

Submission from Massachusetts – December 2022

Description of how the state’s oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations

Department of Development Services (DDS)

From Table 3. Summary of Transition Plan Tasks

- Revise DDS regulations 115 CMR 5.00 (December 2019)
- Revise DDS regulations 115 CMR 7.00 (July 2016)
- Revise Licensure and Certification Manual (September 2019)
- Updated provider guidance – locks, visitation (October 2022)
- Full Implementation of Positive Behavior Supports, including continued training (By March 2023)
- Develop and distribute clear definitions, standards, and criteria of integration for group employment and CBDS (to be included in the coming re-procurement for FY 2020) (March 2019)
- Develop and implement policy manual for MA.40701 and MA.1028 (July 2017)
- Develop and distribute member handbook for MA.40701 and MA.1028 (July 2017)

DDS Regulations

115 CMR Chapter 5.00 – Standards to Promote Dignity

Chapter 5.00 articulates the outcomes regarding community integration, choice, and quality of life consistent with the Community Rule. In February 2020 DDS promulgated amendments to Chapter 5.00 to replace the previous “Behavior Modification” standards with a system of “Positive Behavior Supports,” a widely accepted and utilized framework for both systems change and individual treatment that supports individuals to grow and reach their maximum potential. This approach limits the use of restraint and prohibits highly restrictive interventions. The amendments to the Chapter 5.00 regulations codify the implementation of Positive Behavior Supports and confirm conformity of the regulations with the Community Rule’s protection of participant’s freedom from restraint and coercion. (See Table 3. Summary of Transition Plan Tasks and Timelines). Chapter 5.00 also addresses person centered planning-based protections and freedoms related to individual autonomy and choice, including privacy and visitation. The DDS Individual Support Plan (ISP) Manual (see Table 4 for link) instructs Service Coordinators during the ISP process to note the restrictions to rights of the individual to visitation, possessions, or privacy and the reason for the restriction.

115 CMR Chapter 7.00 – Standards for Services and Supports

Chapter 7.00 articulates the expectations that DDS has of its providers with respect to qualifications of staff, environmental standards, and outcomes for individuals. Such standards were found to be consistent with the CMS Community Rule, with two exceptions. DDS amended Chapter 7.00 to specifically address such inconsistency:

- Locks on bedroom doors. Previous regulations stipulated that locks on bedroom doors that provide access to an egress from the home were not permitted. This stipulation was included to ensure the swift evacuation of all participants in the event of a fire or other emergency. In order

to protect individual safety and at the same time safeguard individuals' right to privacy and choice, DDS current regulation encompasses the general rule that bedroom doors shall be lockable, but recognizes that some exceptions to the general rule may be necessary (115 CMR 7.07(7)(f)).

To further support the regulatory language and provide context, specifically consistency with the Community Rule, DDS issued guidance to providers on the requirement for locks on bedroom doors. (See DDS 2016 Guidance on Locks and DDS 2022 Guidance on Locks, Table 4)

In any specific situation that contraindicates or otherwise results in the participant's bedroom door not being lockable, a specific assessed need must be established via the person centered planning process, including discussion with and agreement by the participant and documented in the participant's ISP. (115 CMR 6.20 - 6.25)

- Capacity. While the Community Rule does not establish a maximum capacity for residential settings, it clearly reflects an overall commitment to community integration and a move away from settings with institutional-like qualities. In this vein, DDS amended an existing regulatory provision to limit the capacity of residential settings to no greater than five residents (115 CMR 7.08(1)). The regulations provide an exception to this limitation, however, and provide that the 151 homes identified by DDS that had a licensed capacity greater than five prior to 1995 will be permitted to retain the capacity approved in the license for the life of the original building if the site can accommodate more than five individuals (115 CMR 7.08(2)). The regulations further provide that capacity in excess of five must be reduced if the Department determines at any time that the site can no longer accommodate more than five individuals. In the event that DDS determines that a site can no longer accommodate more than five individuals, the provider must develop and implement a plan to reduce the capacity. DDS will work collaboratively with the provider on plans to effectuate the reduction in capacity to five or fewer individuals.

DDS also added a section to Chapter 7.00 regulations that set forth standards for both employment and day supports. (115 CMR 7.09). The section is consistent with the requirements of the Community Rule and emphasizes DDS's commitment to employment as the first option for all individuals of working age.

115 CMR Chapter 8.00 – Licensure and Certification

Chapter 8.00 articulates the system DDS uses to license and certify its providers. The stringent standards and processes specified in Chapter 8.00 ensure that all providers that achieve licensure and/or certification meet all the components consistent with the HCBS Community Rule. DDS identified within Chapter 8.00 an opportunity to strengthen this regulation by more clearly aligning certain elements regarding certification with the requirements of the Community Rule. Revisions to this certification process are complete and were implemented on September 1, 2016. (See Table 3. Summary of Transition Plan Tasks DDS Policies and Procedures

Tenancy protection

The CMS rule requires individuals to have a legally enforceable agreement that provides protections comparable to those provided under landlord-tenant law. The intent of this rule is to safeguard

individuals against an arbitrary or capricious eviction from their home. Based on analysis of landlord-tenant law and other applicable law, DDS developed guidance for such an agreement and incorporated requirements related to legally enforceable agreements into the revised licensure and certification tool. (See Table 3. Summary of Transition Plan Tasks and Timelines.)

Emergency transfer is rare, but available when it is necessary to protect a DDS consumer, both waiver participants and non-waiver participants, from abuse or imminent harm in their own household. DDS transfer statute/regulations are more robust than Massachusetts landlord tenant law, and MA landlord/tenant law is considered one of the most "tenant friendly" states in the country. See 115 CMR 6.63.

Non-compliant and future settings

Section V (Site-Specific Assessment) addresses existing settings and describes how DDS is working on transition plans with identified providers that are *currently* not compliant. However, DDS did not have a specific policy in place prior to CMS's issuance of its Community Rule that clearly articulated our position on settings that CMS considers not to meet the criteria for community-based settings. Therefore, DDS developed and disseminated a policy (dated September 2, 2014) that spells out the Department's position on future development of settings as well as how existing settings that are transitioning into compliance with the rule will be addressed. This policy is now in force. (See Table 3. Summary of Transition Plan Tasks and Timelines.)

Community-Based Day Supports (CBDS)

The pillar of DDS's systemic assessment of CBDS programs was a voluntary survey developed by DDS and distributed to 98 CBDS providers, representing 170 CBDS settings. The purpose of the survey was to gather data about establishing standards for what constitutes a meaningful day for individuals, best practices, challenges, and qualitative and quantitative measures for CBDS services. Specifically, it incorporated questions that allowed a provider to discuss areas that were particularly challenging to it related to the Community Rule as a way to note areas that require systemic improvement. The results of the voluntary provider survey have been used to determine systemic changes needed, including but not limited to:

- Development of clear guidelines/standards that define CBDS services, including what constitutes meaningful day activities, and how services and supports can be integrated into the community more successfully;
- Provision of training and staff development activities to enhance the knowledge of providers and their staff with respect to successful strategies to support individuals in meaningful day activities (in part, through the ICI initiative);
- Development of revised certification indicators against which to measure provider performance and quality of services;
- Technical assistance to providers to assist in enhancing their program design and operation; and
- DDS review of contracting provisions to ensure appropriate incentives towards outcomes required by the Community Rule.

Data gleaned from the survey has been used to inform the existing DDS Employment Work Group regarding enhancement of CBDS, as well as a group of advocates, participants/family members, state staff and other stakeholders regarding the following:

- The development of definitions and standards for what constitutes a meaningful day,
- The incorporation of both qualitative and quantitative measures into the DDS licensure and certification process, and
- Systemic strategies to assist all CBDS providers to achieve the outcomes of the Community Rule, including but not limited to technical assistance, staff development and training.

DDS also used data from the survey in the development of a Request for Responses (RFR) (see p.14). In part, the RFR solidified expectations for integration, choice, and meaningful activities. Providers qualified through this procurement/RFR initiated services in July 2019 (see p. 35).

Massachusetts Rehabilitation Commission (MRC)

From Table 3. Summary of Transition Plan Tasks

- Update MRC Provider Policy Manual (April 2016)
- Develop guidance for residency agreements (June 2016)
- Revise UMMS-PNA employment provider credentialing tool to reflect all Community Rule requirements (May 2017)

MRC Regulations

107 CMR Chapter 12.00: MRC regulations for the Statewide Head Injury Program describe the referral, application, and eligibility determination process, case closure process, and rights to appeal. MRC manages compliance with regulations through contractual agreements with providers. These regulations were reviewed and were found to be in compliance with the Community Rule; no changes are recommended.

MRC Policies and Procedures

Residential Settings

Tenancy protection

The Community Rule requires individuals to have a legally enforceable agreement comparable to a lease. The intent of this rule is to safeguard individuals against an arbitrary or capricious eviction from their home. Residential providers, however, did not necessarily have a specific document that either the individual and/or his/her guardian sign to ensure that they will not be evicted without due process. MRC developed guidance for providers regarding development of documents safeguarding individuals as discussed above in April 2016 to support providers in developing and documenting agreements with individuals. This policy states a legally enforceable agreement shall provide the participant with the same responsibilities and protections from eviction that tenants have under the landlord/tenant law(s) in Massachusetts as well as the county or town/city where the participant resides. By June 2017, residential providers had completed and executed such agreements with participants and continue to do so as a matter of practice.

Locks on doors

The Community Rule requires that units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. For reasons associated with health and safety (chiefly, in order to ensure the swift evacuation of all individuals in the event of a fire or other emergency), this was not a common practice in MRC residential homes (provider owned/leased residences) at the time MRC conducted its systemic review. MRC issued a policy as part of the Community Living Division Provider Manual in January 2016 to address this requirement. In any specific instances where health and safety issues necessitate an exception, the modification will be discussed through the participant's person-centered planning process, and agreement obtained and documented.

Number of residents

MRC recognizes the importance of developing homes that are in settings that are integrated into and support full access to the greater community; as a result, MRC will not develop new homes in excess of five people.

Dignity, independence, and individual choice and control

Specifically, MRC determined that the following 10 key policies for residential providers required revision to ensure compliance with the Community Rule: (See Table 3. Summary of Transition Plan Tasks and Timelines.)

- Residential Guidelines regarding family members, significant others, friends, and legal guardians
- Program participant expectations
- Elopement policy for site based programs
- Alcohol and Drug Abstinence Policy
- Leave of Absence Policy
- Sharps Policy
- Smoking Policy
- Telephone, Cable and Internet Usage Policy
- Unsupervised time in Residence/community Policy
- Vacation Policy

MRC convened an internal work group to revise the policies identified above consistent with the Community Rule. The revisions completed by this group removed any restrictive policies or procedures while ensuring the use of comprehensive and ongoing assessments to inform individualized plans. These draft policies were reviewed with stakeholders in March 2015 to ensure MRC fully understood the implications of these changes for providers and participants. MRC shared changes made to its policies and procedures with DDS, as well as with the Statewide Transition Plan Cross-Agency Workgroup to promote consistency between agencies. Once the draft policies were finalized in April 2015, MRC held a statewide training for all staff and providers. These trainings were completed in June 2015. Additional changes were made to the Community Living Division Practices, Policies and Procedures Manual (also referred to as the Provider Policy Manual) in 2016. Both MRC staff and provider staff were trained in the complete 2016 Manual by May 2016.

In response to the policy changes described above, the MRC clinical and program staff, working collaboratively with providers, completed initial assessment of each participant to determine if an individual may require a behavioral intervention plan stemming from clinical support needs and necessitating a modification to their person-centered plan consistent with the Community Rule.

Non-residential Settings

MRC reviewed its Community Living Division Policies and Procedures Manual to ensure compliance with the Community Rule for day and employment settings. Revisions were made with input from stakeholders. Changes applicable to day and employment settings were limited to the incorporation of behavioral assessment and management into the person-centered plan. As noted above, both MRC staff and provider staff were trained in the complete Manual by May 2016.

Executive Office of Elder Affairs (EOEA)

From Table 3. Summary of Transition Plan Tasks

- Revise HCBS Program Guidelines (December 2022)
- Revise Supportive Day Program monitoring/review tool (January 2016)
- Develop congregate housing setting policy guidance and review/monitoring tool (January 2016)

EOEA Regulations

The Frail Elder Waiver (FEW) is administered pursuant to EOEA's Home Care Program regulations (651 CMR 3.00 *et seq.*), which set forth requirements for EOEA in the administration of the Home Care Program, as well as the functions and responsibilities of EOEA's agents (Aging Services Access Points, or "ASAPs," described below under Policies and Procedures). Our review of these regulations focused on the standards and requirements outlined in the CMS Community Rule. The Commonwealth determined that EOEA's Home Care Program regulations, as they apply to administration of the FEW, are fully compliant with the Community Rule.

EOEA Policies and Procedures

Administration of the FEW also includes sub-regulatory guidance in the form of overarching HCBS Program Guidelines and specific Program Instructions (PIs) and Information Memoranda (IMs) that set out programmatic requirements and through which EOEA dictates and communicates certain business practices and policy and program changes to its agents.

EOEA does not recommend any changes to the sub-regulatory guidance, which includes the ASAP contract, PI, and IM documents as part of the transition plan. EOEA identified an opportunity to update and revise the HCBS Waiver Program Guidelines to more clearly align with the requirements of the Community Rule, including to clarify the requirements for settings in which FEW participants reside and receive services. Within the updated HCBS Waiver Program Guidelines the components and areas of review to ensure compliance with the community rule are included and these guidelines outline the requirement that any new waiver applicant's residential setting and any new provider settings must be reviewed for compliance with the community rule. EOEA expects to issue revised HCBS Program Guidelines during calendar year 2022 (see Table 3. Summary of Transition Plan Tasks and Timelines).

Service Plans

ASAPs are responsible for conducting assessments and developing service plans based on the needs of FEW participants. Program instructions developed and distributed to all ASAPs lays out fundamental requirements of all service plans, in particular that they must incorporate the values and preferences of the HCBS waiver participant and be developed in conjunction with the participant and his/her representative(s) and having free choice of providers. The ASAP contract includes specific program instructions related to service plan development and review, such as at a minimum annual update and more frequently as required by changes with the waiver participant.

MassHealth

From Table 3. Summary of Transition Plan Tasks

- Develop process for identifying waiver participants that are also AFC recipients, where the home is not owned or leased by the participant and the AFC caregiver is unrelated, and for validating compliance of those settings. (December 2022)
- Develop processes for ongoing oversight and monitoring of compliance of AFC settings with waiver participants not living in their own home with an unrelated AFC caregiver. (March 2023)

MassHealth Policy

All Massachusetts HCBS waiver participants have access to the Adult Foster Care (AFC) service, which is a MassHealth state plan service, not a HCBS waiver service. The majority of AFC caregivers are family members. While MassHealth's AFC program regulation 130 CMR 408.435(A) addresses qualified AFC settings and explicitly states that AFC settings are not structured as provider operated settings, some waiver participants may choose to move into the home of an unrelated AFC caregiver concurrent to receiving HCBS waiver services in the home. In those instances where the caregiver is unrelated and the participant does not own or lease the home, MassHealth is reviewing those AFC settings to ensure they conform to the requirements of community settings including that the participant has a lease or other legally enforceable agreement providing similar protections.

As of December 2022, MassHealth has issued an AFC Provider Bulletin that states providers must identify AFC members who are HCBS Waiver participants. For each AFC member who is an HCBS Waiver participant, the AFC provider must work with the AFC caregiver and AFC member to complete an attestation, in the form and format required by the Executive Office of Health and Human Services (EOHHS), to determine the application of the Community Rule to the AFC-qualified setting (i.e., where the AFC member/HCBS Waiver participant lives, in the home of an unrelated AFC caregiver). If so, the provider must work with the member and caregiver to confirm compliance with the Community Rule.

Further sub-regulatory guidance is being developed with details about compliance with requirements. These details will include, but will not necessarily be limited to, information about leases and comparable protections for those without a lease; whether and how certain AFC plan of care requirements apply; use of prescribed documentation and related recordkeeping or reporting; and timing for these requirements.

Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance

DDS

From Table 3. Summary of Transition Plan Tasks

- Develop specific mechanism to monitor progress toward system-wide milestones (Residential settings) (December 2015)
- Full implementation of compliance across all group employment settings using enhanced licensure and certification tool (February 2022)

DDS Provider Qualification

Residential Settings

Providers of 24-hour residential settings were the subject of an open bid process and were required to be qualified to provide services and supports. The RFR that providers responded to outlined critical outcomes with respect to choice, control, privacy, rights, integration, and inclusion in community life, consistent with the HCBS settings requirements. All providers that were qualified were shown to adhere to the RFR's requirements for supports to individuals. On an on-going basis, provider qualifications are reviewed through the DDS licensure and certification process described below in DDS's section on Quality Management. No changes are recommended as part of the transition plan for the way in which providers become qualified.

Non-Residential Settings

Providers of Day and Employment services are the subject of an open bid process and are required to be qualified to provide services and supports. All providers that have been qualified are thus shown to adhere to the requirements for supports to individuals. The previous Request for Responses (RFR, 2009) that providers responded to outlines critical outcomes with respect to choice, control, career exploration, employment, rights, integration, and inclusion in community life. This process demonstrates, for all Day and Employment providers, DDS's commitment to the HCBS settings requirements. An integral part of the procurement process was a requirement that providers re-structure their services to create alternative employment program options. Providers were required to submit their plan to DDS about how they would increase the number of individuals working in integrated employment, and how they would phase out sheltered workshop services within a five-year period. The RFR became an important precursor to the "Blueprint for Success."

Day and Employment services have been re-procured through a Request for Responses in the winter of 2019 (see p. 35). In addition to maintaining the critical outcomes as noted above, the RFR process provided further guidance to CBDS providers related to addressing the requirements of the Community Rule.

Following qualification, providers of day and employment services are subject to licensure and certification on an on-going basis. Certification outcomes also focus on rights, choice, control, employment and meaningful day activities, and community integration. As part of ongoing monitoring to ensure that providers are moving to enhance their outcomes, DDS revised its licensure and

certification tool to clarify expectations and even more closely and strongly align the tool with the critical elements of the Community Rule (see Table 3. Summary of Transition Plan Tasks and Timelines).

Quality management and oversight systems

DDS has an extensive and robust quality management system (QMIS) that addresses the criteria in the Community Rule in every aspect of the system. These processes have been in place for many years, and through DDS's review were determined to be responsive to the outcomes addressed in the Community Rule. Listed below are those components that most directly relate to the HCBS rule.

Licensure and certification process

The licensure and certification process is the basis for qualifying providers doing business with the Department. The process applies to all public and private providers of residential, work/day, site-based respite and individualized home support services. The system measures important indicators relating to health, personal safety, environmental safety, communication, human rights, staff competency, and goal development and implementation for purposes of licensure, as well as specific programmatic outcomes related to community integration, support for developing and maintaining relationships, exercise of choice and control of daily routines and major life decisions, and support for finding and maintaining employment and/or meaningful day activities. DDS survey teams review provider performance through on-site reviews on a prescribed cycle. Survey teams observe and interview a statistically significant number of individuals as part of the on-site review for residential and day/employment services. Interview topics for individuals include, but are not limited to, community integration, choice and control, social relationships (friends and family), intimacy and companionship, and their experiences in providing feedback to their provider and how the provider responds to that feedback. Providers are required to make corrections when indicators are not met, and are subject to follow-up by surveyor staff or provider staff. These indicators are supportive of and fully in compliance with the HCBS Community Rule. DDS revised the licensure and certification tool to clarify expectations and even more closely and strongly align the tool with the critical elements of the Community Rule in terms of both residential and non-residential settings (see Table 3. Summary of Transition Plan Tasks and Timelines).

Area Office oversight

DDS Area Office staff conduct bi-monthly visits to all homes providing 24-hour support, and quarterly visits to homes providing less than 24-hour support. A standardized form is used to ensure that health, safety, and human rights protections are in place. Results from these visits are monitored by Area Office staff. Visits ensure an on-going presence and oversight by Department staff.

Service coordinator (SC) supervisor tool

DDS Service Coordinators support waiver participants through the entire service planning process. This person-centered support begins by explaining the service planning process, and includes, but is not limited to, helping the participant prepare for service planning meetings, discussing who to include in the meetings, reviewing the participant's circumstances, and deciding which issues the participants wants to talk about at the meeting. Throughout, the Service Coordinator assists the participant to voice wants and needs. Importantly, the preparation involves a discussion with the participant about the person's own goals and vision for the future, from his or her own perspective, ensuring that the

individual has goals that are personally relevant and meaningful. For each participant, this planning process explores, validates, and supports the person's goals for community integration.

The SC Supervisor tool measures the quality, content and oversight of the person-centered service planning process and its implementation. The tool measures how effective the service planning process is in involving the individual, how well the objectives reflect the vision of the individual, whether the services being delivered address both individual needs and goals, whether the services are modified as needs and goals change, and whether service coordinators are aware of and addressing issues of concern raised by the individual. As this tool reviews important indicators of a process that fully supports the person-centered approach, building off of an individual's desired goals and objectives and ensuring that individuals exercise choice and control of their services and supports, no changes are needed.

Incident reporting

DDS has a web-based incident reporting and management system that requires providers to report a specifically defined set of incidents within 24 hours. The provider must report specific details regarding the incident as well as what actions they took to protect the health and safety of the individual and what long-range actions they may take. For an incident report to be finalized, DDS staff must review and approve the report. Aggregate information from the system is reviewed and analyzed and forms the basis for service improvement targets. Some incidents may involve events that directly relate to the Community Rule; the current Incident Reporting system will continue to be used to monitor these events, as well as identify any systemic issues that must be addressed.

Human rights protections

The Department's Human Rights System is based on the principle that affirmation and protection of individual rights must occur on all levels of the organization and in all services and supports. Therefore, each location where individuals live or work (including CBDS) has a Human Rights officer and providers have a Human Rights Coordinator. On all levels of a provider's service system, individuals are supported to understand their rights, know who they can turn to if they have a complaint, and to speak up on their own behalf. In addition, Human Rights Committees with representation from individuals, families and professionals monitor human rights issues, including the review of behavioral interventions and restraint reports. By virtue of this strong human rights system, individuals are supported to exercise choice, control and informed decision making consistent with the intent of the Community Rule.

Site feasibility

Providers intending to serve individuals in 24-hour residential supports, site-based respite, or site-based day supports must have any proposed sites reviewed for their feasibility to provide the necessary physical site requirements for the individuals proposed to be served. Prior to moving any individual into a home, day or work site, state agency staff of the Office of Quality Enhancement (OQE), who license and certify providers, review the location and ensure that all necessary safeguards are in place and the location can be approved for occupancy.

Specifically, the site feasibility process is conducted to determine if a proposed site offers a safe and suitable living and day support environment for the individuals it is intended to serve. The review is designed to provide technical assistance to providers and Area/Regional staff by identifying any features

of the home or day support affecting the well-being of individuals that would need to be addressed before it can be occupied. The review includes how the anticipated physical features of a proposed home impact programmatic outcomes, such as adequate bedroom size and number to assure privacy, bathroom design to support individuals' needs for privacy and personal care, common dining and living space conducive to interaction with housemates and entertaining visitors. A separate set of features, consistent with Community Rule requirements, is reviewed for day supports. In addition to the site feasibility process, Area and Regional Office staff are integrally involved in working with providers to determine whether a proposed location is integrated in the community, whether it facilitates access to community activities, is consistent with the needs and desires of the individuals as identified through the person-centered planning process, and does not result in homes being clustered together. These questions are also incorporated into the initial intake process prior to the feasibility review. Taken in their entirety, these processes assure that any proposed residential setting or day setting complies with both the physical/site and programmatic requirements of the Community Rule.

Quality Council

The Department has a Statewide Quality Council that includes representation from self-advocates, family members, providers, and DDS staff. The Council is dedicated to reviewing and analyzing data, making recommendations for statewide and local service improvement targets, and monitoring progress toward achieving targets. Since its inception, the Council has reviewed and monitored, among other outcomes, statewide efforts to assist individuals to develop relationships and obtain employment in integrated settings.

National Core Indicator Surveys

Massachusetts has participated in the National Core indicators (NCI) survey for many years. Participation in NCI has enabled the Department to benchmark its performance on several key indicators of quality against other states and the national averages. Data from NCI is incorporated into the QA Briefs. NCI involves indicators related to the experience of individuals in settings. However, because NCI's data collection methods are anonymous, DDS does not intend to use NCI data to review a specific setting. Rather, NCI is but one small part of DDS's quality assurance process. Continued involvement in the NCI surveys reinforces DDS's commitment to the principles and outcomes delineated in the HCBS Community Rule.

MRC

From Table 3. Summary of Transition Plan Tasks

- Revise MRC monitoring tools for day services and employment settings to facilitate monitoring of ongoing compliance (September 2015)

MRC Provider Qualification

Residential Settings

Provider owned/leased residential settings were the subject of an open bid process in 2014 and were required to be qualified to begin or continue to provide residential services. The RFR that providers responded to outlined critical outcomes with respect to choice, control, privacy, rights, integration, and inclusion in community life, consistent with the requirements of the Community Rule.

Non-Residential Settings

The MRC Provider Standards for Acquired Brain Injury (ABI) and Moving Forward Plan (MFP) Waiver Service Providers identify the requirements to become credentialed to provide waiver day and employment services. These standards have general requirements for all providers and additional requirements for each type of service a provider is seeking to provide. A thorough review identified no areas where the standards were in conflict with the Community Rule. Overall, the standards appropriately speak to community inclusion and individualized, person-centered service planning. They also point directly to the MRC Community Living Division Provider Manual, which articulates policies and procedures in alignment with the Community Rule. Changes in the MRC Community Living Division Provider Manual were finalized in February 2016 to strengthen language and ensure alignment with the Community Rule. Under the revised Provider Manual, providers must provide services consistent with the principles of person-centered planning and establish a complaint resolution process that includes providing consumers with a cognitively accessible, written copy of this process.

Provider credentialing

Under the ABI and MFP waivers, MRC uses the University of Massachusetts Medical School Provider Network Administration unit (UMMS-PNA) to credential day and employment services providers. UMMS-PNA, under a contract with MassHealth, credentials organizations following the MRC Provider Standards. Additionally, MRC supports the credentialing process of new day service providers by conducting an initial site visit and subsequent annual site visits. These visits use a comprehensive monitoring tool inclusive of an assessment of the physical site; policies and procedures to ensure safety and quality; staffing requirements and qualifications; individualized service planning; and community integration. For the credentialing of employment providers, MRC collaborated with UMMS-PNA to ensure that the requirements of the Community Rule are reflected in the review tool used by the UMMS-PNA in the credentialing and recredentialing process.

Procurement

Providers of day and employment services under the TBI Waiver are the subject of open bid processes and are qualified by either MRC or DDS (or both agencies) to provide these services and supports. The Request for Responses (RFR) that day and employment providers respond to outlines critical outcomes with respect to choice, control, career exploration, employment, rights, integration and inclusion in community life.

Quality management and oversight systems

MRC has an extensive and robust quality management system that addresses the criteria in the HCBS rule in every aspect of the system. Below are those components of the MRC system that monitor and relate to outcomes addressed in the Community Rule; DDS, in close partnership with MRC, has responsibility for quality oversight for the ABI-N and MFP-CL waivers.

MRC Monitoring Tool

The Monitoring Tool measures the quality, content and oversight of the person-centered service planning process and its implementation. This tool measures how effective the service planning process is in involving the individual, how well the objectives reflect the vision of the individual, whether the services being delivered address both individual needs and goals, whether the services are modified as

needs and goals change, and whether case managers are aware of and addressing issues of concern raised by the individual. Proper implementation of this tool is targeted to ensure optimal person-centered outcomes.

Residential Monitoring

MRC staff conduct monthly site visits for all residential providers in connection with routine, in-person case management meetings with participants. As part of these visits, MRC staff utilize a residential monitoring tool that assesses provider compliance with all MRC requirements, ensuring that participants are receiving services consistent with their desired goals and objectives as described in their person-centered plan. No changes were identified as being necessary to ensure that this tool reviews appropriate indicators to ensure compliance with Community Rule requirements.

Credentialing process

The credentialing process conducted by UMMS-PNA is the basis for qualifying providers under the ABI and MFP waivers. As detailed above in the section on provider qualification standards and processes, this process occurs for both initial qualification of a provider for a specific waiver service as well as annually thereafter to ensure continued qualification for these services. The annual credentialing visits are conducted by MRC agency staff.

Incident reporting

MRC uses access to a web-based incident reporting and management system, HCSIS, for two of its referenced waivers, ABI-N and MFP-CL. This incident reporting system is the result of a collaborative interagency project that leveraged and expanded the functionality of DDS's robust incident management system used with other HCBS waivers that are operated by DDS. For TBI waiver participants, a separate incident reporting system is maintained but with a nearly identical incident reporting tool and requirements. In both systems, the provider must report specific details regarding the incident as well as what actions they took to protect the health and safety of the individual and what additional long-range actions they may take. Aggregate information from both systems is reviewed and analyzed and forms the basis for service improvement targets.

Site feasibility

Providers intending to serve individuals in site-based settings must have any proposed sites reviewed by MRC staff for their feasibility to provide the necessary physical site requirements for the individual participants. Prior to serving any participant in a residential, day or employment site, review of the location is conducted to ensure that all necessary safeguards are in place and the location can be approved for occupancy. These safeguards include accessibility issues, so ongoing compliance with certain aspects of the Community Rule will be monitored for new providers and settings.

EOEA

From Table 3. Summary of Transition Plan Tasks

- Revise Supportive Day Program monitoring/review tool (January 2016)
- Develop congregate housing setting policy guidance and review/monitoring tool (January 2016)
- EOEA agents assess each Supportive Day Program setting
- EOEA conducts Supportive Day Program site visits as needed
- EOEA reviews congregate housing site-specific assessment results

- EOEAs review Supportive Day Program site-specific assessment results
- EOEAs verify full compliance of all congregate housing settings

EOEA Provider Qualification

Pursuant to the provider contract management section 3.5 of the ASAP contract, ASAPs review the qualifications of waiver service providers, including Supportive Day Program services. Qualifications are reviewed as part of initial on-site review visits with new providers, as well as when conducting regular monitoring visits of each provider at a minimum of every three years as part of the provider contract renewal process. EOEAs have developed and, through its agents implemented, tools designed to detect, monitor, and ensure provider compliance with the CMS Community Rule on an on-going basis. Although EOEAs found that the previous tool ASAPs used to review providers was consistent with the Community Rule, EOEAs identified an opportunity to strengthen the tool to align more clearly with the requirements of the Rule. The Supportive Day provider review tool was therefore revised to incorporate specific questions related to the Rule's requirements to better facilitate compliance monitoring. For example, the tool includes questions about Plans of Care, meaningful activities, and physical setting. In addition, Program Instruction PI-09-13 (Home Care Program Service Definitions, Attachment A) establishes detailed Home Care program service definitions for Supportive Day services that are consistent with requirements outlined in the CMS Community Rule.

HCBS services provided through the FEW are largely delivered to participants in their current home setting. The participant's home is not chosen as part of FEW enrollment. Some participants have chosen to live in congregate housing. Congregate housing is not a waiver service within the FEW. However, since some participants live in such settings, EOEAs reviewed these settings to confirm their community character.

Quality management and oversight systems

The administrative structure in place for the Frail Elder Waiver includes several layers of program oversight and quality management. At the state level, EOEAs are the operating agency for the Massachusetts 1915(c) Frail Elder Home and Community Based Services Waiver. Reporting to the Executive Office of Health and Human Services (EOHHS), EOEAs are subject to EOHHS's oversight authority. The Office of Medicaid, the medical assistance unit within EOHHS, oversees EOEAs' administration of the FEW. Within this structure, the Director of Home and Community Programs and the Home Care Unit Quality Manager at EOEAs have responsibility for ensuring that effective quality management systems are in place.

As EOEAs' agents, ASAPs implement clinical eligibility, financial, contract management, quality, and other administrative functions of the Home Care Program, including with respect to FEW participants. EOEAs' oversight of ASAP operations includes on-site visits ("designation reviews") every three years. In addition, each ASAP must submit annually an attestation of compliance with program guidelines and waiver requirements in order to maintain continued designation as an appropriate contractor. At the local level, ASAPs conduct operational and administrative functions such as quality monitoring, service provider contracting, and monitoring and incident reporting under the direction of EOEAs.

Each ASAP's Executive Director manages day-to-day compliance with waiver guidelines along with the ASAP Home Care Program Manager and RN Manager. The provider contract manager, an employee of

the ASAP, conducts all provider monitoring, including quality monitoring for all waiver services delivered to FEW participants.

A standing quality improvement committee which meets at least monthly is an ASAP requirement. This includes an agency quality improvement plan that is updated at least annually and a staff member with assigned responsibility for operational management of quality improvement activities. Tracking performance measures, including aggregation, remediation, and follow up with EOEAs is specified in the ASAP contract.

Provider network management and quality assurance

ASAPs proactively manage the performance of providers in accordance with the Provider Network Quality Assurance Manual, including monitoring and enforcing standards and instruction from EOEAs. These requirements include ensuring licensure and certification, when applicable, implementing satisfaction surveys, having processes to log, track, and respond appropriately to provider, critical incidents, complaints and compliments, and conducting monitoring reviews in accordance with EOEAs standards.

Service Plan Quality Improvement

The approved FEW application details the performance measures that are tracked and acted upon to ensure waiver services are delivered in accordance with the service plan and that they are meeting the participant's needs and preferences. Case managers document their review of waiver participant service plans in the data management system, and an annual report is produced out of that system for use in FEW quality performance reporting. For the FEW participants who are SCO members, the SCO plans provide similar data. In the event problems are discovered, EOEAs and MassHealth will ensure that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, EOEAs, and MassHealth are responsible for identifying and analyzing trends related to the service plans and operations of the FEW waiver and determining strategies to address quality-related issues.

MassHealth

From Table 3. Summary of Transition Plan Tasks

- Develop process for identifying waiver participants that are also AFC recipients, where the home is not owned or leased by the participant and the AFC caregiver is unrelated, and for validating compliance of those settings. (December 2022)
- Develop processes for ongoing oversight and monitoring of compliance of AFC settings with waiver participants not living in their own home with an unrelated AFC caregiver. (March 2023)

Policies and Procedures

Adult Foster Care

All Massachusetts HCBS waiver participants have access to the Adult Foster Care (AFC) service, which is a MassHealth state plan service, not a HCBS waiver service. The majority of AFC caregivers are family members. While MassHealth's AFC program regulation 130 CMR 408.435(A) addresses qualified AFC settings and explicitly states that AFC settings are not structured as provider operated settings, some

waiver participants may choose to move into the home of an unrelated AFC caregiver concurrent to receiving HCBS waiver services in the home. In those instances where the caregiver is unrelated and the participant does not own or lease the home, MassHealth will review those AFC settings to ensure they conform to the requirements of community settings including that the participant has a lease or other legally enforceable agreement providing similar protections.

As of December 2022, MassHealth has issued an AFC Provider Bulletin that states providers must identify AFC members who are HCBS Waiver participants. For each AFC member who is an HCBS Waiver participant, the AFC provider must work with the AFC caregiver and AFC member to complete an attestation, in the form and format required by the Executive Office of Health and Human Services (EOHHS), to determine the application of the Community Rule to the AFC-qualified setting (i.e., where the AFC member/HCBS Waiver participant lives, in the home of an unrelated AFC caregiver). If so, the provider must work with the member and caregiver to confirm compliance with the Community Rule.

Further sub-regulatory guidance is being developed with details about compliance with requirements. These details will include, but will not necessarily be limited to, information about leases and comparable protections for those without a lease; whether and how certain AFC plan of care requirements apply; use of prescribed documentation and related recordkeeping or reporting; and timing for these requirements.

By March 2023, AFC providers will have completed and executed agreements with HCBS waiver participants whose residential settings are subject to the community rule and will continue to do so as a matter of practice. MassHealth is devising processes for validation and continued monitoring.

Description of a beneficiary's recourse to notify the state of provider noncompliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback.

MassHealth has a process by which HCBS waiver participants may notify the state when they believe a provider to be noncompliant with the HCBS Community Settings Rule. This process includes the following components:

- Dedicated phone number with voicemail
- Dedicated email address and inbox
- Intake form available on the Massachusetts' Home and Community Based Services (HCBS) Settings Community Rule webpage

Staff from the MassHealth HCBS Waiver Unit monitor these channels and triage cases to designated contacts at the Executive Office of Elder Affairs, Massachusetts Rehabilitation Commission, and Department of Developmental Services, depending on the waiver participation of the submitter. State agency investigation of the complaint will involve the waiver participant, the waiver participant's case manager, as well as the provider in question, and all efforts will be made to complete the review within 30 days of submission of the complaint to MassHealth. Depending on the outcome of the investigation, resolution may entail further education of the provider and/or the waiver participant on the Community

Rule; work with the provider on steps to bring the setting into compliance; and communication with the waiver participant around interim solutions until compliance can be reached.

MassHealth has created a factsheet to educate waiver participants and case managers about the requirements of the Community Rule and to promote awareness of this new process. The factsheet outlines a waiver participant's rights, relative to the Rule, and provides instructions on the various mechanisms by which to report concerns and complaints. Case managers educate waiver participants on this process either as part of the annual ISP process or with distribution of other waiver participation materials.

For more information about how to submit a grievance, or for a link to the factsheet, go to <https://www.mass.gov/home-and-community-based-services-hcbs-settings-community-rule>