acceptable workplace conduct and dress, developing workplace problem solving skills and strategies, safety and mobility training that are associated with the successful performance of compensated work. The service may include volunteer work that contributes to the development of non job specific skills that promote employability. Individuals receiving pre-vocational services must have employment related goals identified in their Individual Service Plan which are reviewed at least annually. This service may include the identification of specific habilitative skills, the development and implementation of an individualized plan of supports and strategies, education about the benefits or work for individuals and their families, a preference assessment using inventories, observations, situational assessments, volunteer experiences and tours. Participation in pre-vocational services is not required for participation in individual or group supported employment.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- The aggregate number of day and employment supports cannot exceed the total number of business days per month as expressed in 8 hours per day. The maximum number of hours varies per month but the total cannot exceed 184 hours of combined day and employment supports in any month.
- The service is intended to be time limited.
- Services that are furnished to the individual are prevocational rather than vocational in accordance with 42 CFR ~440.18(c)(2)(i).

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified Center Based Day Agency Provider

Chore Services

SERVICE CODE(S):

5725 Chore Services

SERVICE DEFINITION: Services needed to maintain the home in a clean, sanitary, and safe environment. This service includes minor home repairs, general housekeeping and heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, and moving heavy furniture in order to provide safe egress and access.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- These services are only provided 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 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 the service.
- Service is not available in a provider operated setting.
- Chore service must be paid through a self-directed budget.
- Provider of services can be a relative as long as the relative is not legal guardian or legal representative.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd

SERVICE DELIVERY METHOD:

- Qualified Chore Services Individual Provider

Community Based Day Supports

SERVICE CODE(S):
3163 Community Based Day Supports
9163 MCB Day Supports

SERVICE DEFINITION: This program of supports is designed to enable an individual to enrich his or her life and enjoy a full range of community activities in a community setting by providing opportunities for developing, enhancing, and maintaining competency in personal, social and community activities. The service may include career exploration, including assessment of interests through volunteer experiences or situational assessments; community integration experiences to support fuller participation in community life; development and support of activities of daily living and independent living skills, socialization experiences and enhancement of interpersonal skills and pursuit of personal interests and hobbies. The service is intended for individuals of working age who may be on a pathway to employment, a supplemental service for individuals who are employed part-time and need a structured and supervised program of services during the time that they are not working, and for individuals who are of retirement age. Community based day supports provides a structured and supervised program of services and supports in a group setting which promotes socialization and peer interaction and development of habilitative skills and achieve habilitative goals.

WAIVER PROGRAM(S):
- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:
- The aggregate number of day and employment supports cannot exceed the total number of business days per month as expressed in 8 hours per day. The maximum number of hours varies per month but the total cannot exceed 184 hours of combined day and employment supports in any month.

ALLOWABLE LIVING ARRANGEMENTS:
- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:
- Qualified Community Based Day Agency Provider

Day Habilitation Supplement

SERVICE CODE(S):
3285 Day Habilitation Supplement

SERVICE DEFINITION: Day Habilitation Supplement consists of supplemental services that are provided at freestanding Day Habilitation program sites. The supplemental services consist of focused one-to-one assistance for individuals who have significant support needs who are either medically fragile with issues such as dysphasia, aspiration, and repositioning and/or exhibit extreme behavioral actions such as serious self-injurious behavior or injurious behavior directed at others such as pica, severe head-banging, pulling out fingernails and toenails, biting and other forms of aggression. The one-to-one assistance insures that the health and safety issues of both the participant and others who participate in the Day Habilitation program are met. Many of the participants have severe intellectual disability and are fully dependent on caregivers for risk management and protection.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- These supplemental services are not available to waiver participants in any other program, setting or site outside of a Day Habilitation program site.
- These supplemental services are not otherwise available under the MassHealth State plan, and are services that DDS has determined are necessary to enable the individual to participate in a day habilitation program.
- Transportation between the participant's place of residence and the day habilitation site is not provided.
- Meals are not provided.
- This service cannot be self-directed.
- This service is limited to 5 days per week and no more than 6 hours per day based on assessed need of the waiver participant.
- The scope and nature of these services do not otherwise differ from day habilitation services furnished under the MassHealth State plan.
- The aggregate number of day and employment supports cannot exceed the total number of business days per month as expressed in 8 hours per day. The maximum number of hours varies per month but the total cannot exceed 184 hours of combined day and employment supports in any month.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified Day Habilitation Supplement Agency Provider

Family Training

SERVICE CODE(S):
3709 Family Training
5709 Family Training
6709 Family Training

SERVICE DEFINITION: Family Training is designed to provide training and instruction about the treatment regimes, behavior plans, and the use of specialized equipment that supports the individual waiver participant to participate in the community. Family Training may also include training in family leadership, support of self-advocacy, and independence for their family member. The service enhances the skill of the family to assist the waiver participant to function in the community and at home. Documentation in the individual's record demonstrates the benefit to the individual. For the purposes of this service "family" is defined as the persons who live with or provide care to a waiver participant and may include a parent or other relative. Family Training may be provided in a small group format or the Family Trainer may provide individual instruction to a specific family based on the needs of the family to understand the specialized needs of their family member. The one to one family training is instructional. Service is available to those waiver participants who either live in the family home, receive less than 24 hours of support per day and for those individuals who regularly visit their family home from a residential setting.

WAIVER PROGRAM(S):
- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:
- Family does not include individuals who are paid caregivers.
- It is not counseling.
- It is not available to individuals who reside in a residential setting who do not have regular contact with family.
- This service may be self-directed.

ALLOWABLE LIVING ARRANGEMENTS:
- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:
- Qualified Family Training Individual Provider
- Qualified SSQUAL Family Training Agency Provider

Group Supported Employment

SERVICE CODE(S):
3181 Group Supported Employment

SERVICE DEFINITION: Group Supported employment services consist of the ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need support to perform in a regular work setting. The outcome of the service is sustained paid employment and work experience leading to further career development and individual integrated community employment for which the individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefit paid by the employer for the same or similar work performed by individuals without disabilities. Small group supported employment are services and training activities provided in regular business, industry and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile work crews, enclaves and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Services must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities including co-workers, customers, and supervisors. Group supported employment may include any combination of the following services: job-related discovery or assessment, assisting the participants to locate a job or develop a job on behalf of the participants, job analysis, training and systematic instruction, job coaching, negotiation with prospective employers, and benefits support. Typically group supported employment consists of 2-8 individuals, working in the community under the supervision of a provider agency. The individuals are generally considered employees of the provider agency. They are paid and receive benefits from that agency. Group supported employment includes activities needed to sustain paid work by participants including supervision and training and may include transportation if not available through another source.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- Transportation between the participants' place of residence and the employment site or between the provider site and the group employment site may be provided.
- Federal financial participation cannot be claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:

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

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

    3) Payments for training that is not directly related to a participant's supported employment program.

- Group supported employment does not include volunteer work or vocational services provided in facility based work settings.
- When supported employment services are provided at work sites where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required for participants receiving the waiver service as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting.
- The aggregate number of day and employment supports cannot exceed the total number of business days per month as expressed in 8 hours per day. The maximum number of hours varies per month but the total cannot exceed 184 hours of combined day and employment supports in any month.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified Group Supported Employment Agency Provider

Home Modifications and Adaptations

SERVICE CODE(S):

5731 Home Modifications and Adaptations

SERVICE DEFINITION: Those physical adaptations to the private residence of the participant, required by the participant's service plan, that are necessary to ensure the health, welfare, and safety of the individual, or that enable the individual to function with greater independence in the home. Service includes the assessment and evaluation of home safety modifications. This service can only be provided in the individual's primary residence. Such adaptations include but are not limited to:

- Installation of ramps and grab-bars;
- Widening of doorways/hallways;
- Modifications of bathroom facilities;
- Lifts: porch or stair lifts;
- Installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies, and which are necessary for the welfare of the individual;
- Installation of specialized flooring to improve mobility and sanitation;
- Specialized accessibility/safety adaptations/additions;
- Automatic door openers/door bells;
- Voice activated, light activated, motion activated and electronic devices;
- Door and window alarm and lock systems;
- Air filtering devices and cooling adaptations and devices; and
- Specialized non-breakable windows.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- Excluded are those adaptations or improvements to the home that are of general utility, and which are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning.
- All services shall be provided in accordance with State or Local Building codes.
- Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.
- General household repairs are not included in this service.
- The Service Coordinator will explore with the individual and family when relevant, utilization of appropriate modifications that are portable to accommodate changes in residence, size of the individual, and changes in equipment and needs. In addition, all proposals for home adaptations shall plan for the reuse of portable accommodations.
- This service must be an identified need and documented in the service plan.
- Funding for Home Adaptations is not available for use in any state operated or provider residence, or in the home of a home sharing care provider.
- No permanent adaptations to the structure can be made to property rented or leased by the participant, guardian or legal representative.
- The cost of services is not to exceed $15,000 in a five-year period.
- This service is only available to individuals who live in the family home or in a home of their own.
- All payments for Home Adaptations must be purchased through a self-directed budget.
- Waiver funding shall only be used for renovations that will allow the individual to remain in his/her home (primary residence), and must specifically relate to the functional limitation(s) caused by the individual's disability. It is not available to individuals who visit home periodically but who otherwise reside elsewhere.
- Provider of services can be a relative as long as relative is not a legal guardian or legal representative.
- Any use of Waiver funds for home adaptation requests must be submitted and approved in advance via the following steps:
    - The Service Coordinator must receive for his/her review and recommendation the following information: a proposal detailing the request for funding, and the completed Vehicle/Home Adaptations Funding Request Form. The participant's Individual Support Plan that clearly defines and explains the need for a home adaptation must be attached to this information.
    - If the DDS Service Coordinator recommends the proposal for funding, the request is then forwarded to the Area and then the Regional Director for review and recommendation of funding.
    - If a home adaptation request is approved, the individual/family must submit, at a minimum, 3 bids that contain costs and a work agreement, to the Department.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivFam

SERVICE DELIVERY METHOD:

- Qualified Home Modification and Adaptations Services Individual Provider

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Individual Goods and Services

SERVICE CODE(S):
5728 Individual Goods and Services

SERVICE DEFINITION: Individual Goods and Services are services, equipment or supplies that will provide direct benefit and support specific outcomes that are identified in the individual waiver participant's service plan. The Individual Goods and Services:

- Promote community integration;
- Provide resources to expand opportunities for self-advocacy;
- Decrease the need for other MassHealth services;
- Reduce the reliance on paid support; and/or
- Are directly related to the health and safety of the waiver participant in his/her home or community.

Examples of allowable Individual Goods and Services include:

- Enrollment fees;
- Dues;
- Membership costs associated with the individual's participation in community habilitation;
- Training,
- Supplies, and
- Materials that promote skill development and increased independence for the individual with a disability in accessing and using community resources.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- These services are used only when the waiver participant does not have the funds to purchase the item or service from any other sources and it is not possible to have them provided through other waiver services or the MassHealth State Plan.
- The Individual Goods and Services must be purchased through a self-directed budget.
- This service must be pre-approved by the Team and subject to DDS rules.
- The identified need must be documented in the service plan.
- Experimental and prohibited treatments are excluded.
- The Individual Goods and Services may not be provided at the same time as respite, or any employment or day activity program.

- Individual Goods and Services excludes all services and supplies provided under specialized medical equipment and supplies or assistive technology.
- This service is limited to $1,500 per waiver year.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified Individual Goods and Services Individual Provider

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Individualized Day Supports

SERVICE CODE(S):

5704 Individualized Day Supports
6704 Individualized Day Supports

SERVICE DEFINITION: Services and supports provided to individuals tailored to their specific personal goals and outcomes related to the acquisition, improvement, and/or retention of skills and abilities to prepare and support an individual for work and/or community participation and/or meaningful retirement activities, and could not do so without this direct support. This service originates from the home of the individual and is generally delivered in the community.

Examples:

- Develop and implement an individualized plan for day services and supports;
- Assist in developing and maintaining friendships of choice and skills to use in daily interactions;
- Provide support to explore job interests or retirement options;
- Provide opportunities to participate in community activities, including support to attend and participate in post-secondary or adult education classes;
- Provide support to complete work or business activities including supports for individuals who own their own business;
- Training and support to increase or maintain self-help, socialization, and adaptive skills to participate in own community; and
- Develop, maintain or enhance independent functioning skills in the areas of sensory-motor, cognition, personal grooming, hygiene, toileting, etc.
- The aggregate number of day and employment supports cannot exceed the total number of business days per month as expressed in 8 hours per day. The maximum number of hours varies per month but the total cannot exceed 184 hours of combined day and employment supports in any month.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- A qualified family member or relative, independent contractor or service agency may provide services.
- This service is not provided in or from a facility-based (center-based or community based) day program.
- This service is not provided from a provider-operated or state-operated group residence.
- This service may not be provided at the same time as:
  - Group Supported Employment (3181);
  - Individual Supported Employment (3168, 3197, 5168, 3180 or 5180);
  - Individualized Goods and Services Supports (5728);
  - Center Based Day Supports (3166, 3169, 4169, or 9168);
  - Community Based Day (3163 or 9163); or
  - When other services that include care and supervision are provided.
- This service must be pre-approved by the Team, subject to DDS rules stated above, and must be an identified need and documented in the service plan.
- The Individualized Day Supports must be purchased through a self-directed budget through either the Fiscal Intermediary or the Agency with Choice.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified Individual Goods and Services Individual Provider

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Individualized Home Supports

SERVICE CODE(S):

3703 Individual Home Supports
5703 Individual Home Supports
6703 Individual Home Supports
3798 Individualized Community Supports

SERVICE DEFINITION: Individualized Home Supports consists of services and supports in a variety of activities that may be provided regularly but that are less than 24 hours per day that are determined necessary to prevent institutionalization. This service provides the support and supervision necessary for the participant to establish, live in and maintain on an on-going basis a household of their choosing, in a personal home or the family home to meet their habilitative needs. These services assist

and support the waiver participant and may include teaching and fostering the acquisition, retention or improvement of skills related to personal finance, health, shopping, use of community resources, community safety, and other social and adaptive skills to live in the community as specified in the Plan of Care. It may include training and education in self-determination and self-advocacy to enable the participant to acquire skills to exercise control and responsibility over the services and supports they receive to become more independent, integrated and productive in their communities. The service includes elements of community habilitation and personal assistance.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- This service excludes room and board, or the cost of facility upkeep, and maintenance.
- An assessment is conducted during the Individual Support Plan Process and a Plan of Care is developed based on that assessment.
- The service is limited to the amount specified in the waiver participant's Plan of Care.
- This service may be delivered in a one's own home, or a family home, or in the community.
- The locating of appropriate housing is not covered as part of this service.
- No individual provision duplicates services provided under Targeted Case Management.
- This service may not be provided at the same time as:
  - Self-directed 24 hour supports.
  - Respite ((3701, 5701, 6701, 3702, 5702, 3721, or 3759);
  - Group Supported Employment (3181);
  - Individual Supported Employment (3168, 3197, 5168, 3180 or 5180);
  - Individualized Day Supports (5704 or 6704);
  - Center Based Day Supports (3166, 3169, 4169, or 9168);
  - Community Based Day (3163 or 9163); or
  - Individualized Goods and Services (5728);
  - Adult Companion (3703, 5707, 6707); or
  - When other services that include care and supervision are provided.
- This service may be self-directed through either the Fiscal Intermediary or Agency with Choice.
- This service is 23 hours or less per day.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam

SERVICE DELIVERY METHOD:

- Qualified Individualized Home Supports Individual Provider
- Qualified SSQUAL Individualized Home Supports Agency Provider

Individual Supported Employment

SERVICE CODE(S):
3168 Supported Employment
3197 Employment Services LUSA
5168 Supported Employment
3180 CIES - Competitive Employment
5180 CIES - Competitive Employment

SERVICE DEFINITION: Individual supported employment services consist of ongoing supports that enable a participant, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of his/her disabilities, needs support to perform in a regular work setting. Individual supported employment may include assisting the participants to locate a job or develop a job on behalf of the participant. Individual supported employment is conducted in a variety of settings, particularly typical work sites where persons without disabilities are employed. Emphasis is on work in an integrated environment with the opportunity for individuals to have contact with co-workers, customers, supervisors and others without disabilities. In individual supported employment the individual has a job based on his/her identified needs and interests, located in a community business. It may also include self-employment or a small business, or a home-based self-employment, or temporary services which may assist an individual in securing an individual position within a business. Individual supported employment may include job-related discovery or assessment; person-centered employment planning; job placement; job development; negotiation with prospective employers; job analysis, training and systematic instruction; job coaching in the form or regular or periodic assistance. Training and support are provided for the purpose of developing, maintaining and/or improving job skills and fostering career advancement opportunities. Job coaching at the job site is not designed to provide continuous on-going support; it is expected that as the individual develops more skill and independence the level of support will decrease and fade over time as the natural supports in the work place are established. Some ongoing intermittent job related support may be provided to assist the waiver participant to successfully maintain his/her employment situation. Natural supports are developed by the provider to help increase inclusion and independence of the individual within the community setting.

WAIVER PROGRAM(S):
- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:
- Individuals are paid by the employer.
- Transportation assistance between the participants' place of residence and the employment site is included in the rate paid to providers of individual supported employment services. Ongoing transportation for an individual participant is excluded from the rate. Time-limited transportation for components of discovery, career exploration, job development is provided. Once the individual is hired, transportation ceases.
- Individual supported employment may be self-directed.
- Federal financial participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:

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

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

3) Payments for training that is not directly related to a participant's supported employment program.

- When supported employment services are provided at work sites where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required for participants receiving the waiver service as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting.
- This service excludes individuals working in mobile crews or in small groups.
- This service excludes volunteer work.
- Service utilization is not to exceed 160 hours per month.
- The aggregate number of day and employment supports cannot exceed the total number of business days per month as expressed in 8 hours per day. The maximum number of hours varies per month but the total cannot exceed 184 hours of combined day and employment supports in any month.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified Individual Supported Employment Individual Provider
- Qualified Individual Supported Employment Agency Provider

Live-In Caregiver

SERVICE CODE(S):
5719 Live-In Caregiver

SERVICE DEFINITION: Live-in Caregiver provides for the additional costs of rent and food that can reasonably be attributed to a live-in personal caregiver who resides in the same household as the waiver participant. The live-in caregiver receives free room and board as a result of the live - in caregiver service. The Live - in caregiver service is an agreement between two roommates. The two individuals agree on how to divide up the household chores, whether they will participate in social activities together and any other typical roommate scenarios.

WAIVER PROGRAM(S):

- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- DDS requires that a written agreement regarding mutual expectations be developed between the consumer and the live-in caregiver. The two parties should discuss and commit to a division of household chores, internet service, an agreed upon notification period if either of the parties wishes to end the living arrangement, a policy about smoking, guests/overnights, pets, if permitted by the landlord.
- Payment of the live - in caregiver service is paid directly to the waiver participant who will use the money to pay the live-in caregiver's portion of the rent, utilities and food. Because payment is paid directly to the participant and not the provider, service coordinators/brokers must retain a copy of the lease and utility bills (if applicable) for audit purposes.
- The live-in caregiver cannot be related by blood or marriage of any degree.
- The live-in caregiver cannot be employed by a provider of waiver services.
- Non-Waiver Billable Service Codes under 5400 cannot be used with Live-In Caregiver as the rate includes provisions for the additional incremental cost of rent, food and utilities that are related to having an additional person living with them in a two bedroom unit.
- The individual cannot live in the caregiver's home or in a residence that is owned or leased by the provider of MassHealth services.
- The live-in caregiver service does not pay mortgage payments, real estate taxes, etc.
- Vehicle modification services can only be provided on the individual's own vehicle and not the live – in caregiver's vehicle.
- The live-in caregiver may provide up to 40 hours per week (maximum amount allowed) of direct service including:
  - Self-directed adult companion (5707);
  - Self-directed individualized home support (5703);
  - Self-directed individual supported employment (5168 or 5180); or
  - Self-directed individualized day supports (5704).
- The live-in caregiver service must be self-directed and paid through the Fiscal Intermediary.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd

SERVICE DELIVERY METHOD:

- Qualified Live-in Caregiver Individual Provider

Occupational Therapy

SERVICE CODE(S):
5243 Occupational Therapy

SERVICE DEFINITION: Occupational Therapy Services, including the performance of a habilitative or maintenance program, are provided by a licensed Occupational Therapist. Occupational therapy programs are designed to improve the quality of life by recovering competence, preventing further disability or injury,improving the individual's ability to perform tasks of daily living required for independent functioning and/or ameliorating sensory issues. The practice of Occupational Therapy encompasses evaluation, treatment, and consultation. Occupational Therapy services promote/maintain fine motor skills and coordination. Services are habiltiative and are designed to maintain or prevent the worsening of functioning. Occupational therapy services include but are not limited to specifically designed activities and exercises to teach daily living skills and to develop independent skills to enhance the areas of neurodevelopment, cognition, perceptual motor, sensory integrative and psychomotor functioning. Occupational Therapy may also design or apply selective orthotic or prosthetic devices or selected adaptive equipment and assist in the design of adapting environments. Services may also include the training and oversight necessary for the participant, family member or another person to carry out the maintenance program. Occupational Therapy under the waiver is different from MassHealth State plan services in nature and scope in that they allow for maintenance therapy not otherwise covered under the MassHealth State plan. Services are delivered in both offices and in the natural environments of the participant. The service may be provided individually and in small groups, in the natural milieu of the individual or in the community. The provider qualifications specified in the MassHealth State Plan apply.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- Occupational Therapy services must be authorized by the Service Coordinator as part of the ISP Team process.
- This service is not subject to the Medical Referral Requirements found at 130 CMR 432.414 or the requirements for Prior Authorization found at 130 CMR 432.417.
- The Occupational Therapy must be evidence-based and conform with acceptable medical practice; no experimental or alternative treatments are permitted.
- Any devices used in the provision of the service must be FDA approved.
- This service will not duplicate any services available through the MassHealth State Plan or private health insurance.
- This service cannot occur in Day Habilitation or in other sites where therapy is being provided.
- No more than one individual treatment and one group therapy session per day may be authorized.

- Payment will not be made for a treatment for the same date of service as a comprehensive evaluation.
- Occupational therapy must be purchased through a self-directed budget through the Fiscal Intermediary.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified SSQUAL Occupational Therapy Agency Provider
- Qualified Occupational Therapy Individual Provider

Peer Supports

SERVICE CODE(S):

3716 Peer Supports
5716 Peer Supports
6716 Peer Supports

SERVICE DEFINITION: Peer supports are designed to provide training, instruction and mentoring to individuals about self-advocacy, participant direction, civic participation, leadership, benefits, and participation in the community. Peer supports are designed to promote and assist the waiver participant's ability to participate in self-advocacy through either a peer mentor or through an individual/agency peer support facilitator. Peer supports may be provided in 1) small groups or 2) peer support may involve one individual who is either a peer or an individual peer support facilitator providing support to a waiver participant. The one to one peer support is instructional. The service enhances the skills of the individual to function in the community and/or family home.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- This service may be provided in small groups or as a one-to-one support for the individual.
- Peer support is available to individuals who receive less than 24 hours of support per day and those who reside in residential settings.
- This service is not counseling.
- This service may be self-directed.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified SSQUAL Peer Support Agency Provider
- Qualified Peer Support Individual Provider

Physical Therapy

SERVICE CODE(S):

5250 Physical Therapy

SERVICE DEFINITION: Physical Therapy services, including the performance of a habilitative or maintenance program, are provided by a licensed Physical Therapist. Services must be considered necessary by DDS for the participant to habilitate, maintain or prevent the worsening of functioning. Services are directed toward the management of movement dysfunction and/or the enhancement of physical and functional abilities. Physical Therapy Services promote/maintain gross/fine motor skills and facilitate independent functioning. Services may also include the training and oversight necessary for the participant, family member or other person to carry out the maintenance program. Physical Therapy under the waiver is different from MassHealth State plan services in nature and scope in that they allow for maintenance therapy not otherwise covered under the MassHealth State plan. The provider qualifications specified in the MassHealth State Plan apply.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- Physical Therapy services must be authorized by the Service Coordinator as part of the Individual Service Plan.
- The Physical Therapy must be evidence-based and conform with acceptable medical practice; no experimental or alternative treatments are permitted.
- Any devices used in the provision of the service must be FDA approved.
- Services are delivered in both offices and in the natural environments of the participant.
- The service may be provided individually and in small groups.
- This service is not subject to the Medical Referral Requirement found at 130 CMR 432.415 or the requirements for Prior Authorization found at 130 CMR 432.417.
- This service will not duplicate any services available through the MassHealth State Plan or private health insurance.
- This service cannot occur in Day Habilitation or in other sites where the therapy is being provided.
- No more than one individual treatment and one group therapy session per day may be authorized.

- Payment will not be made for a therapy in which there is no DDS assessment or authorization.
- Payment will not be made for a treatment for the same date of service as a comprehensive evaluation.
- Physical Therapy must be purchased through a participant-directed budget through the Fiscal Intermediary.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified SSQUAL Physical Therapy Agency Provider
- Qualified Physical Therapy Individual Provider

Residential Habilitation

SERVICE CODE(S):

3150 Placement Services
3153 Residential habilitation
3161 Residential LUSA
4157 State Operations
9150 Placement Services
9153 Residential Habilitation

SERVICE DEFINITION: Residential habilitation consists of ongoing services and supports by paid staff that are designed to assist individuals to acquire, maintain, or improve the skills necessary to live in a non-institutional setting. Residential habilitation is available to individuals who need daily staff intervention with care, supervision and skills training in activities of daily living, home management and community integration and live in a certified or licensed home with 24 hour staffing. Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports such as safety sign recognition and money management, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision 24 hours a day.

This service may also include the provision of medical and health care services that are integral to meeting the daily needs of the participants. Transportation between the participant's place of residence and other service sites or places in the community may be provided as a component of residential habilitation services and included in the rate paid to providers of residential habilitation services. Provider owned or leased facilities where residential habilitation services are furnished are compliant with the Americans with Disabilities Act.

The types of residential habilitation are Provider or State Operated Group Residences where residential habilitation is delivered with 24 hour paid staff in a licensed home with other individuals receiving supports and Placement Services where residential habilitation is delivered through a support agency which provides placement, guidance and oversight for individuals with 24 hour paid supports who live in the home of a care provider or live in their own homes with a care provider who lives with them. The care provider is unrelated to the individual and is not an employee of the support agency.

WAIVER PROGRAM(S):

- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- Residential habilitation is not available to individuals who live with their immediate family unless the immediate family member (grandparent, parent, sibling or spouse) is also eligible for the Department's supports.
- Payment is not made for the cost of room and board including the cost of building maintenance, upkeep and improvements.
- Residential habilitation provided in a provider licensed Group Residence cannot be self-directed. Individuals residing in licensed group residences may however, choose to self-direct other services in this waiver.
- Individuals cannot receive both Residential Habilitation and 24-Hour Self- Directed Home Sharing Support or Live-in Caregiver services.
- Only one residential support is permitted.

ALLOWABLE LIVING ARRANGEMENTS:

- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified Residential Habilitation Agency Provider

Respite

SERVICE CODE(S):

3701 Respite-Recipient's Home
5701 Respite-Recipient's Home
6701 Respite-Recipient's Home
3702 Respite-Caregiver's Home
5702 Respite-Caregiver's Home
3731 Respite-Recipient's Home
3759 Respite-Site Based

SERVICE DEFINITION: Respite services are provided on a short-term overnight basis where there is an absence or need for relief of those persons who normally provide care for the participant or due to the needs of the waiver participant.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- Services are provided in either:
  - Licensed respite facility:
  - In the home of the participant;
  - In the family home; or
  - In the home of an individual family provider to waiver participants who are unable to care for themselves.
- Respite care may be made available to participants who receive other services on the same day, such as Group or Individual Supported Employment, Centered Based Work Supports or adult day-care; however, payment will not be made for respite at the same time when other services that include care and supervision are provided.
- Respite may not be provided at the same time as Individualized Goods and Services, when a service rather than a good is being provided.
- Facility-based respite cannot be participant-directed. Others forms of respite may be self-directed.
- The choice of the type of respite is dependent on the waiver participant's living situation.
- Federal financial participation will only be claimed for the cost of room and board when provided as part of respite care furnished in a facility licensed by the state.
- Respite may be provided up to 30 days per year and is reflected in the Individual Service Plan based on assessed need.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam

SERVICE DELIVERY METHOD:

- Qualified SSQUAL Respite Agency Provider
- Qualified Respite Individual Provider

Specialized Medical Equipment and Supplies

SERVICE CODE(S):

5756 Specialized Medical Equipment and Supplies

SERVICE DEFINITION: Specialized medical equipment and supplies include:

1) Devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living;

2) Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live;

3) Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

4) Such other durable and non-durable medical equipment not available under the MassHealth State plan that is necessary to address participant functional limitations; and

5) Necessary medical supplies not available under the MassHealth State plan.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the MassHealth State plan and exclude those items that are not of direct medical or remedial benefit to the participant.
- Accessing the MassHealth state plan benefits must occur before accessing this service.
- All items shall meet applicable standards of manufacture, design and installation.
- The medical support devices or equipment must have proven evidenced-based support and conform with acceptable medical practice; no experimental or alternative devises or equipment are permitted to be purchased.
- Any devices used in the provision of the service must be FDA approved.
- Specialized Medical Equipment and Supplies must be authorized by the Service Coordinator as part of the Individual Service Plan process.
- Specialized medical equipment and supplies must be purchased through a self-directed budget.
- This service is limited to $3,500 per waiver year.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam

SERVICE DELIVERY METHOD:

- Qualified SSQUAL Respite Agency Provider
- Qualified Respite Individual Provider

Speech Therapy

SERVICE CODE(S):
5245 Speech Therapy

SERVICE DEFINITION: Speech Therapy services, including the performance of a habilitative or maintenance program provided by a licensed Speech Therapist. Services are habilitative and are designed to maintain or prevent the worsening of functioning in the areas of communication and ability to eat, drink, swallow and manage aspiration risks. Speech-language pathology refers to the application of principles, methods and procedures related to the development of disorders that impede oral, pharyngeal, or laryngeal competencies and the normal process of human communication including but not limited to disorders of speech, articulation, fluency, voice, and the application of augmentative communication treatments. Services may also address swallowing dysfunction. Services may also include the training and oversight necessary for the participant, family member or other person to carry out the maintenance program. Speech Therapy under the waiver is different from MassHealth State plan services in nature and scope in that they allow for maintenance therapy not otherwise covered under the MassHealth State plan. The provider qualifications in the MassHealth State Plan apply.

WAIVER PROGRAM(S):
- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:
- Service may be delivered in both offices and in the natural environments of the participant.
- The service may be provided individually or in small groups.
- Speech Therapy services are authorized by the Service Coordinator as part of the ISP Team process.
- The Speech Therapy must be evidence-based and conform with acceptable medical practice; no experimental or alternative treatments are permitted.
- Any devices used in the provision of the service must be FDA approved.
- The service can only be provided by licensed personnel.
- This service is not subject to the Medical Referral Requirements found at 130 CMR 432.414 or the requirements for Prior Authorization found at 130 CMR 432.417.
- This service will not duplicate any services available through the MassHealth State Plan or private health insurance.
- This service cannot occur in Day Habilitation or in other sites where therapy is being provided.
- No more than one individual treatment and one group therapy session per day may be authorized.
- Payment will not be made for a treatment for the same date of service as a comprehensive evaluation.
- Speech Therapy must be purchased through a self-directed budget through the Fiscal Intermediary.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified SSQUAL Speech Therapy Agency Provider
- Qualified Speech Therapy Individual Provider

Stabilization

SERVICE CODE(S):
3182 Emergency Stabilization Residence – Site-Based
3712 Emergency Stabilization Residence – Caregiver's Home

SERVICE DEFINITION: This service is designed to provide stabilization and support for waiver participants who due to either behavioral or environmental circumstances cannot remain in their current residence or family home. The service is provided in either a licensed respite facility or in the home of an individual family provider to waiver participants who are unable to care for themselves. The home of an individual family provider is overseen by a qualified stabilization agency. Based on the waiver participant's assessed needs for stabilization and support and the need to develop a new Individual Plan of Care, which will meet the participant's needs, there is no time limit imposed on the service. The service includes over-night supervision and support.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- Stabilization services may be available to participants who receive other waiver services on the same day, such as:
  - Group Supported Employment (3181);
  - Individual Supported Employment (3168, 3197, 5168, 3180 or 5180);
  - Individualized Day Supports (5704 or 6704);
  - Center Based Day Supports (3166, 3169, 4169, or 9168);
  - Community Based Day (3163 or 9163); or
  - Day habilitation supplement (3285).
- Stabilization services cannot be provided when other services that provide care and supervision are being provided.
- The length of stay is based on the assessed needs of the waiver participant and is regularly reviewed by the Regional Management Team.
- This service cannot be self-directed.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified SSQUAL Stabilization Agency Provider

Transitional Assistance

SERVICE CODE(S):

3284 Transitional Assistance Services
5284 Transitional Assistance Services

SERVICE DEFINITION: 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 whether or not 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:

1) Security deposits that are required to obtain a lease on an apartment or home;

2) 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;

3) Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;

4) Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;

5) Activities to assess need; and

6) Arrange for and procure needed resources.

Transitional Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources.

WAIVER PROGRAM(S):

- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- Transitional assistance services do not include:
  - Monthly rental or mortgage expense;

- Food,
- Regular utility charges;
- Household appliances; and/or
- Items intended for purely diversional/recreational purposes.

- This service may be self-directed paid through the Fiscal Intermediary.
- Room and board costs are excluded.

ALLOWABLE LIVING ARRANGEMENTS:

- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified Transitional Assistance Individual Provider

Transportation

SERVICE CODE(S):

3196 Transportation
5196 Transportation
5197 Transportation Pass/Unit
5198 Transportation - Mileage

SERVICE DEFINITION: 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.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- Transportation services under the waiver are offered in accordance with the participant's service plan. The provision of transportation in the service plan must meet the need in the most cost-effective manner.
- Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.
- This service includes travel to and from day programs and travel for accessing community activities and resources.
- Transportation may also include the purchase of transit and bus passes for public transportation systems and mileage reimbursement for qualified drivers.
- Transportation that is part of a day or residential program or a contracted transportation provider cannot be self-directed.
- This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the MassHealth State Plan defined at 42 CFR 440.170 (a), and does not replace them.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam
- Residential Habilitation and Placement Services (3150, 3153, 3161, 4157, 9150 or 9153)

SERVICE DELIVERY METHOD:

- Qualified SSQUAL Transportation Agency Provider
- Qualified Transportation Individual Provider

Vehicle Modification

SERVICE CODE(S):
5734 Vehicle Modification

SERVICE DEFINITION: This service consists of adaptations or alterations made to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

Examples of vehicle adaptations include:

- Van lift;
- Tie downs;
- Ramp;
- Specialized seating equipment; and/or
- Seating/safety restraint.

WAIVER PROGRAM(S):

- Adult Support
- Community Living
- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- The following are specifically excluded vehicle modifications:
  - Adaptations or improvements made to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
  - Purchase or lease of a vehicle; and/or
  - Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the adaptations.
- The individual must be in the family home.
- Vehicle modification is not available to individuals who reside in a provider residential setting or in 24 self-directed 24 home sharing supports or in the live-in caregiver model.

- Funding for adaptations to a new van or vehicle purchased/leased by family can be made available at the time of purchase/lease to accommodate the special needs of the participant.
- This service must be an identified need and documented in the service plan.
- The Vehicle modifications must be purchased through a participant-directed budget and paid through the Fiscal Intermediary
- The Service Coordinator must receive in advance for his/her review and recommendation the following information: a proposal detailing the request for funding and the completed Vehicle/Home Adaptations Funding Request Form. The participant's Individual Support Plan that clearly defines and explains the need for a vehicle adaptation must be attached to this information.
- If the DDS Service Coordinator recommends the proposal for funding, the request is then forwarded to the Area and then the Regional Director for review and recommendation of funding.
- Cost not to exceed $15,000 over a five year period.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivFam

SERVICE DELIVERY METHOD:

- Qualified Transportation Individual Provider

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24 Hour Self-Directed Home Sharing

SERVICE CODE(S):

5156 24 Hour Self-Directed Home Sharing Tier 1
5157 24 Hour Self-Directed Home Sharing Tier 2
5158 24 Hour Self-Directed Home Sharing Tier 3

SERVICE DEFINITION: 24-Hour Self-Directed Home Sharing Support consists of ongoing services and supports by paid care giver(s) that is designed to assist individuals to acquire, maintain, or improve the skills necessary to live in a non-institutional setting. 24-Hour Self-Directed Home Sharing Support provides individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, recognition and money management, social and leisure skill development that assist the participant to reside in the most integrated setting appropriate to his/her needs. 24-Hour Self-Directed Home Sharing Support also includes personal care and protective oversight and supervision 24 hours a day. This service can also include the provision of medical and health care services that are integral to meeting the daily needs of the participants or arranging and assisting individuals to access the health care system. Transportation between the participant's place of residence and other service sites or places in the community may be provided as a component of 24-Hour Self-Directed Home Sharing Support and is included in the individual's participant budget.

WAIVER PROGRAM(S):

- Intensive Supports

SERVICE LIMITS/GUIDANCE:

- The care provider is identified and supervised directly by the waiver participant or the legally responsible individual.
- Family members who are either the legal guardian or legal representative or spouse cannot provide 24-Hour Self-Directed Home Sharing Support. Other family members such as siblings or cousins, aunts, uncles may provide these services.
- Payment is not made for the cost of room and board of the participant including the cost of building maintenance, upkeep and improvements. All individuals who receive room and board assistance from DDS are expected to make a financial contribution towards their monthly room and board costs through their SSI income.
- 24- Hour Self-Directed Home Sharing Support is limited to one individual in the same site. This limitation is in place to allow the self – directed provider to not have to participate in the licensing and certification process for Shared Living within DDS.
- This service may not be provided at the same time as:
  - Respite,
  - Individualized Home Supports, or
  - Adult Companion.
- Because this is a self–directed service, licensed providers may not act as the employer of the care provider and may not provide services in one of their licensed settings.
- The physical site is either owned or leased directly by the waiver participant or the direct care provider; not by a provider agency.

ALLOWABLE LIVING ARRANGEMENTS:

- zLivInd
- zLivCare
- zLivFam

SERVICE DELIVERY METHOD:

- Qualified 24 Hour Self-Directed Home Sharing Individual Provider

Chapter

5

Chapter 5

Person-Centered Service Planning – ISP & POC

Every participant in a Waiver Program must be determined through the DDS needs assessment process to meet the Level of Care (LOC) for a Waiver Program and have a current Plan of Care (POC) that identifies the Waiver and non-Waiver services and supports being provided to meet their assessed health and welfare needs. They must also have a current DDS Individual Support Plan (ISP) (for more information on ISPs please refer to the ISP Manual). The POC is the primary document that both CMS and MassHealth monitors to ensure that the DDS is providing Waiver services in compliance with the requirements outlined in the Department's approved Waiver applications to CMS. It is critical that the LOC, POC, and ISP are accurate and completed at least annually or more frequently, as needed. The entire process is the Person Centered Planning Process (PCP). Under the Patient Protection and Affordable Care Act, referred to as the ACA includes section 2402(a), entitled "Oversight and Assessment of the Administration of Home and Community-Based Services," the PCP process is defined and described. The expectation is that the individual directs the planning process and the process is entirely person centered.

The POC, ISP, and LOC determination are distinct but inter-related processes and documents that are based on required and optional assessments. They are part of an annual process that determines whether an individual requires Waiver Program services and establishes the supports necessary to meet the individual's assessed needs.

A key requirement of the ISP and POC is ongoing monitoring to assure a participant's health and welfare and effective delivery of service. The purpose of monitoring is to ensure that services are furnished in accordance with both the ISP and POC, meet the participant's needs and achieve their intended outcomes. Monitoring also identifies any problems related to the participant's health and welfare that may require action.

The POC is an agreement between DDS and the participant that the services identified and the frequency/duration of those services meet the individual needs of the participant. Because of this,

the document is appealable and individuals must be afforded the opportunity to appeal every time a change is made to the POC as noted below in section "When to Generate a POC." (See Appeals in Chapter 2)

DDS also uses the generation and approval of a POC as a claim check for Federal Financial Participation (FFP[12]). There must be a POC generated and approved at least every 365 days. When CMS audits occur[13], DDS is obligated to provide the ISP, POC and LOC related to the service that is being audited. Those documents must confirm to CMS that the service was performed because of an identified need and was provided according to what the POC stated.

Plan of Care Organization

The Plan of Care (POC) is a two-page document that contains identifying information about the participant and the services and supports provided.

The first page of the POC lists the Waiver Program services provided to the participant by the type of support, the provider of each type of Waiver Program support, and the frequency/duration of each support. The second page of the POC lists the non-Waiver supports provided to the participant, including but not limited to state-funded DDS supports, MassHealth State Plan services, natural supports, and supports provided through other resources (i.e. other state agencies, private pay, other insurance, etc.).

The source of the service data listed on both pages of the POC are the service enrollments listed in MEDITECH. Home and Community Based Service Information System (HCSIS) pulls those services into the Participant Allocation Management (PAM) module where the generation of the POC takes place. It is critical that the MEDITECH data is always accurate, complete and up to date.

The combination of Waiver and non-Waiver Program services identified on pages one and two of the POC address the participant's assessed health and welfare needs that the service planning team determines should be addressed to prevent the need for institutional services.

Plan Development

The POC is developed at least annually at a single service-planning meeting that generates both the DDS Individual Support Plan (ISP) and the Waiver Program Plan of Care (POC). The participant's person centered service-planning team, which includes the participant, the Service Coordinator, guardians, or legal representatives, involved family, providers and others of the participant's choice work together to develop both plans. The Service Coordinator supports the participant through the

12 For every dollar spent by the Commonwealth of Massachusetts on a Waiver service, the federal government will reimburse the Commonwealth up to $0.50.

13 Known as Payment Error Rate Measurement (PERM)Audit.

entire person centered service-planning process. Once completed, the POC is reviewed and approved by the Area Director or his/ her designee.

- The Level of Care evaluation and reevaluation (Refer to Chapter 3) ensures that based on the DDS needs assessment process, an individual meets the level of care for a Waiver Program.
- The ISP identifies the participant's wants and needs, and sets forth the participant's goals and objectives along with the strategies that will be employed to achieve those goals and objectives. (Refer to the ISP Manual for additional information)
- The POC identifies in detail the services (both Waiver Program and non-Waiver Program) provided to meet the participant's health and welfare needs as determined to be addressed to prevent the need for institutional services.

Entering the Service Enrollments:
Any new service enrollments identified for the participant are entered into MEDITECH. HCSIS will then pull the service enrollments into the PAM module where the POC is generated.

Within the appropriate HCSIS PAM Screen, the frequency/duration and respective rate if applicable must be entered for each Waiver service enrollment before an individual's POC can be generated. Frequency/duration entries should only be changed when an individual has a permanent assessed change in need. The date entered in MEDITECH for the frequency/duration CDS screen should be the date at which the assessed change in need occurred.

The Initial/Annual ISP and POC are generated, approved and signed by the Area Director and copies are sent to the participant/guardian and service providers in a timely manner; along with information regarding appeal rights. Copies of the signed POC is retained in the participant's file and sent to the primary service providers.

Any time a new POC is generated and approved based upon the instructions below "When to Generate a POC," a POC cover letter and the POC appeal rights notice should be sent to the individual/guardian.

Should an individual's assessed needs change resulting in the need to change Waivers please refer to Chapter 2 and/or 10.

When to Generate a POC

A POC must be generated at the time one or more of the following occurs:

- Enrollment into a Waiver Program;
- ISP initial/annual renewal;
- Enrollment in a new service;
- Existing service enrollment is ended;
- A permanent decrease in frequency/duration of an enrolled service due to an assessed change in need; and/or

- A permanent decrease in a participant-directed service budget due to an assessed change in need.

A new POC does not need to be generated if the frequency/duration of a service enrollment is increased. For example, if the frequency/duration of a group and center-based day service is increased from four hours a day to six hours per day, a new POC does not need to be generated until the time of the next ISP renewal (see exception below).

In addition, a new POC does not need to be generated if the frequency/duration of one or more participant-directed service enrollments is altered, but the individual's overall participant-directed service budget stays the same. For example, if the frequency/duration of participant-directed Respite service is reduced to permit the increase of a participant-directed Individualized Home Supports service, but the individual's total overall participant-directed service budget remains the same, a new POC does not need to be generated until the time of the next ISP renewal (see exception below).

The *exception* to either of these scenarios would be if another event occurs between the annual ISP dates resulting in one of the bulleted items listed above to take place, then a POC must be generated.

HCSIS PAM will not allow a POC to be generated if:

- The individual is not enrolled in a waiver;
- The individual is not enrolled in a living arrangement;
- The individual is receiving services that are not allowed in his/her waiver program and/or living arrangement;
- The individual is enrolled in incompatible services;
- One or more of the individual's waiver service enrollments is missing a frequency entry; and/or
- One or more of the individual's services enrollments with a band of standard rates is/are missing a rate.

Plan of Care Approval

The Area Director must approve each POC in MEDITECH before it is distributed to the participant/guardian and service providers. The Area Director reviews the POC developed through the service planning process to ensure that:

- Services, frequency/duration are accurate on the POC;
- The POC has been developed with participant/guardian input;
- Participant's choices have been considered in the development of the POC;
- The participant/guardian has been afforded the opportunity to choose between or among Waiver Program services and providers: and
- The services identified in the POC meet the Waiver Program participant's identified health and welfare needs necessary to prevent institutionalization.

Maintaining Documentation

The participant's POC is maintained in his/her client record at the Area Office. An electronic version also resides in HCSIS PAM. A copy of the POC, approved by the Area Director, with a notification of appeal rights must be mailed to the participant and his/her guardian as close to the approval date as possible. The letter of appeal states that individuals have 30 days upon receipt of the POC to appeal its contents. Primary service providers also receive a copy of the POC.

POC Satisfaction and Appeals

A participant may appeal their POC. (See Appeals in Chapter 2)

Non-Waiver Program services identified in the POC are appealed through the entity that funds the service and it is up to that entity to provide the individual with their appeal rights. For example:

- Non-Waiver services provided by DDS on Page 2 of the POC, depending upon the service, may be subject to an ISP appeal.
- MassHealth State Plan services may be appealed through the Office of MassHealth.
- Services provided by other agencies such as the Department of Education, Massachusetts Rehabilitation Commission, etc. may be appealed through the appeals processes for those agencies.

Monitoring Service Provision

A POC and LOC determination **must be generated annually**. This differs from the ISP process where ISPs are completed every two years with an update meeting being held in the intervening year.

Quality Assurance Activities

The Service Coordinator has overall day-to-day responsibility for monitoring the implementation of the POC to ensure that the participant is satisfied with the Waiver services that are furnished in accordance with their service plan, that they meet the participant's needs and that they achieve their intended outcomes. These activities are done through periodic progress/update meetings and ongoing contact with the participant and service providers. In addition to this monitoring, the Department's Quality Management System conducts several activities to ensure the integrity of the POC and the services being delivered. Service Coordinator Supervisors administer a Supervisor Tool that examines the components of the POC process conducted by the staff who they supervise.

Through these efforts, DDS monitors that:

- Service Plans are person centered and include required components, e.g. vision, goals, specific objectives, support strategies.
- Service Plans include required assessments;
- Service Plans reflect the participant's needs, particularly with respect to health and welfare as identified through the assessment process;
- Service Plans are completed within prescribed timelines and updated annually;
- Participants are receiving the services identified in their Service Plans;

- There is evidence in the system that the participant was offered a choice of service providers and internet web link www..mass.gov/dds to the directory of providers (PDM) was identified for them or if requested, a print copy provided;
- There is evidence in the system that the participant was offered a choice of service delivery methods if interested;
- There is timely completion of LOCs and POCs which is monitored through PAM and includes reports regarding timely and overdue LOCs and POCs; and
- There is timely completion of ISPs, which is monitored through HCSIS that include alerts and reports regarding the ISP timelines.

The Department assesses participant satisfaction and provider performance in meeting POC goals and objectives through its survey and certification process and through its participation in the National Core Indicators Project[14]. As part of the survey and certification process, a sample of each provider's clients is selected for intensive review. This includes an evaluation of the extent to which the supports being provided to the participant meet his or her health, safety, and developmental needs. Participant and family feedback through the National Core Indicators Project provides important information regarding the responsiveness of the POC process to changes in participant needs.

In addition to the monitoring methods above, the following groups external to DDS also monitor service provision:

- The UMASS Revenue Division submits claims on behalf of DDS and through the claim check, LOCs and POCs must be completed accurately and timely.
- DDS maintains individualized participant files at each Area Office. POCs and files are subject to sample reviews by MassHealth. MassHealth staff notifies DDS that a file or set of files is subject to a review. The Department is given no less than 24 hour notice of such review. When applicable, requests are made through written notification. MassHealth monitoring and oversight activity ensures that service plans for Waiver participants are consistent with all applicable safeguards and standards of care.
- Every 3 years, or as needed, CMS performs a statewide Payment Error Rate Measurement (PERM) Audit where a contracted Agency working on behalf of CMS will request randomly selected paid claims for review. DDS is obligated to provide evidence that the claim in question was delivered correctly according to the ISP and POC.
- At any time, the State Auditor's Office, MassHealth, CMS or other official agency could request an audit of any of the DDS Adult Waiver functionality.

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[14] The **National Core Indicators** (NCI) began in 1997 as a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). The goal of the Program was to encourage and support NASDDDS member agencies to develop a standard set of performance measures that could be used by states to manage quality and across states for making comparisons and setting benchmarks. NCI is used in many states' quality management systems and aligns with basic requirements for assuring quality in HCBS Waivers.

Chapter

6

Chapter 6

Participant Direction

All three Adult Waivers afford participants the opportunity to lead the design of any or all of their service delivery through a participant directed (self-directed) process. DDS will provide consumer-directed options for participants who choose to direct the development of their Individual Support Plans and to have choice and control over the selection and management of their Waiver services.

Every individual eligible for DDS services is informed about the opportunity to self-direct services. As part of the initial and on-going planning process of assessment and service planning, an individual is provided with information by the Regional Eligibility Team and/or the Area Office about the Waivers and the opportunity to self-direct services. An individual may also express interest when s/he learns about the opportunity in other ways. S/he may have attended a formal open training, have had a discussion at his/her ISP meeting or responded to a suggestion from Area staff. The Service Coordinator must discuss the range of service delivery options with an individual as part of the planning process and throughout the implementation of the support plan. This includes the benefits, mechanics, and responsibilities of directing one's own services. This discussion must be noted in the individual's record. An individual may direct a variety of services and it is possible to receive some traditional services while self-directing other services.

While self-direction may not be appropriate for everyone, it can enhance the quality of life for those individuals who are ready to put the philosophy of self-determination into the practice of self-direction. Self-directing one's own services can produce powerful results in peoples' lives.

In addition to the information presented in this chapter, DDS' participant directed manual and the PPL website contains specific information and tools/forms related to the implementation of self-directed services. This chapter provides a high-level review of participant direction. DDS' participant directed manual can provide specific information related to how to implement self-direction.

Determining an Individual's Ability to Self-Direct

Each participant who desires to self-direct their services will be assessed to determine their capacity to do so and what types of supports are required to assist them. Individuals must demonstrate an ability and desire to self-direct. The assessment will occur during the service planning process by the Team and reviewed annually. The Department will work with individuals who require significant assistance to self-direct their services to identify what is needed to help them.

Models for Self-Directing Services

A participant may employ three basic models for self-directing services. The individual could use one to all three models or any combination of the three. They are:

Budget Authority: Under Budget Authority, the participant has decision-making authority and management responsibility for their budget. This permits the participant to make decisions about the acquisition of goods and services that are authorized in their service plan. The primary characteristic of this model is the establishment of a participant-directed budget.

Employer Authority: Under Employer Authority, the participant recruits, hires, supervises, and directs the workers who provide services. The participant exercises choice and control over workers and functions as the common law employer of these workers. The primary characteristic of this model is that the participant, rather than an agency, carries out the employer responsibilities for workers. The individual recruits, interviews, hires, trains and if applicable terminates the relationship. The individual must use a Fiscal Intermediary (FI)[15] for payroll and any credentialing functions.

The Agency with Choice (AWC): With AWC the individual directs his/ her services as a co-employer. Instead of taking direct responsibility for directing one's services including the management of staff, the individual shares the responsibility with a qualified agency. This means that the duties are split between the Agency, which serves as the employer, and the participant who serves as the managing employer. A person becomes an employee of the agency and the agency agrees to help the participant train and manage that employee.

The individual participates in the process of managing staff with the support of an agency. Unlike the employer authority discussed above, the agency has ultimate responsibility and decision-making authority over staff selection and management. Agency staff can recruit, interview, hire, train, supervise, pay, and terminate staff. For those individuals who cannot or do not want to assume responsibility for staffing decisions and overall management, this model may be right for them.

15 DDS contracts with Public Partnership LLC (PPL) as the Fiscal Intermediary [also known as a Fiscal Management Service (FMS)].

Self-Directed Waiver Services

Self-Directed Waiver Services including employer and/or budget authority (definitions are located in Chapter 4) include:

- 5707 Adult Companion
- 5283 Assistive Technology
- 5710 Behavioral Supports and Consultation
- 5725 Chore Services
- 5731 Home Modifications and Adaptations
- 5728 Individual Goods and Services
- 5704 Individualized Day Supports
- 5703 Individual Home Supports
- 5168 Individual Supported Employment
- 5719 Live-In Caregiver
- 5243 Occupational Therapy
- 5716 Peer Supports
- 5250 Physical Therapy
- 5701 Respite-Recipient's Home
- 5702 Respite-Caregiver's Home
- 5756 Specialized Medical Equipment and Supplies
- 5245 Speech Therapy
- 5284 Transitional Assistance Services
- 5196 Transportation
- 5197 Transportation Pass/Unit
- 5198 Transportation - Mileage
- 5734 Vehicle Modification
- 5156 24 Hour Self-Directed Home Sharing Tier 1
- 5157 24 Hour Self-Directed Home Sharing Tier 2
- 5158 24 Hour Self-Directed Home Sharing Tier 3

Agency With Choice Waiver Services (definitions are located in Chapter 4) include:

- 6707 Adult Companion
- 6709 Family Training
- 6704 Individualized Day Supports
- 6703 Individual Home Supports
- 6716 Peer Supports
- 6701 Respite-Recipient's Home

Chapter

7

Chapter 7

Participant Choice

Participant Choice of Provider and Service Delivery Method

The Waiver Program allows participants to choose; to self-direct their services or to receive them through the traditional service delivery system and to choose among qualified, willing service provider(s).

Waiver Program participants have the right to select freely from among any qualified, willing provider of Waiver services anywhere in the state. Participants also have the right to choose their service delivery method. They can receive services through the traditional provider system and/or they can elect to self-direct their services.

Upon enrollment in the Waiver Program and during preplanning activities for the Person Centered ISP meeting, the Service Coordinator provides the participant with the following:

- Information about the range of services and supports offered through this Waiver and other sources such as the MassHealth State Plan;
- Information about potential providers of these services (the DDS Service Directory (PDM) website location or if requested, a paper list of providers);
- Information about the various options for DDS service delivery (the "Choosing Which Service Delivery Method is Best for Me" brochure and "The User Guide for Individuals and Families"); and
- Information about the availability of provider licensure and certification reports located on the DDS website.

If the participant chooses to receive services through the traditional system, the Service Coordinator supports the participant in identifying appropriate providers and securing their services. This support includes:

- Providing information regarding any licensure or certification requirements that must be met;
- Assisting the participant in arranging for services; and
- Informing the individual of his/her opportunity to change providers and the process for doing so.

If the participant expresses an interest in self-directing their services, the Service Coordinator refers them to the Self-Direction Regional Manager who can provide information that is more specific to the participant.

Chapter

8

Chapter 8

Waiver Quality Assurance

Waiver Quality Assurance

As part of each state's Waiver application, CMS requires the submission of a Quality Improvement Strategy that addresses the following items:

- The measures and processes the state will use to determine that each Waiver assurance is met;
- The measures and processes employed to correct identified problems;
- The roles and responsibilities of the parties involved in measuring performance and making improvements;
- The processes employed to aggregate and analyze trends in the identification and remediation of problems;
- The processes employed to establish priorities, develop strategies for and assess implementation of system improvements;
- The process and timelines for compiling the information and communicating to Waiver participants, families, service providers, other interested parties and the public; and
- The frequency and processes used to evaluate and revise the Quality Improvement System (QIS).

Key Principles

In response to CMS' requirements, the Department's Quality Management and Improvement System (QMIS) is robust and involves individuals in all levels of the Department as well as providers, self-advocates, families and important stakeholders.

The QMIS system is designed to assure that essential safeguards are met with respect to health, safety and quality of life for Waiver participants as well as to use data and information to inform systemic quality improvement efforts. The system has been implemented based on these key principles:

1) The system creates a continuous loop of quality including the identification of issues, correction, follow-up, analysis of patterns and trends and service improvement activities.

2) Quality is imbedded in all activities of the Department and involves everyone.

3) The measurement of quality is based upon a set of outcomes in peoples' lives agreed upon with stakeholders.

4) The system involves active participation from individuals, families and other key stakeholders.

5) The system rigorously measures health, safety and human rights, and other quality of life domains

6) The system integrates data and information from a variety of different sources.

7) The system collects, aggregates and analyzes data to identify patterns and trends to inform service improvement activities.

8) Service improvement targets are tracked to allow for measurement of progress over time.

Overall Philosophy

Quality is approached from three perspectives: the individual, the provider and the system. On each tier, the focus is on discovery of issues, remediation and service improvement. Information gathered on the individual and provider level is used not only to remedy situations on those levels, but also to inform overall system performance efforts.

Systems level improvement efforts are organizationally structured to occur on essentially two levels – the regional level and the statewide level. The 4 Regional Offices are overseen by a Regional Director, under whose direct supervision the 23 separate Area Offices and Area Directors function. It is ultimately the Regional Directors, who report directly to the Deputy Commissioner, who are accountable for assuring that identified service improvement efforts are implemented and reviewed. Area Offices work most closely with the individuals the Department serves and their providers through the service planning and oversight processes.

On a statewide level, in DDS Central Office, the Office of Quality Management maintains overall responsibility for designing and overseeing the Department's QMIS and assuring that appropriate data are collected, disseminated, reviewed and service improvement targets established for both Waiver and non-waiver DDS clients. The Assistant Commissioner for Quality Management reports

in a direct line to the Commissioner, in order to maintain independence from the Operational Services Division (Waiver Unit). In addition, specific staff in the Central Office/DDS function as "subject leaders" and take responsibility for discrete data sets and their analyses. For example, the Director of Health Services is responsible for reviewing and analyzing all data relating to medication occurrences, health care records and deaths, the Director of Human Rights reviews all restraint reports and the Director of Risk Management reviews data regarding risk management plans.

Different statewide groups are also charged with specific tasks related to the QMIS. For example, the Statewide Quality Council is comprised of DDS staff, self-advocates, family members and providers. The Council's function is to review and analyze the different analyses and reports that are generated with respect to systemic performance, to make recommendations for service improvement and to track progress towards achievement of service improvement targets.

In addition to the Quality Council, there is a Statewide Incident Review Committee (SIRC), composed of staff from legal, investigations, human rights, survey and certification, risk management, health services, and operations. The committee reviews the analyses that are generated from the Home and Community Services Information System (HCSIS). With the research support of the University of Massachusetts Medical School/Center for Developmental Disabilities Evaluation and Research, aggregate reports analyzing specific incident types are generated. The reports are reviewed by the committee and form the basis of service improvement targets. Reports generated from the risk management committee are also reviewed by the Quality Council and mutually agreed upon service improvement targets are developed.

Data and Reports

DDS has a variety of databases that enable it to collect information on important outcomes related to the 6 assurances under the waiver. These include the Meditech system which collects data on level of care, plans of care, enrollment, expenditures for waiver participants and risk management plans; HCSIS which collects information regarding the development and oversight of Individual Support Plans, incidents, restraints, medication occurrences, investigations, health status, and deaths; and the Survey and Certification database which collects information on both outcomes for individuals served by the Department as well as provider performance.

From these databases, DDS staff develop and draft a number of reports. For example, DDS distributes QA Reports which focus on specific subject areas, e.g. rights, health, and safety. The reports present information in a user friendly manner, relying on easy to use graphs and arrows delineating both positive and negative change. The reports compare outcomes year to year and allow for a clear analysis of patterns and trends over time. The Statewide Quality Council has the specific responsibility to review these reports and other data and make recommendations to the Commissioner and other DDS staff for service improvement targets.

Since March 2008, Area, Region and provider specific aggregate data on incidents began to be disseminated monthly (for frequently occurring incidents) and quarterly (for less frequently occurring incidents). These reports show data on incidents by both number and rate that enable comparison between an Area to a Region to the state. Data from month to month are shown and fluctuations below and above 25% are noted. Field staff (i.e. Area Office staff) analyze patterns and trends in

their respective locations. In addition to individual incident reports, Areas receive monthly reports on individuals who have reached a threshold of specifically designated incidents that then trigger a review on an Area level. These reports enable Areas and Regions to identify patterns and trends with respect to particular individuals they support, and to "connect the dots" between different incidents. Areas review the reports and enter follow up notes to assure that individuals who may be at risk have been identified and followed up on. As part of the on-going quality assurance process, Regional Risk Managers do a quarterly review of a random sample of individuals who have reached the "trigger" threshold. The review looks into whether follow up actions were taken and whether the actions were consistent with the issues identified.

Performance Measures

Performance Measures are one key method of collecting, organizing, analyzing and reporting data on the assurances and sub-assurances. As noted above, the Department has many databases and reports from which to draw data for these measures.

Service Coordinators and Quality Enhancement surveyors perform work-related activities with and on behalf of consumers and providers, which provide data in these many databases including HCSIS and Quality Enhancement 5 (QE5). Supervisors and other personnel at the Area, Region and Central s review reports and other documentation related to these activities. Area Directors, Regional Directors and Central Office waiver and quality management staff as well as other stakeholders that are part of the Quality Council analyze and synthesize data for reporting to CMS. Thus, reiterating one of the key principles for this QM system, the Department's success in achieving and assuring compliance with CMS' Waiver program is dependent on the daily fulfillment of Waiver Program requirements by staff at all levels of the system.

The following is a list of all CMS Waiver assurances, sub-assurances and selected performance measures with data source to present the scope, breadth and depth of the performance measures.

1) **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.

Number of service provider reviews conducted in accordance with waiver policies and procedures/ Total number of service provider reviews due during this period	Survey & Certification Database

2) **Level of care:** 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 care provided in a hospital, nursing facility, or ICF/ID-DD.
    a. An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Number of adult individuals who receive an initial LOC determination/Number of applicants for DDS services	Meditech/ MT reporting
Number of individuals who received an initial LOC assessment within 90 days of Waiver application/ number of individuals who received an initial LOC assessment	Meditech/ MT reporting

b. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of care.

Number of exception reports completed by licensed psychologists of level of care instruments that are returned for cause/ Total number of initial level of care assessments administered	Exception report

3) **Service Plan:** The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

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

Number of service plans that address needs identified during the assessment process/Number of service plans reviewed (revised)	SC Supervisor Tool Report

b. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Number of individuals whose service plans are completed and updated annually/ Number of individuals with service plans reviewed	SC Supervisor Tool Report
Number of service plans updated when needs change/number of participants reviewed with changing needs	SC Supervisor Tool Report

c. Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

Number of individuals who are receiving services according to the type, amount, frequency and duration identified in their plan of care/Number of individual plans of care reviewed	SC Supervisor Tool Report

d. Participants are afforded choice between/among waiver services and providers.

Number of individuals with a signed choice form indicating choosing community over institutional care/ Number of individuals reviewed	SC Supervisor Tool Report
Number of individuals reporting that they were given a choice/Number of individuals surveyed	NCI Survey report

4) **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.
    a. 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.

Number of new providers that received a license to operate within 6 months of initial review/Number of new providers that were selected to provide supports	Survey & Certification Database
Number of licensed clinicians with appropriate credentials/Number of licensed clinicians providing services	FMS tracking database/ PDM when operational
Number of providers that continue to meet licensure/certification standards/Number of providers subject to licensure/certification	Survey & Certification Database

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

Number of SSQUAL agency providers that meet the qualifications to provide services/ Number of SSQUAL agency providers providing services	SSQUAL database
Number of performance based objectives achieved by the FMS/Total number of performance based objectives measured	FMS Database
Number of individuals self-directing supports reporting that their staff come when they are scheduled/ Number of individuals interviewed who are self-directing	NCI Survey report

    c. The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.

Number of licensed providers with staff trained in required trainings/ Number of providers reviewed through survey and certification	Survey and Certification Database

Number of individual providers who have received training in reporting abuse/neglect/ Number of individual providers providing services	FMS tracking database/ PDM when operational

5) **Health and Welfare:** The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.
    a. The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

Number of substantiated complaints by type/number of total adults served and rate per 1000 adults	HCSIS Investigations Database
Number of intakes screened in for investigation where the need for protective services were reviewed by the Area Office/ Total number of intakes where a review was recommended by the senior investigator	HCSIS Investigations Database
Number of individuals who know how to report abuse and/or neglect/ Number of individuals reviewed	Survey & Certification Database
Number of providers that conduct CORI's of prospective employees and take required action/ Total number of providers reviewed	CORI database report
Number of medication occurrences reports/ Number of medication doses administered	HCSIS Medication Occurrence Report database
Number of deaths that have a clinical review/ Total number of deaths required to have a clinical review	HCSIS Death Reporting database

    b. 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.

Number of incidents that reach the "trigger" threshold for which action has been taken/ Total number of incidents that were reviewed	HCSIS Monthly Trigger Reports
Number of action plans implemented for substantiated investigations/Total number of action plans written for substantiated investigations)	HCSIS Investigations database

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

Number of providers that are in compliance with requirements concerning restrictive interventions/Number of providers reviewed by survey and certification with restrictive interventions	Survey & Certification Database

Number of people with high utilization of restraints reviewed/Total number of individuals with high utilization of restraints	HCSIS Restraint Database

d. 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.

Number of individuals with a documented physician visit in the past 15 months/Number of individuals reviewed (proposed)	Survey & Certification Database
Number of individuals with a documented dental visit in the past 15 month/ Number of individuals reviewed (proposed)	Survey & Certification Database

6) **Financial Accountability:** The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.

a. 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.

Number of approved claims filed with the FMS/ Total number of claims filed with the FMS	FMS Database
Approved and paid MMIS claims/ Total service claims submitted	MMIS reports
Dollar value of claims denied/ Total dollar value of claims submitted	MMIS reports

b. The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Number of services with rates derived from and consistent with rate regulations/Number of services for which claims were submitted (proposed)	Financial reports

Quality Improvement

In addition to monitoring and managing quality, the QMIS also identifies areas for targeted improvements through the analysis of performance measures and other information on an ongoing basis. The Office of Quality Management and senior management staff of the Department have primary responsibility for monitoring the effectiveness of system design changes and improvements. Implementation of strategies to meet service improvement targets can occur on a variety of levels depending upon the nature of the target. As an example, before the "Blueprint for Employment", the Quality Council established an increase in real employment for individuals in the Department as a statewide service improvement target. Regional employment solutions teams were established to develop strategies. Providers were required to submit specific plans and target numbers for increasing individual employment options.

Some reviews of the effectiveness of selected service improvement targets are conducted by the Center for Developmental Disabilities Evaluation and Research (CDDER) of the University of Massachusetts Medical School. As an independent research and policy support to the Department, CDDER has conducted several formative and summative evaluations of specific service improvement initiatives. Methods have included focus groups, surveys and evaluation of specific indicators related to the service improvement target. An example of CDDER's role was its evaluation of the Department's Health Promotion and Coordination Initiative.

Some targeted service improvement efforts may involve a more discrete number of individuals who have specific responsibility in the subject of the effort. For example, the Director of the Office of Human Rights disseminates quarterly reports to Regional Directors regarding the use of restraints. A service improvement target to reduce the number of restraints for "high utilizers" was identified and worked on with the specific Areas and providers involved. Change was tracked by the Office of Human Rights and noted.

The Department shares most statewide quality assurance and service improvement data with a host of internal and external stakeholders. The Quality Assurance Reports the Annual Mortality Report, analyses of HCSIS incident data, and provider licensure/certification reports are all posted on the Department's web site as well as distributed in hard copy. Individuals, families and providers are also active members of the Statewide Quality Council, Area Citizen Advisory Boards, and statewide committees. In this capacity, all quality improvement data and reports are shared, discussed and reviewed with them.

Chapter

9

Chapter 9

Waiver Capacity

Each of the DDS Waiver Program applications to CMS identifies the Waiver capacity for each year of that specific Waiver. Waiver capacity is measured by CMS cumulatively as an unduplicated count of Waiver participants. This means that whether someone participates in a Waiver Program for one day or 365 days, CMS counts that individual towards the total capacity for that year. If that individual was dis-enrolled from the Waiver during the year, another individual cannot use that slot within the same Waiver Year. The exception would be if the slot is vacated by the death of an individual. Waiver Years runs from July 1 through June 30, in sync with the state's fiscal year. Waiver capacity is based on consideration of historical patterns and trends, projected changes in population, and available resources. In the current CMS Waiver applications, a set number of new slots have been added each year, which increases the capacity for each Waiver year.

At the beginning of each Waiver year, the new capacity is combined with vacant slots or "turnover" capacity that becomes available as participants are dis-enrolled from the Waiver Program for reasons such as no longer needing Waiver services, moving out of state, or loss of MassHealth benefits. CMS allows states to identify set numbers of individuals in specific target groups for which the DDS wants to reserve capacity for vacant slots. This is referred to as "reserve capacity". (See Chapter 2)

Chapter

10

Chapter 10

Dis-enrollment

When a Waiver participant does not meet one or more of the eligibility criteria for continued participation in a Waiver Program, such as a permanent loss of MassHealth eligibility, s/he is dis-enrolled from the Program. Temporary changes (less than 90 days) such as rehabilitation stays in nursing facilities allow the individual to maintain their Waiver enrollment pending return to their Waiver services. In some cases, the Area needs to change the individual's MEDITECH enrollment to "Non-DDS Residential" to indicate that the individual is no longer living in the community. This section outlines the reasons for dis-enrollment and the established procedures for executing a dis-enrollment.

Dis-enrollment

A dis-enrollment form must be sent by the Area Office to the WMU for any of the following situations in order for the dis-enrollment from the Waiver Program to be completed.

1. **Individual moves out of state**
   An individual who permanently relocates to another state (longer than 90 days) must be dis-enrolled from the Waiver Program effective the date they relocate. It is important that all provider billing is submitted.

   Residency is based on an individual's residential address. It is not acceptable to use a Provider's corporate address (often used in Shared Living) as the individual's address.

2. **Change in DDS Eligibility**
   An individual who is no longer DDS eligible or does not have a diagnosis of intellectual disability must be dis-enrolled from the Waiver Program.

3. **Incarceration**
   An individual who is incarcerated must be dis-enrolled from the Waiver Program.

4. **Individual no longer meets the Level of Care for the Waiver Program**
   An individual who no longer meets the ICF-ID LOC must be dis-enrolled from the Waiver

Program. If the score on the HCBW is 9 or higher the individual meets LOC. If during an annual reevaluation of LOC, the individual's HCBW score is 6, 7, or 8, a the Area Director must use clinical judgement to determine whether the individual meets LOC. If the HCBW score is 5 or if the ICAP score exceeds 85 the individual does not meet LOC and s/he must be dis-enrolled from the Waiver Program.

5. **The individual's health and safety can no longer be assured**
An individual whose health and safety cannot be assured must be dis-enrolled from their Waiver Program. Risk assessment and mitigation are core elements of the person-centered service planning process. Through health, behavioral and safety assessments, the potential risk(s) are identified. If a risk is identified, the individual will need an active risk plan. Services offered must address the individual's needs and the Service Coordinator needs to maintain a greater level of contact.

Assuring health and safety does not mean the elimination of all risk nor does it guarantee its absence. The Department and its providers must have a good faith plan and strategy of implementation. If the individual's needs cannot be met in the particular Waiver, a change in Waivers might be warranted.

6. **MassHealth Eligibility**

   - **Loss of MassHealth coverage or No longer in correct Waiver MassHealth Category**
     Individuals enrolled in the Waiver who either lose their MassHealth coverage or convert to a non-Waiver Program category of MassHealth when the UMass Benefits Unit determines it cannot be changed back to a Waiver category must be dis-enrolled from their Waiver Program.

   - **Over Asset and spend-down is not anticipated**
     An individual who exceeds the allowable asset level of $2,000 for MassHealth loses their MassHealth coverage. If the individual has a spend down amount greater than $7,000, the individual must be dis-enrolled from the Waiver Program. They may be re-enrolled at the time the countable assets are below $2,000.

7. **Change of residence to an ICF-ID, nursing home or hospital that is expected to continue indefinitely**
Individuals admitted to an ICF-ID, nursing facility or a hospital cannot be billed on the Waiver Program as long as they reside in one of these settings. If the stay is expected to continue indefinitely (more than 90 days), and the individual is not expected to return to a community Program, they must be dis-enrolled from the Waiver Program.

8. **Individual leaves Waiver Program services voluntarily**
An individual who chooses to withdraw from a Waiver Program service must be provided an opportunity to reconsider leaving the services prior to being dis-enrolled from the Program.

9. **The individual is not receiving a Waiver service**
If an individual's services change such that a Waiver Program service is no longer being

provided, the individual must be dis-enrolled from their Waiver Program. If a person does not receive a Waiver service on at least a monthly basis, the Service Coordinator must provide monthly monitoring and the person is maintained in the Waiver Program. After 90 days and no Waiver service has been provided, the individual must be dis-enrolled from the Waiver Program.

The following situations should be monitored and the WMU notified if dis-enrollment becomes necessary. In these instances, Waiver billing is suspended.

1. **Individual leaves the state on an extended leave (example the individual vacations with parents in the winter)**
   An individual who leaves the state for an extended period cannot be billed on the Waiver while not participating in their Waiver Program service(s). Therefore, if an individual has a planned absence identified in their individual support plan, the individual can remain in the Waiver Program. These types of planned absence cannot exceed 90 days. If the absence extends beyond 90 days, the individual is dis-enrolled from the Waiver Program. Extended leaves of 30 days or less do not require notification.

2. **Change of residence to an ICF-ID, nursing facility or hospital and the individual is expected to return to the community.**
   Individuals admitted to an ICF-ID, nursing facility or a hospital for a temporary stay who is expected to return to their community program, remains enrolled in their Waiver Program. The Area Office must change their service enrollment in MEDITECH to reflect the admission to one of these facilities.

   Individuals receiving respite at an ICF-ID will be re-evaluated to determine their ICF-ID needs during the first 30 days of admission. If the stay lasts longer than 90 days, on the 91st day, the individual must be dis-enrolled from the Waiver. However, if the stay is slightly longer and the individual is returning to the community, the individual maybe re-enrolled in their original Waiver Program. There may be an issue with whether the individual can return to their original Waiver or in fact needs a new Waiver assignment based on their assessed needs. A Change in Needs form may be warranted.

   An individual who enters a Nursing Facility for rehabilitation and is expected to return to their community Program remains enrolled in their Waiver Program for up to 90 days. On the 91st day, the individual must be dis-enrolled from the Waiver. However, if the stay is slightly longer and the individual is returning to the community, the individual maybe re-enrolled in their original Waiver Program. There may be an issue with whether the individual can return to their original Waiver or in fact needs a new Waiver assignment based on their assessed needs. A Change in Needs form may be warranted (refer to change in need process below.) Admissions for 30 days or less do not require notification.

3. **The individual is not receiving the enrolled Waiver service but is monitored monthly by the Targeted Case Manager for the needs associated with the service.**
   In some circumstance, an individual may not be receiving any Waiver Program services each month but remains enrolled in those services. Typically, this is the result of hospitalization, stabilization, or respite. In these situations, the individual will return to the Waiver Program

service. The Service Coordinator continues to monitor the individual in the alternative situation monthly at a minimum. The individual can continue to be enrolled but claiming is suspended for the first 90 days and then the individual is dis-enrolled from the Waiver Program on the 91st day.

4. **The individual exceeds MassHealth asset limits. Spend-down is in process.**
   If an individual has an asset level between $2,000 and $7,000 and is expected to spend down to an allowable level within 30 days and receive their MassHealth benefit again, s/he remains enrolled in their Waiver Program while spend-down is in process. No claiming is made during this period.

5. **The individual's MassHealth benefit changed to a non-Waiver category.**
   Remediation is in process. In order to be enrolled in the Waiver Program, an individual must be MassHealth eligible in a Waiver Program eligible MassHealth category. If an individual enrolled in a Waiver has his/her benefit convert to a non-Waiver Program category of MassHealth, the Regional UMass Benefits Unit may remediate the problem by working with the MassHealth Enrollment Center (MEC). During this period, the individual remains enrolled in his/her Waiver however, no claiming is done while the MEC investigates conversion to an appropriate MassHealth category. If the category cannot be changed, the individual must be dis-enrolled from the Waiver Program.
   .

Process for Dis-enrollment

The following process must be initiated once the Area Office has identified an individual as needing to be dis-enrolled from his/her Waiver Program. The Area reviews the criteria for Waiver Program disenrollment.

- A member of the Area management team or designee completes a "WAIVER PROGRAM DIS-ENROLLMENT NOTICE" identifying the reasons for dis-enrollment and provides a brief comment explaining the reason(s) selected.
- The form is emailed to the Waiver Management Unit (WMU).
- The WMU reviews the form and checks MEDITECH to confirm the reason is documented in data (such as "Individual has moved out of state") where relevant, and may communicate with the Area Office if necessary.
- The WMU issues a notification to the individual or guardian, including his/her appeal rights and copies the Area Office and the MassHealth Enrollment Center (MEC). While an appeal is pending, waiver services must be continued.
- The WMU notifies the appropriate Central Office or Regional billing personnel of any billing action if applicable.

Changing Needs/ Changing Waivers

Individuals whose needs have changed resulting in their prospective budget exceeding the specific limitations for the Waiver they are currently in will require a change of need form to be submitted to the WMU. The Service Coordinator should explain to the participant the need for the Waiver change. The Area Office informs the WMU using the Waiver Change in Need form as soon as the

individual begins receiving the additional service(s) under the new Waiver Program. At that time, the WMU will check to make sure there is an application on file stating the individual had applied for "ANY" Waiver. If not, the WMU will request that the Service Coordinator obtain an appropriate application. If a new application is requested and not received after 90 days of the change in need, the individual will be dis-enrolled from the Waiver s/he is currently enrolled in and a notice will be sent to the individual with appeal rights included. While an appeal is pending, waiver services must be continued.

After all correct documentation is in place and a slot is available in the requested Waiver change, the WMU will dis-enroll the individual from their current Waiver Program under which s/he previously received services and enroll his/her into the appropriate Waiver. The individual will be notified of both the dis-enrollment and enrollment and be provided with the appropriate appeal rights. While an appeal is pending, waiver services must be continued.

Suspension from Waiver Billing

The Waiver assures CMS that HCBS services will not be provided under the Waiver to individuals who are inpatients of a hospital, SNF, ICF-ID or jail. Therefore, the Department may not bill for services for Waiver recipients during periods when the recipients are in those settings. This necessitates the Waiver being suspended for these periods. Many of these situations are time-limited and may lead to eventual dis-enrollment from a Waiver Program if the situation continues beyond 90 days. **Suspensions** are claiming activities where no claims are processed for any Waiver Program services pending a change in circumstances that allow billing to resume. Provider billing and payment continues during this period.

There are two technical situations in MEDITECH and HCSIS PAM where claiming is automatically suspended and can be easily corrected by the Area Office.

a) When an individual does not have an assigned Service Coordinator in MEDITECH**,** billing is suspended electronically. An individual must have an assigned Service Coordinator or have Supervisor coverage if there is a Service Coordinator vacancy to meet Waiver Program requirements. Once the Area assigns a Service Coordinator or Supervisor coverage, claiming will resume.

b) When the most current Plan of Care is greater than 365 days, claiming is suspended until a new POC is generated. An individual must have a current Plan of Care to meet Waiver Program requirements. "Current" is defined as within 364 days of the prior year's POC.

Resources

For additional information or assistance:

Please contact the Waiver Management Unit by using the Global Address Group:

DDS-DDL-Waiver Management Unit or by contacting:

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