# 130 CMR 630.000: HOME- AND COMMUNITY-BASED SERVICES WAIVER SERVICES

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## 630.401: Introduction

130 CMR 630.000 governs the provision of services under the Acquired Brain Injury Home- and Community-based Services waivers (ABI Waivers) and the Moving Forward Plan Home- and Community-based Services waivers (MFP Waivers). All providers of services under these Home- and Community-based Services (HCBS) waivers must comply with MassHealth regulations set forth in 130 CMR 630.000 and 130 CMR 450.000: *Administrative and Billing Regulations*, and with HCBS regulations and requirements established by the Centers for Medicare & Medicaid Services.

630.402: Definitions

The following terms used in 130 CMR 630.000 have the meanings given in 130 CMR 630.402, unless the context clearly requires a different meaning.

Acquired Brain Injury (ABI). All forms of brain injury that occurs after 22 years of age including, without limitation, brain injuries caused by external force, but not including Alzheimer's disease and similar neurodegenerative diseases of which the primary manifestation is dementia.

Acquired Brain Injury Home- and Community-based Services Waivers (ABI Waivers). Home- and community-based services waivers approved by the Centers for Medicare and Medicaid Services (CMS) under § 1915(c) of the Social Security Act for persons with acquired brain injury who are transitioning from long-stay facilities into the community. The two separate Acquired Brain Injury Waivers, each with different covered services and eligibility requirements are: the Acquired Brain Injury with Residential Habilitation (ABI-RH) Waiver and the Acquired Brain Injury Non-residential Habilitation (ABI-N) Waiver.

Activities of Daily Living (ADL). Certain basic tasks required for daily living, including the ability to bathe, dress/undress, eat, toilet, transfer in and out of bed or chair, get around inside the home, and manage incontinence.

Adult Companion Service. Nonmedical care, supervision, and socialization provided to a participant. Companions may assist or supervise the participant with such light household tasks as meal preparation, laundry, and shopping.

Assisted Living Services. Services consist of personal care and supportive services (for example, homemaker, chore, personal care services, meal preparation) that are furnished to participants who reside in an assisted living residence (ALR) that meets all applicable requirements of 42 CFR 441.301(c)(4) (Home and Community-based Settings Rule), and include 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety, and security. Services may also include social and recreational programs, and medication assistance (consistent with ALR certification and to the extent permitted under State law). Nursing and skilled therapy services are incidental rather than integral to the provision of Assisted Living Services. Intermittent skilled nursing services and therapy services may be provided to the extent allowed by applicable regulations.

Assistive Technology Device. An item, piece of equipment, or product system that is used to develop, increase, maintain, or improve functional capabilities of participants, and to support the participant to achieve goals identified in their Plan of Care. This service includes purchase, lease, or other acquisition costs of cell phones, tablets, computers, and ancillary equipment necessary for the operation of the assistive technology devices that enable the individual to participate in telehealth.

Assistive Technology Evaluation and Training. The evaluation of the assistive technology needs of the participant, *i.e.* functional evaluation of the impact of the provision of appropriate Assistive Technology devices and services to the participant in the customary environment of the participant; the selection, customization and acquisition of Assistive Technology devices for participants; selection, design, fitting, customization, adaption, maintenance, repair, and/or replacement of Assistive Technology devices; coordination and use of necessary therapies, interventions, or services with Assistive Technology devices that are associated with other services contained in the Plan of Care; training and technical assistance for the participant, and, 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.

Chore. An unusual or infrequent household maintenance task that is needed to maintain the participant's home in a clean, sanitary, and safe environment. Chores include heavy household work such as washing floors, windows, and walls; tacking down loose rugs and tiles; and moving heavy items of furniture to provide safe access and exit.

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Community-based Day Supports. A service designed to enable a participant to enrich their life and enjoy a full range of community activities by providing opportunities for developing, enhancing, and maintaining competency in personal, social interactions and community engagement. Community-based Day Supports uses a small group model to provide a flexible array of individualized supports through activities primarily in non-center-based settings separate from the participant's private residence or other residential living arrangement.

Community Behavioral Health Support and Navigation. A service that provides outreach and support services to enable participants to access and utilize clinical behavioral health treatment services and other supports. Community Behavioral Health Support and Navigation services are staffed by paraprofessionals, supported by clinical supervision, and are designed to be maximally flexible in supporting participants to implement the goals in their plan of care and attain the skills and resources needed to successfully maintain community tenure.

Community Family Training. A service designed to provide training and instruction about the treatment regimes, behavior plans, and the use of specialized equipment that support a participant in the community. Community Family Training may also include training in family leadership, support of self-advocacy and independence for the family member. The service enhances the skills of the family to assist the waiver participant to function in the community and at home.

Coverage Type. a scope of services that are available to MassHealth members who meet specific eligibility criteria.

Day Services. A structured, site-based, group program for participants that fosters community integration and offers assistance with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills, and that takes place in a nonresidential setting separate from the participant's private residence or other residential living arrangement. Services often include assistance to learn ADLs and functional skills; language and communication training; compensatory, cognitive and other strategies; interpersonal skills; prevocational skills; and recreational and socialization skills.

Department of Developmental Services (DDS). The state agency within the Executive Office of Health and Human Services that is organized pursuant to M.G.L. c. 19B, to provide specialized services and supports to individuals with intellectual disabilities and developmental disabilities and to promote full and meaningful participation of the individuals as valued members of their communities.

Electronic Visit Verification (EVV). The method or system designated or approved by EOHHS to electronically verify service delivery in the form and format as required by the MassHealth agency.

Executive Office of Health and Human Services (EOHHS). The Executive Office of Health and Human Services established under M.G.L. c. 6A.

Family Member. A spouse or any legally responsible relative of the participant.

Fiscal Intermediary (FI). An entity under contract with EOHHS to perform employer-required tasks and related administrative tasks as described in 130 CMR 422.419(B).

Home Accessibility Adaptations. Physical modifications to the participant's home that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home.

Home- and Community-based Services (HCBS) Waiver. A federally approved program operated under § 1915(c) of the Social Security Act that authorizes the U.S. Secretary of Health and Human Services to grant waivers of certain Medicaid statutory requirements so that a state may furnish home- and community-based services to certain Medicaid beneficiaries who need a level of care that is provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disability (ICF/ID). For the purpose of 130 CMR 630.000, Home- and Community-based Services Waiver refers to the two ABI waivers and the two MFP waivers.

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Home Health Aide. A person who performs certain personal care and other health-related services as described in 130 CMR 403.000: *Home Health Agency*.

Home Delivered Meals. The provision of well-balanced meals to participants to maintain optimal nutritional and health status. Home Delivered Meals service includes the preparation, packaging, and delivery of meals by trained and supervised staff.

Homemaker. A person who performs light housekeeping duties (for example, cooking, cleaning, laundry, and shopping) for the purpose of maintaining a participant's household.

Independent Living Supports. A service that ensures 24-hour, seven-days-per-week access to supportive services for participants who have intermittent, scheduled and unscheduled needs for various forms of assistance, but who do not require 24-hour supervision. It provides participants with services and supports in a variety of activities such as: ADLs and instrumental activities of daily living (IADLs), support and companionship, emotional support and socialization. This service is provided by a site-based provider, and is available to participants who choose to reside in locations where a critical mass of individuals reside who require such support and where providers of such supports are available.

Individual Support and Community Habilitation. Regular or intermittent services designed to develop, maintain, and/or maximize the participant's independent functioning in self-care, physical and emotional growth, socialization, communication, and vocational skills, to achieve objectives of improved health and welfare and to the support the ability of the participant to establish and maintain a residence and live in the community.

Instrumental Activities of Daily Living (IADL). Certain basic environmental tasks required for daily living, including the ability to prepare meals, do housework, laundry, and shopping, get around outside, use transportation, manage money, and use the telephone.

Laundry. Service provided to a participant which includes pick up, washing, drying, folding,wrapping, and returning of laundry.

Legally Responsible Individual. Any person who has a duty under state law to care for another person including, but not limited to, a legal guardian or a spouse of a participant.

Massachusetts Rehabilitation Commission (MRC). The state agency within the Executive Office of Health and Human Services that is organized pursuant to M.G.L. c. 6, §§ 74 through 84, to provide comprehensive services to individuals with disabilities, which maximize their quality of life and economic self-sufficiency. MRC accomplishes its work through multiple programs in its Community Living Division, the Disability Determination Service Division and the Vocational Rehabilitation Division.

MassHealth. The medical assistance and benefit programs administered by EOHHS pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services for eligible members.

Moving Forward Plan Waivers (MFP Waivers). Two Massachusetts Home- and Community-based Services Waivers approved by the CMS under § 1915(c) of the Social Security Act for persons with disabilities who are transitioning from long-stay facilities. Massachusetts operates two separate MFP Waivers – the Moving Forward Plan Residential Supports (MFP-RS) Waiver and the Moving Forward Plan Community Living (MFP-CL) Waiver – each with different covered services and eligibility requirements.

Occupational Therapist. A person who is licensed by the Massachusetts Division of Registration in Allied Health Professions and registered by the American Occupational Therapy Association (AOTA) or is a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by AOTA.

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Occupational Therapy. Therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, maintain, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Occupational therapy programs are designed to improve quality of life by recovering competence and preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living. Occupational therapy services may include the performance of a maintenance program beyond the scope of coverage in the state plan. Services may also include training and oversight for the participant or a family member or other person to carry out a maintenance program.

Orientation and Mobility Services. Services that teach a participant with vision impairment or legal blindness how to move or travel safely and independently in their home and community. Orientation and Mobility Services include participant training, environmental evaluations, and caregiver/direct care staff training on sensitivity to blindness/low vision. Orientation and Mobility Services are tailored to the participant's needs and may extend beyond residential settings to other community settings as well as public transportation systems.

Participant. A MassHealth member determined by the MassHealth agency to be eligible for enrollment in one of the HCBS waivers, who chooses to receive HCBS waiver services, and for whom a service plan has been developed that includes one or more HCBS waiver services.

Peer Support. Ongoing services and supports designed to assist participants to acquire, maintain or improve the skills necessary to live in a community setting. This service provides supports necessary for the participant to develop the skills that enable them to become more independent, integrated into, and productive in their communities. The service enables the participant to retain or improve skills related to personal finance, health, shopping, use of community resources, community safety, and other adaptive skills needed to live in the community.

Personal Care. Services provided to a participant, which may include physical assistance, supervision or cuing of participants, for the purpose of assisting the participant to accomplish activities of daily living (ADLs) including, but not limited to, eating, toileting, dressing, bathing, transferring, and ambulation.

Physical Therapist. A person licensed by the Massachusetts Division of Registration in Allied Health Professions to provide physical therapy.

Physical Therapy. Therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, maintain, or prevent the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functioning levels. Physical therapy services may include the performance of a maintenance program beyond the scope of coverage in the state plan. Services may also include training and oversight for the participant or a family member or other person to carry out a maintenance program.

Prevocational Services. A service that consists of a range of learning and experiential type activities that prepare a participant for paid or unpaid employment in an integrated, community setting. Services are not job-task oriented but instead, aimed at a generalized result (*e.g.*, attention span, motor skills). The service may include teaching such concepts as attendance, task completion, problem solving and safety as well as social skills training, improving attention span, and developing or improving motor skills. Basic skill-building activities are expected to specifically involve strategies to enhance a participant's employability in integrated, community settings.

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Provider Agreement. The contract between the MassHealth agency and a person or organization under which the provider agrees to furnish services to MassHealth members in compliance with state and federal Title XIX requirements. Federal regulations concerning provider agreements are located in 42 CFR § 431.107.

Residential Family Training. A service designed to provide training and instruction about treatment regimes, behavior plans, and the use of specialized equipment that support a participant in the community. Residential family training may also include training in family leadership, support of self-advocacy, and independence for the family member. The service enhances the skill of the family to assist the waiver participant to function in the community and at home when the waiver participant visits the family home.

Residential Habilitation. Ongoing services and supports provided to a participant in a provider-operated residential setting that are designed to assist participants in acquiring, maintaining, or improving the skills necessary to live in a community setting. Residential habilitation provides participants with daily staff intervention including care, supervision, and skills training in activities of daily living, home management, and community integration in a qualified residential setting with 24-hour staffing. This service may include the provision of medical and health-care services that are integral to meeting the daily needs of participants.

Respite. Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of unpaid caregivers.

Room and Board. Room means shelter-type expenses, including all property-related costs, such as rental or purchase of real estate, maintenance, utilities, and related administrative services. Board means up to three meals a day or any other full nutritional regimen.

Self-directed Services. A model of service delivery in which a waiver participant has decision making authority over certain aspects of the delivery of their care.

Service Plan. A written document that specifies the waiver and other services (regardless of funding source) along with any informal supports that are furnished to meet the participant's needs and goals, as assessed and identified through a person-centered planning process, and to assist a participant in remaining in the community. Service Plan is also known as the individual service plan and can include the waiver plan of care.

Shared Home Supports. An individually tailored supportive service that assists with the acquisition, retention, or improvement in skills related to living in the community. A participant is matched with a shared home supports caregiver. Shared home supports are overseen by a residential support agency. Shared home supports do not include 24-hour care. Shared Home Supports include such supports as: adaptive skill development, assistance with ADLs and IADLs, adult educational supports, social and leisure skill development, and supervision.

Shared Living – 24-hour Supports. A residential service that matches a participant with a shared living caregiver, an arrangement overseen by a residential support agency. Shared Living – 24-hour Supports is an individually tailored 24-hour, seven-days-per-week, supportive service available to a participant who needs daily structure and supervision. This service includes supportive services that assist with the acquisition, retention, or improvement of skills related to living in the community. This includes such supports as: adaptive skill development, assistance with ADLs and IADLs, adult educational supports, social and leisure skill development, protective oversight, and supervision.

Short-term Alternative Shared Home Support Days. A short-term placement during which a member receives shared home supports from an alternative caregiver when the shared home supports caregiver is temporarily unavailable or unable to provide care.

Short-term Alternative Shared Living – 24-hour Support Days. A short-term placement during which a member receives 24-hour shared living supports from an alternative caregiver when the Shared Living – 24-hour Supports caregiver is temporarily unavailable or unable to provide care.

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Skilled Nursing. The assessment, planning, provision, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that require the skills of a nurse. Skilled nursing services are provided by a person licensed as a registered nurse or a licensed practical nurse by a state's board of registration in nursing.

Specialized Medical Equipment and Supplies. Devices, controls, or appliances to increase abilities in activities of daily living, or to control or communicate with the environment.

Speech/Language Therapist. A person who is licensed by the Massachusetts Division of Registration in Speech-language Pathology and Audiology and has either a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA) or a statement from ASHA of certification equivalency.

Speech/Language Therapy. Therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, maintain, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies or injuries. Speech therapy services may include the performance of a maintenance program beyond the scope of coverage in the state plan. Services may include training and oversight for the participant or a family member or other person to carry out a maintenance program.

Supported Employment. Regularly scheduled services that enable participants, through training and support, to work in integrated work settings in which individuals are working toward compensated work, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals.

Supportive Home Care Aide. Services provided to participants with Alzheimer's/dementia or behavioral health needs to assist with ADLs and IADLs. These services include personal care, shopping, menu planning, meal preparation including special diets, laundry, light housekeeping, escort, and socialization /emotional support.

Telehealth. The delivery of services to participants *via* telephone, video-conferencing, or other electronic modality. Services that may be delivered *via* telehealth modalities are described in HCBS Waiver Provider Bulletin 23. EOHHS may publish updates or clarifications related to the provision of telehealth for HCBS Waiver Services by bulletin or other written issuance.

Transitional Assistance Services. Non-recurring residential set-up expenses for participants who are transitioning from a nursing facility or hospital to a community living arrangement where the participant is directly responsible for their own set-up expenses. Allowable expenses are those that are necessary to enable a person to establish a basic household and do not constitute Room and Board.

Transportation. Conveyance of participants by vehicle, from their residence to and from the site of HCBS waiver services and other community services, activities, and resources, including physical assistance to participants while entering and exiting the vehicle.

Tuberculosis Screening. Administration of the Massachusetts Tuberculosis Risk Assessment published by the Massachusetts Department of Public Health or a similar tool by a medical provider to identify asymptomatic individuals for testing for latent tuberculosis infection.

Vehicle Modification. Necessary adaptations or alterations to an automobile or van that is the participant's primary means of transportation and that is not owned or leased by an entity providing services to the participant. Vehicle modifications are necessary when they are required to accommodate special needs of the participant. Examples of vehicle modifications include: van lift, tie downs, ramp, specialized seating equipment and seating/safety restraint.

Visit. A face-to-face or telehealth contact with the participant for the purpose of providing an HCBS waiver service.

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Waiver Provider. A qualified individual or organization that meets the requirements of 130 CMR 630.000, provides waiver services to participants, and has signed a provider agreement with the MassHealth agency.

Waiver Services. Home- and community-based services that are covered in accordance with the requirements of 130 CMR 630.000 for participants enrolled under an ABI waiver or MFP waiver.

630.403: Eligible Members

(A) MassHealth pays for services under an HCBS waiver only when provided to eligible MassHealth members who are enrolled as participants in the HCBS waiver, in accordance with 130 CMR 519.007(G): *Home- and Community-based Services Waivers for Persons with Acquired Brain Injury* and (H): *Moving Forward Plan Home- and Community-based Services Waivers*, subject to the restrictions and limitations described in 130 CMR 630.000 and 130 CMR 450.000: *Administrative and Billing Regulations*. 130 CMR 630.405 specifically states, for each HCBS waiver, which HCBS waiver services are covered and which HCBS waiver participants are eligible to receive those services.

(B) For information on verifying member eligibility and coverage type, *see* 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

630.404: Provider Eligibility

(A) Requirements for Participation. An individual or organization seeking to participate as a provider of services under an HCBS waiver must

(1) be duly authorized to conduct a business in Massachusetts that delivers health or human services to elderly or disabled adult populations;

(2) comply with all standards, requirements, policies, and procedures established by DDS or MRC for the provision of services under an HCBS waiver;

(3) meet the applicable HCBS waiver service provider application qualifications;

(4) comply with all standards, requirements, policies, and procedures established by the MassHealth agency for the participation of providers in MassHealth, including all provider participation requirements described in 130 CMR 630.000 and 130 CMR 450.000: *Administrative and Billing Regulations*;

(5) obtain, as required, a MassHealth provider number; and

(6) accept MassHealth payment, DDS payment, or MRC payment where applicable, as payment in full for all services provided under an HCBS waiver.

(B) Required Documentation. All required MassHealth application documentation will be specified by the MassHealth agency. In order to participate as an HCBS waiver provider, an applicant must submit all required documentation, and the MassHealth agency or its designee must approve it.

(C) Periodic Inspections. The MassHealth agency or its designee may conduct periodic inspections of HCBS waiver providers to ensure compliance with all provider participation requirements described in 130 CMR 630.000 and 130 CMR 450.000: *Administrative and Billing Regulations*. An HCBS waiver provider must cooperate with any inspection and furnish any requested records.

(D) HCBS Waiver Provider Eligibility Requirements by Service Type.

(1) Adult Companion. In order to participate as a provider of adult companion services under an HCBS waiver, a provider must be a health or human service organization or an individual with experience providing nonmedical care, supervision, and socialization for persons with disabilities in accordance with all standards, requirements, policies, and procedures established by the MRC for the provision of such services.

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(2) Assisted Living Services. In order to participate as a provider of assisted living services under a HCBS waiver, a provider must be certified as an assisted living residence by the Executive Office of Elder Affairs in accordance with 651 CMR 12.00: *Certification Procedures and Standards for Assisted Living Residences*, meet all applicable requirements of 42 CFR 441.301(c)(4) (Home and Community-based Settings Rule), and maintain compliance with all standards, requirements, policies, and procedures established by DDS for the provision of such services.

(3) Assistive Technology Evaluation and Training Services. In order to participate as a provider of assistive technology evaluation and training services under an HCBS waiver, a provider must have a bachelor's degree or training in a related technology field and at least one year of proven experience providing adaptive technological assessment. A provider must have knowledge and experience in evaluating the needs of individuals with disabilities, including functionally evaluating the individual in the individual's environment.

(4) Assistive Technology Devices. In order to participate as a provider of assistive technology devices under the HCBS waiver, a provider must ensure that all devices and accessories have been examined and/or tested by Underwriters Laboratory (or other appropriate organization), and comply with FCC regulations, as appropriate. In addition, providers licensed, certified, and qualified by DDS in accordance with 115 CMR 7.00: *Standards for All Services and Supports* (Department of Developmental Services (DDS) regulations for all DDS supports and services provided by public and private providers and those services subject to regulation by the Massachusetts Rehabilitation Commission, which provide social and pre-vocational supports and work training) will be considered to have met these standards.

(5) Chore. In order to participate as a provider of chore services under an HCBS waiver, a provider must be a health or human service organization or an individual with experience providing services needed to maintain the home in a clean, sanitary, and safe condition, in accordance with all standards, requirements, policies, and procedures established by MRC for the provision of such services.

(6) Community-based Day Supports. In order to participate as a provider of community-based day supports under an HCBS waiver, a provider must be a human service agency or rehabilitation agency with experience providing functional, community-based services and living skills training and a demonstrated commitment to the philosophy of maximizing independence and supporting meaningful community membership with an appropriate blend of comprehensive services, in accordance with all standards, requirements, policies, and procedures established by DDS or MRC for the provision of such services. Community-based day supports must be provided in settings that are physically and programmatically distinct from day habilitation services settings (*see* 130 CMR 419.000: *Day Habilitation Center Services*) and waiver day services settings. All provider-owned or -operated settings in which waiver participants may gather must meet all requirements of 130 CMR 630.438.

(7) Community Behavioral Health Support and Navigation. In order to participate as a provider of community behavioral health support and navigation under an HCBS waiver, a provider must be a not-for-profit or proprietary organization that provides mental health and/or substance use disorder services and be licensed within the Commonwealth of Massachusetts, and in accordance with all standards, requirements, policies, and procedures established by MRC for the provision of such services. Organizations providing community behavioral health support and navigation must employ a multi-disciplinary staff with established experience, skills, and training in the acute treatment of mental health and co-occurring mental health and substance use conditions, including a minimum of one full-time master's or doctorate-level, licensed behavioral health clinician responsible for operation of the program and supervision of staff. Supervision must include participant-specific supervision, as well as a review of mental health, substance use disorder and medical conditions, and integration principles and practices.

(8) Community Family Training and/or Residential Family Training. In order to participate as a provider of community family training and/or residential family training under an HCBS waiver, a provider must be an organization or an individual with experience in providing training and instruction about treatment regimes, behavior plans, and the use of specialized equipment that supports the waiver participant to participate in the community, in accordance with all standards, requirements, policies, and procedures established by DDS or MRC for the provision of such services to participants of an HCBS waiver. If an agency or individual is providing services where licensure or certification is necessary, the agency or individual must have the necessary licensure and certifications.

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(9) Day Services. In order to participate as a provider of day services under an HCBS waiver, a provider must be a health or human service organization with experience providing day services to persons with disabilities in accordance with all standards, requirements, policies, and procedures established by DDS or MRC for the provision of day services to participants of an HCBS waiver. Day services must be provided at a provider-operated site in the community and not in a participant's residence. A provider of day services must meet all applicable requirements of 42 CFR 441.301(c)(4) (Home and Community-based Settings Rule), and meet the location requirements of 130 CMR 630.438.

(10) Home Accessibility Adaptations. In order to participate as a provider of home accessibility adaptations under an HCBS waiver, a provider must be qualified to perform environmental and minor home adaptations in accordance with applicable state and local building codes, and comply with any applicable registration or licensure requirements. Providers must also be under contract with MRC in accordance with its standards, requirements, policies, and procedures for the provision of home accessibility adaptations.

(11) Home Delivered Meals. In order to participate as a provider of home delivered meals under an HCBS waiver, a provider must have current local Board of Health inspection or certification. If the town or city where the program will be sited does not require a Board of Health inspection, the provider must submit supporting documentation.

(12) Home Health Aide. In order to participate as a provider of home health aide services under an HCBS waiver, a provider must be an organization engaged in the business of home health aide services in accordance with all standards, requirements, policies, and procedures established by MRC for the provision of such services, and meet the following requirements:

(a) employ registered nurses who have a current license by the Massachusetts Board of Registration in Nursing and who supervise the home health aides; and

(b) employ home health aides who have certification in CPR and either a certificate of home health aide training or certificate of certified nurse's aide training.

(13) Homemaker. In order to participate as a provider of homemaker services under an HCBS waiver, a provider must be an individual homemaker or an organization engaged in the business of homemaker services in accordance with all standards, requirements, policies, and procedures established by MRC for the provision of such services. Homemakers must have at least one of the following qualifications:

(a) certificate of home health aide training;

(b) certificate of nurse's aide training;

(c) certificate of 40-hour homemaker training; or

(d) certificate of 60-hour personal care training.

(14) Independent Living Supports. In order to participate as a provider of independent living supports services under an HCBS waiver, a provider must be a site-based organization that ensures 24-hour, seven-days-per-week access to supportive services for participants who have intermittent, scheduled, and unscheduled needs for various forms of assistance, but who do not require 24-hour supervision, in accordance with all standards, requirements, policies, and procedures established by MRC for the provision of such services.

(15) Individual Support and Community Habilitation. In order to participate as a provider of individual support and community habilitation under an HCBS waiver, a provider must be a health or human service organization or an individual with experience providing services that are designed to develop, maintain, or maximize independent functioning in self-care, physical and emotional growth, socialization, communication, and vocational skills for persons with disabilities in accordance with all standards, requirements, policies, and procedures established by DDS or MRC for the provision of such services.

(16) Laundry. In order to participate as a provider of laundry services under an HCBS waiver, a provider must be a not-for-profit or proprietary organization that is engaged in the business of providing laundry services at a separate laundry facility, and must have provisions in place for the handling of soiled laundry to minimize personnel exposure to contaminants and the separation of cleaned and soiled laundry during transportation to prevent spillage or cross contamination during transport.

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(17) Orientation and Mobility Services. In order to participate as a provider of orientation and mobility services under an HCBS waiver, a provider must be an individual, or an agency that employs individuals, with a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from a university program certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP), and maintain compliance with all standards, requirements, policies, and procedures established by DDS or MRC for the provision of such services to participants of an HCBS waiver.

(18) Peer Support. In order to participate as a provider of peer support services under an HCBS waiver, a provider must be an agency or individual with relevant competencies and experiences in peer support, in accordance with all standards, requirements, policies, and procedures established by DDS or MRC for the provision of such services to participants of an HCBS waiver. For an agency providing this service, the agency needs to employ individuals who meet all relevant state and federal licensure or certification requirements in their discipline.

(19) Personal Care. In order to participate as a provider of personal care services under an HCBS waiver, a provider must be an individual personal care worker or an organization engaged in the business of

(a) providing assistance with the performance of ADLs to persons with disabilities in accordance with all standards, requirements, policies, and procedures established by MRC for the provision of such service; and

(b) providing personal care services through personal care workers who must have a certificate in CPR and at least one of the following qualifications:

1. certificate of home health aide training;
2. certificate of nurse's aide training; or
3. certificate of 60-hour personal care training.

(20) Prevocational Services. In order to participate as a provider of prevocational services under an HCBS waiver, a provider must be a prevocational service agency with experience in providing services that prepare a participant for paid or unpaid employment in an integrated, community setting, in accordance with all standards, requirements, policies, and procedures established by DDS or MRC for the provision of such services to participants of an HCBS waiver.

(21) Residential Habilitation. Residential habilitation under an HCBS waiver must be provided by organizations under contract with DDS in accordance with its standards, requirements, policies, and procedures for the provision of residential habilitation services to persons with disabilities, and must demonstrate compliance with applicable requirements under:

(a) 115 CMR 7.00: *Standards for All Services and Supports* and 115 CMR 8.00: *Licensure and Certification of Providers*; or

(b) 104 CMR 28.00: *Licensing and Operational Standards for Community Services*.

(22) Respite. In order to participate as a provider of respite services under an HCBS waiver, a respite provider must be in accordance with all standards, requirements, policies, and procedures established by MRC for the provision of such services to participants of an HCBS waiver, and be:

(a) licensed as a hospital by the Massachusetts Department of Public Health under 105 CMR 130.00: *Hospital Licensure*;

(b) certified as an assisted living residence by the Executive Office of Elder Affairs under 651 CMR 12.00: *Certification Procedures and Standards for Assisted Living Residences*;

(c) licensed as a nursing facility by the Massachusetts Department of Public Health under 105 CMR 153.000: *Licensure Procedure and Suitability Requirements for Long Term Care Facilities*;

(d) able to meet site-based respite requirements established by the Massachusetts Department of Developmental Services under 115 CMR 7.00: *Standards for All Services and Supports*;

(e) licensed as a respite care facility by the Department of Developmental Services in accordance with 115 CMR 7.00: *Standards for All Services and Supports* and 115 CMR 8.00: *Licensure and Certification of Providers*;

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(f) licensed as a rest home by the Massachusetts Department of Public Health under 105 CMR 153.000: *Licensure Procedure and Suitability Requirements for Long Term Care Facilities*; or

(g) enrolled in MassHealth as a participating adult foster care provider under 130 CMR 408.000: *Adult Foster Care*.

(23) Self-directed Services. Participants who choose to self-direct waiver services will have the authority and responsibility for recruiting and hiring workers to provide their self-directed services, subject to the standards, requirements, policies and procedures for the hiring of such workers under the participant's HCBS waiver.

(24) Shared Home Supports. In order to participate as a provider of shared home supports, a provider must be an organization licensed by DDS as a provider of placement services in accordance with its standards, requirements, policies, and procedures for the provision of these services to persons with disabilities, and must demonstrate compliance with applicable requirements under:

(a) 115 CMR 7.00: *Standards for All Services and Supports* and 115 CMR 8.00: *Licensure and Certification of Providers*; or

(b) 104 CMR 28.00: *Licensing and Operational Standards for Community Services*.

(25) Shared Living – 24-hour Supports. In order to participate as a provider of shared living – 24-hour supports under an HCBS waiver, organizations must be under contract with DDS in accordance with its standards, requirements, policies, and procedures for the provision of shared living – 24-hour supports services to persons with disabilities, and must demonstrate compliance with applicable requirements under:

(a) 115 CMR 7.00: *Standards for All Services and Supports* and 115 CMR 8.00: *Licensure and Certification of Providers*; or

(b) 104 CMR 28.00: *Licensing and Operational Standards for Community Services*.

(26) Skilled Nursing. In order to participate as a provider of skilled nursing services under an HCBS waiver, a provider must be an organization engaged in the business of providing nursing services that employs nurses who are a registered nurse or a licensed practical nurse by the Massachusetts Board of Registration in Nursing, and maintains compliance with all standards, requirements, policies, and procedures established by DDS or MRC for the provision of such services to participants of an HCBS waiver.

(27) Specialized Medical Equipment. In order to participate as a provider of specialized medical equipment and supplies under an HCBS waiver, a provider must be an individual or entity engaged in the business of furnishing durable medical equipment, medical/surgical supplies, or customized equipment, or a provider participating in MassHealth under 130 CMR 409.000: *Durable Medical Equipment Services* or a pharmacy participating in MassHealth under 130 CMR 406.000: *Pharmacy Services*, in accordance with all standards, requirements, policies, and procedures established by DDS or MRC for the provision of such services to participants of an HCBS waiver.

(28) Supported Employment. In order to participate as a provider of supported employment services under an HCBS waiver, a provider must be a human service organization with experience providing supported employment programs in accordance with all standards, requirements, policies, and procedures established by DDS or MRC for the provision of supported employment to persons with disabilities.

(29) Supportive Home Care Aide. In order to participate as a provider of supportive home care aide services under an HCBS waiver, a provider must be an organization engaged in the business of supportive home care aide services in accordance with all standards, requirements, policies, and procedures established by MRC for the provision of such services to participants of an HCBS waiver, that employs supportive home care aides who:

(a) have a certification in CPR and either a certificate of home health aide training or certificate of certified nurse's aide training; and

(b) have completed an additional 12 hours of training in the area of serving individuals with behavioral health needs or the 12-hour training developed by the Alzheimer's Association, Massachusetts Chapter on serving individuals with Alzheimer's disease or related disorders.

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(30) Therapy Services.

(a) Occupational Therapy. In order to participate as a provider of occupational therapy under an HCBS waiver, a provider must be an occupational therapist participating in the MassHealth program under 130 CMR 432.000: *Therapist Services*, a rehabilitation center participating in MassHealth under 130 CMR 430.000: *Rehabilitation Center Services*, a home health agency participating in MassHealth under 130 CMR 403.000: *Home Health Agency*, a chronic disease and rehabilitation inpatient hospital participating in MassHealth under 130 CMR 435.000: *Chronic Disease and Rehabilitation Inpatient Hospital Services*, or a chronic disease and rehabilitation outpatient hospital participating in MassHealth under 130 CMR 410.000: *Outpatient Hospital Services*, in accordance with all standards, requirements, policies, and procedures established by MRC or DDS for the provision of such services to participants of an HCBS waiver.

(b) Physical Therapy. In order to participate as a provider of physical therapy under an HCBS waiver, a provider must be a physical therapist participating in the MassHealth program under 130 CMR 432.000: *Therapist Services*, a rehabilitation center participating in MassHealth under 130 CMR 430.000: *Rehabilitation Center Services*, a home health agency participating in MassHealth under 130 CMR 403.000: *Home Health Agency*, a chronic disease and rehabilitation inpatient hospital participating in MassHealth under 130 CMR 435.000: *Chronic Disease and Rehabilitation Inpatient Hospital Services*, or a chronic disease and rehabilitation outpatient hospital participating in MassHealth under 130 CMR 410.000: *Outpatient Hospital Services*, in accordance with all standards, requirements, policies, and procedures established by MRC or DDS for the provision of such services to participants of an HCBS waiver.

(c) Speech Therapy. In order to participate as a provider of speech therapy under an HCBS waiver, a provider must be a speech/language therapist participating in MassHealth under 130 CMR 432.000: *Therapist Services*, a speech and hearing center participating in MassHealth under 130 CMR 413.000: *Speech and Hearing Center Services*, a rehabilitation center participating in MassHealth under 130 CMR 430.300: *Rehabilitation Center Services*, a home health agency participating in MassHealth under 130 CMR 403.000: *Home Health Agency*, a chronic disease and rehabilitation inpatient hospital participating in MassHealth under 130 CMR 435.000: *Chronic Disease and Rehabilitation Inpatient Hospital Services*, or a chronic disease and rehabilitation outpatient hospital participating in MassHealth under 130 CMR 410.000: *Outpatient Hospital Services*, in accordance with all standards, requirements, policies, and procedures established by MRC or DDS for the provision of such services to participants of an HCBS waiver.

(31) Transitional Assistance Services. Transitional assistance services under an HCBS waiver must be provided by organizations under contract with MRC or DDS in accordance with its standards, requirements, policies, and procedures for the provision of transitional assistance services to persons with disabilities.

(32) Transportation. In order to participate as a provider of transportation under an HCBS waiver, a provider must be an organization engaged in the business of transporting persons with disabilities in accordance with all standards, requirements, policies, and procedures established by DDS or MRC for the provision of such services.

(33) Vehicle Modification. In order to participate as a provider of vehicle modifications under an HCBS waiver, a provider must be an individual or organization engaged in the business of vehicle modification and be under contract with MRC for the provision of vehicle modification to persons with disabilities.

630.405: HCBS Waiver Coverage Types

A participant is eligible for HCBS waiver services according to the applicable HCBS waiver under which the participant is enrolled. *See* 130 CMR 519.007: *Individuals Who Would Be Institutionalized*. Each HCBS waiver coverage type is described in 130 CMR 630.405(A) through (D). Payment for the covered services listed in 130 CMR 630.000 is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

630.405: continued

(A) Acquired Brain Injury with Residential Habilitation (ABI-RH) Waiver. The following ABI waiver services are covered for eligible MassHealth members who are enrolled as participants under the ABI-RH Waiver:

(1) assisted living services;
(2) assistive technology;
(3) community-based day supports;
(4) community behavioral health support and navigation;
(5) day services;
(6) home accessibility adaptations;
(7) individual support and community habilitation;
(8) occupational therapy;
(9) orientation and mobility services;
(10) peer support;
(11) physical therapy;
(12) prevocational services;
(13) residential family training;
(14) residential habilitation;
(15) shared living – 24-hour supports;
(16) skilled nursing;
(17) specialized medical equipment;
(18) speech therapy;
(19) supported employment;
(20) transitional assistance services; and
(21) transportation.

(B) Acquired Brain Injury Non-residential Habilitation (ABI-N) Waiver. The following ABI waiver services are covered for eligible MassHealth members who are enrolled as participants under the ABI-N Waiver:

(1) adult companion;
(2) assistive technology;
(3) chore;
(4) community-based day supports;
(5) community behavioral health support and navigation;
(6) community family training;
(7) day services;
(8) home accessibility adaptations;
(9) home delivered meals;
(10) home health aide;
(11) homemaker;
(12) independent living supports;
(13) individual support and community habilitation;
(14) laundry;
(15) occupational therapy;
(16) orientation and mobility services;
(17) peer support;
(18) physical therapy;
(19) personal care;
(20) prevocational services;
(21) respite;
(22) shared home supports;
(23) skilled nursing;
(24) specialized medical equipment;
(25) speech therapy;
(26) supported employment;
(27) supportive home care aide;
(28) transitional assistance services;
(29) transportation; and
(30) vehicle modification.

630.405: continued

(C) Moving Forward Plan Residential Supports (MFP-RS) Waiver. The following HCBS waiver services are covered for eligible MassHealth members who are enrolled as participants under the MFP-RS Waiver:

(1) assisted living services;
(2) assistive technology;
(3) community-based day supports;
(4) community behavioral health support and navigation;
(5) day services;
(6) home accessibility adaptations;
(7) individual support and community habilitation;
(8) occupational therapy;
(9) orientation and mobility services;
(10) peer support;
(11) physical therapy;
(12) prevocational services;
(13) residential family training;
(14) residential habilitation;
(15) shared living – 24-hour supports;
(16) skilled nursing;
(17) specialized medical equipment;
(18) speech therapy;
(19) supported employment;
(20) transitional assistance services; and
(21) transportation.

(D) Moving Forward Plan Community Living (MFP-CL) Waiver. The following HCBS waiver services are covered for eligible MassHealth members who are enrolled as participants under the MFP-CL Waiver:

(1) adult companion;
(2) assistive technology;
(3) chore;
(4) community-based day supports;
(5) community behavioral health support and navigation;
(6) community family training;
(7) day services;
(8) home accessibility adaptations;
(9) home delivered meals;
(10) homemaker;
(11) home health aide;
(12) independent living supports;
(13) individual support and community habilitation;
(14) laundry;
(15) occupational therapy;
(16) orientation and mobility services;
(17) peer support;
(18) personal care;
(19) physical therapy;
(20) prevocational services;
(21) respite;
(22) shared home supports;
(23) skilled nursing;
(24) specialized medical equipment;
(25) speech therapy;
(26) supported employment;
(27) supportive home care aide;
(28) transitional assistance services;
(29) transportation; and
(30) vehicle modification.

630.406: HCBS Waiver Conditions for Payment

(A) The MassHealth agency pays an HCBS waiver provider for the provision of waiver services in accordance with the applicable payment methodology and rate schedule established by EOHHS.

(B) Payment for services is subject to the conditions, exclusions, and limitations set forth in 130 CMR 630.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) The MassHealth agency pays an HCBS waiver provider for a waiver service only if

(1) the member was enrolled as a participant under one of the HCBS waivers on the date of service;

(2) the service billed was appropriate and necessary;

(3) the service billed was authorized and included in the service plan for the participant pursuant to 130 CMR 630.409(A);

(4) the waiver services were provided by an HCBS waiver provider in accordance with the requirements of 130 CMR 630.000 and 130 CMR 450.000: *Administrative and Billing Regulations*;

(5) any service delivered *via* telehealth is authorized under HCBS Waiver Provider Bulletin 23. EOHHS may publish updates or clarifications related to the provision of telehealth for HCBS Waiver Services by bulletin or other written issuance; and

(6) the service is provided with the use of EVV as required by the MassHealth agency. The MassHealth agency may make clarifications on the meaning or application of this EVV requirement by bulletin or other written issuance, including to which programs, services, or providers the EVV requirement applies.

(D) Additional conditions of payment for waiver services by service type are located as applicable in 130 CMR 630.410 through 630.437.

(E) Self-directed Services. Participants who self-direct their services will submit timesheets to the fiscal intermediary (FI) for each worker who provided self-directed services through EVV as required by the MassHealth agency. The FI reviews the time sheets and verifies that they are in accordance with the participant's service plan and that payment is permissible. The FI sends approved payments to the participant who is responsible for making payment to the worker for the self-directed services.

630.407: HCBS Waiver Coverage Requirements

(A) Limitations on Covered Services. The MassHealth agency pays for HCBS waiver services provided to a participant who resides in a home- or community-based setting, which may include, without limitation, a temporary residence. With the exception of respite services, as described in 130 CMR 630.427, and transitional assistance, as described in 130 CMR 630.435, the MassHealth agency does not pay for HCBS waiver services provided to a participant who is a resident or inpatient of a hospital, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID), or any other medical facility subject to state licensure or certification.

(B) Least Costly Form of Care. The MassHealth agency pays for HCBS waiver services only when services are the least costly form of comparable care available in the community.

630.408: Nonpayable Services

(A) The MassHealth agency does not pay for any HCBS waiver services that are furnished before the development of the service plan or that are not included in a participant's service plan pursuant to 130 CMR 630.409(A).

(B) The MassHealth agency does not pay for HCBS waiver services that are provided to any individual other than the participant who is eligible to receive such services and for whom such services are approved in the service plan.

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(C) The MassHealth agency does not pay an HCBS waiver provider for
(1) any service that is not listed as a covered service for the participant under 130 CMR 630.405;
(2) any service that is not authorized in the service plan;
(3) any service delivered *via* telehealth that is not authorized to be delivered *via* telehealth under HCBS Waiver Provider Bulletin 23. EOHHS may publish updates or clarifications related to the provision of telehealth for HCBS Waiver Services by bulletin or other written issuance;
(4) any service to a person who is a resident or inpatient of a hospital, nursing facility, ICF/ID, or any other medical facility subject to state licensure or certification, except for respite services, in accordance with 130 CMR 630.427, and transitional assistance, in accordance with 130 CMR 630.435;
(5) any service that duplicates the provision of another waiver or state plan service;
(6) any service to a participant who is receiving a service from another home- and community-based waiver program;
(7) the cost of room and board, unless provided as part of respite care in accordance with 130 CMR 630.427;
(8) the cost of maintenance, upkeep, an improvement, or home accessibility adaptations to a residential habilitation site, group home, or other provider-owned and -operated residential setting;
(9) the cost of maintenance, upkeep, or an improvement to a participant's place of residence, except for home accessibility adaptations in accordance with 130 CMR 630.417, and transitional assistance in accordance with 130 CMR 630.435; and
(10) any service that is provided without the use of EVV, as required by the MassHealth agency. The MassHealth agency may make clarifications on the meaning or application of this EVV requirement by bulletin or other written issuance, including to which programs, services, or providers the EVV requirement applies.

(D) The MassHealth agency does not pay for HCBS waiver services furnished by legally responsible individuals as defined in 130 CMR 630.402.

(E) The MassHealth agency does not pay for HCBS waiver services that are unsafe, inappropriate, or unnecessary for a participant. Each HCBS waiver provider is responsible for ensuring that the HCBS waiver services it provides are safe, appropriate, and necessary for the participant.

(F) The MassHealth agency does not pay for HCBS waiver services in excess of the units identified and authorized in the participant's service plan.

(G) The MassHealth agency does not pay for HCBS waiver services that duplicate care provided by another payment source or by a family member or legally responsible individual as defined in 130 CMR 630.402.

(H) Additional information about nonpayable services by service type is located as applicable in 130 CMR 630.410 through 630.437.

630.409: Service Plan and Notice of Approval or Denial of HCBS Waiver Services

(A) Service Plan.
(1) The MassHealth agency or its designee assigns a case manager to each participant under an HCBS waiver.
(2) The participant will lead the service plan process where possible. The participant's representative should have a participatory role, as needed and as defined by the participant, unless the legal representative has decision-making authority.

630.409: continued

(3) The service planning process must comply with requirements in the federally approved HCBS waiver application and HCBS waiver policies for service planning established by DDS or MRC, and must include identification of the strengths, preferences, and cultural considerations of the participant, goals, desired outcomes, clinical and support needs, HCBS services and supports to be furnished, strategies for solving disagreement within the process, and modifications that are supported by a specific assessed need and justified in the service plan.

(4) The service plan must also comply with all requirements in the federally approved HCBS waiver application and HCBS waiver policies for service plans established by DDS or MRC including, but not limited to, containing the HCBS services and supports to be furnished, the amount, frequency, and duration of each service, and the type of provider to furnish each service; reflecting that the setting in which the participant resides was chosen by the participant; reflecting clinical and support needs as identified through an assessment of functional needs; reflecting risk factors and measures in place to minimize them; and documenting that any additional conditions are supported by a specific assessed need and justified in the service plan.

(5) The service plan may not be backdated.

(B) Notice of Approval. For all HCBS waiver services authorized and included in a service plan, the MassHealth agency or its designee will provide a copy of the service plan to the participant. The service plan must contain, at a minimum, the types of HCBS waiver services to be furnished, the amount, frequency, and duration of each service, and the effective date of the authorization.

(C) Notice of Denial or Modification and Right of Appeal.

(1) A participant and the participant's authorized representative, as applicable, will receive a written notification from the MassHealth agency or its designee whenever a service plan contains a denial or modification of a requested HCBS waiver service requested by a participant or the participant's authorized representative. The notification will describe the reason for the denial or modification and provide information about the participant's right to appeal and the appeal procedure.

(2) A participant may request a fair hearing whenever the MassHealth agency or its designee denies or modifies the participant's request for an HCBS waiver service. As described in 130 CMR 630.409, a denial or modification includes the MassHealth agency's denial, suspension, reduction, or termination of a requested HCBS waiver service as well as the agency's failure to act on the participant's request for an HCBS waiver service within 30 days of receiving such request. The participant must request a fair hearing in writing within the time limits set forth in 130 CMR 610.015(B)(1) or (2), as applicable. The Office of Medicaid Board of Hearings conducts the hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(D) Information for HCBS Waiver Providers. The MassHealth agency or its designee will furnish applicable information from each service plan to an HCBS waiver provider that provides an HCBS waiver service to a participant. Applicable information will include the amount, frequency, duration, and effective date of the HCBS waiver service that is authorized in the service plan. The information will be provided in a manner and format specified by the MassHealth agency or its designee.

(E) Information for Fiscal Intermediary (FI). Waiver participants will be given the option to self-direct certain waiver services as specified in the particular HCBS waiver in which they are enrolled. Participants who choose to self-direct will have those self-directed waiver services listed in their service plan. Information regarding the frequency and duration of the self-directed services in the service plan must be forwarded to the FI. The information will be provided in a manner and format specified by the MassHealth agency or its designee.

630.410: Adult Companion

(A) Conditions of Payment. Adult companion services must be provided in accordance with a therapeutic goal in the service plan. Adult companion services are covered where the adult companion enables the participant to function with greater independence within the participant's home or community.

(B) Nonpayable Services.

(1) Adult companion services are not covered where the services are purely recreational or diversionary in nature.

(2) Homemaker, home health aide, personal care, adult companion, individual support and community habilitation, and supportive home care aide services, in combination are limited to no more than 84 hours per week. The MassHealth agency or its designee may grant exceptions to the limit on a 90-day basis in order to maintain a participant's tenure in the community, to provide respite to a caregiver who lives with the participant, to facilitate transitions to a community setting, to ensure that a participant at risk for medical facility admission is able to remain in the community, or to otherwise stabilize a participant's medical condition. Exceptions may also be granted for participants awaiting transition to a residential waiver. Exceptions to the 84 hours per week limit must be included in the participant's waiver plan of care.

630.411: Assisted Living Services

(A) Conditions of Payment. Assisted living services are covered when the participant requires personal care and supportive services (homemaker, chore, personal care services, and meal preparation) and the availability of 24-hour on-site response capability to meet scheduled or unpredictable resident needs.

(B) Nonpayable Services. Assisted living services do not cover the cost of room and board, including items of comfort or convenience, or the costs of property or building maintenance, upkeep, and improvement. Assisted living services do not include, and payment will not be made for, 24-hour skilled care. The following waiver services are not available to participants receiving assisted living: residential habilitation and shared living – 24-hour supports.

630.412: Assistive Technology

(A) Assistive Technology Devices.

(1) Conditions of Payment. Assistive technology devices include device installation and set up costs. This service includes purchase, lease, or other acquisition costs of cell phones, tablets, computers, and ancillary equipment necessary for the operation of the assistive technology devices that enable the individual to participate in telehealth.

(2) Nonpayable Services. Assistive technology excludes installation and set-up and ongoing provision fees related to internet service. This service does not cover devices purchased for purely diversional/recreational purposes. Participants may not receive duplicative devices through this service and either the Transitional Assistance Service or the Specialized Medical Equipment Service.

(B) Assistive Technology Evaluation and Training.

(1) Conditions of Payment. Assistive technology evaluation and training includes the evaluation of the assistive technology needs of the participant, *i.e.*, functional evaluation of the impact of the provision of appropriate assistive technology devices and services to the participant in the customary environment of the participant. This service includes training and technical assistance for the participant, and, 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.

(2) Nonpayable Services. Assistive Technology Evaluation and Training excludes evaluation and training for devices to be used for purely diversional/ recreational purposes. Participants may not receive duplicative evaluation and training through this service and either the Transitional Assistance Service or the Specialized Medical Equipment Service.

630.413: Chore Services

(A) Conditions of Payment. Chore services are covered only on a one-time or infrequent basis and only when an unusual household task is required to be performed to maintain a participant's home in a clean, sanitary, and safe condition.

(B) Nonpayable Services. Chore services are not covered when the participant or someone else in the household is capable of performing the tasks or when a relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for provision of the tasks. In the case of rental property, the responsibility of the landlord, pursuant to a lease agreement, is examined before authorizing any chore services in a service plan.

630.414: Community-based Day Supports

(A) Conditions of Payment. Community-based day supports are covered only when the participant requires support to develop, enhance, and maintain a range of skills and competencies needed to engage in integrated activities in the community.

(B) Nonpayable Services.

(1) Community-based day supports services will not be covered on the same day as waiver *per diem* day services are covered, but are allowable on the same day as partial *per diem* day services.

(2) Day services, community-based day supports, supported employment, and prevocational services, in combination, are limited to no more than 156 hours per month, with each day of day services considered to be six hours. The MassHealth agency or its designee may grant individualized exceptions to the limit on a 30-day basis in order to maintain a participant's tenure in the community, to facilitate transitions to a community setting, or to otherwise facilitate the participant's successful engagement in community-based waiver services. Exceptions to the 156 hours per month limit must be included in the participant's waiver plan of care.

(C) Recordkeeping. In addition to the requirements of 130 CMR 630.441, the provider must maintain records that include detailed descriptions of community-based day supports services provided and documentation of all units of service provided.

630.415: Community Behavioral Health Support and Navigation

(A) Conditions of Payment. Community behavioral health support and navigation is covered when a participant has behavioral health needs, such as a psychiatric diagnosis or substance use disorder(s), that interfere with their ability to access essential medical and behavioral health services.

(B) Recordkeeping. In addition to the requirements of 130 CMR 630.441, the provider must maintain records that include detailed descriptions of community behavioral health support and navigation services provided and documentation of all units of services.

630.416: Community Family Training and Residential Family Training

(A) Conditions of Payment. Documentation in the participant's record must demonstrate the benefit of this service to the participant. Community family training and residential family training is not available for individuals who are employed to care for the participant. 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 family's understanding of the waiver participant's specialized needs. The one-to-one family training is instructional; it is not counseling.

(1) Community Family Training. For purpose of this service, family is defined as the persons who live with or provide unpaid care to a waiver participant and may include a parent or other relative.

(2) Residential Family Training. For purpose of this service, family is defined as the persons who provide unpaid care to a waiver participant and may include a parent or other relative.

630.416: continued

(B) Nonpayable Services.

(1) Community Family Training. This service is not available to those participants who do not live in the family home or do not regularly visit with their family.

(2) Residential Family Training. This service is not available in provider-operated residential habilitation or assisted living sites or in shared living settings, unless the participant regularly leaves the site to visit their family.

630.417: Day Services

(A) Conditions of Payment. Day services are covered for participants who need a structured day activity program and who are not interested in employment or not ready to join the general workforce.

(B) Nonpayable Services.

(1) *Per diem* day services will not be covered on the same day as community-based day supports, supported employment, or prevocational services are covered. However, partial *per diem* day services may be provided on the same day as community-based day supports, supported employment, or prevocational services.

(2) Day services, community-based day supports, supported employment, and prevocational services, in combination, are limited to no more than 156 hours per month, with each day of day services considered to be six hours. The MassHealth agency or its designee may grant individualized exceptions to the limit on a 30-day basis in order to maintain a participant's tenure in the community, to facilitate transitions to a community setting, or to otherwise facilitate the participant's successful engagement in community-based waiver services. Exceptions to the 156 hours per month limit must be included in the participant's waiver plan of care.

(C) Recordkeeping. In addition to the requirements of 130 CMR 630.441, the provider must maintain records that include detailed descriptions of day services provided and documentation of all units of services.

630.418: Home Accessibility Adaptations

(A) Conditions of Payment.

(1) Home accessibility adaptations are covered only when the participant would be unable to reside in the participant's home without the accessibility adaptations and the adaptations enable the participant to function with greater independence within the participant's home.

(2) All home accessibility adaptations must be provided in accordance with applicable state and local building codes.

(B) Nonpayable Services. Home accessibility adaptations are not covered when the adaptations:

(1) bring a substandard dwelling up to minimum standards or to make improvements to a residence that are of general utility (for example, new carpeting, roof repairs, or central air conditioning) and are not of direct medical or remedial benefit to the participant;

(2) are required by law to be made by a landlord or other third-party;

(3) are made to a residential habilitation site, group home, or other provider-owned and -operated residential setting; or

(4) add to the total square footage of the home, except when necessary to complete an adaptation (for example, in order to improve entrance and egress to a residence or to configure a bathroom to accommodate a wheelchair).

630.419: Home-delivered Meals

Conditions of Payment. Home-delivered meals are limited to the provision of one per day, although multiple meals may be delivered at the same time provided the proper storage is available in the home. This service is limited to participants residing in their own private residence.

630.420: Home Health Aide

(A) Conditions of Payment.

(1) Home health aide services are covered when the participant requires a range of assistance with ADLs and IADLS related to independent living and when the home health aide service enables the participant to function with greater independence within the participant's home and community.

(2) Home health aide services are covered if the home health aide receives supervision by a registered nurse with a current license by the Massachusetts Board of Registration in Nursing, and if services are expected to exceed the amount, duration, or scope of home health aide services provided under the state plan.

(B) Nonpayable Services. Homemaker, home health aide, personal care, adult companion, individual support and community habilitation, and supportive home care aide services, in combination are limited to no more than 84 hours per week. The MassHealth agency or its designee may grant exceptions to the limit on a 90-day basis in order to maintain a participant's tenure in the community, to provide respite to a caregiver who lives with the participant, to facilitate transitions to a community setting, to ensure that a participant at risk for medical facility admission is able to remain in the community, or to otherwise stabilize a participant's medical condition. Exceptions may also be granted for participants awaiting transition to a residential waiver. Exceptions to the 84 hours per week limit must be included in the participant’s waiver plan of care.

630.421: Homemaker

(A) Conditions of Payment. Homemaker services are covered on a short-term or periodic basis when the individual who is regularly responsible for these activities is temporarily absent or unable to manage the home and care for the participant.

(B) Nonpayable Services.

(1) Homemaker services are not covered when the participant or someone else in the household is capable of performing the tasks or when a relative, caregiver, landlord, community/volunteer agency, or third-party payer is capable of or responsible for homemaking tasks.

(2) Homemaker, home health aide, personal care, adult companion, individual support and community habilitation, and supportive home care aide services, in combination are limited to no more than 84 hours per week. The MassHealth agency or its designee may grant exceptions to the limit on a 90-day basis in order to maintain a participant's tenure in the community, to provide respite to a caregiver who lives with the participant, to facilitate transitions to a community setting, to ensure that a participant at risk for medical facility admission is able to remain in the community, or to otherwise stabilize a participant's medical condition. Exceptions may also be granted for participants awaiting transition to a residential waiver. Exceptions to the 84 hours per week limit must be included in the participant's waiver plan of care.

630.422: Independent Living Supports

(A) Conditions of Payment.

(1) Independent living supports are covered when the participant requires assistance with intermittent, scheduled, and unscheduled needs for ADLs, IADLs, support and companionship, emotional support, and socialization.

(2) The independent living supports service provider cannot be the owner of the building in which the services are delivered to the waiver participant.

(B) Nonpayable Services. Duplicative services including, but not limited to, personal care, homemaker, adult companion, shared home supports, and supportive home care aide, are not available to participants receiving independent living supports services.

630.423: Individual Support and Community Habilitation

(A) Conditions of Payment.

(1) Individual support and community habilitation is covered when a participant needs assistance to develop, maintain, or maximize independent functioning in self-care, physical and emotional growth, socialization, communication, and vocational skills. This service includes 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, and to become more independent, integrated, and productive in the community.

(2) Individual support and community habilitation may be provided regularly or intermittently. These services may not be provided on a 24-hour basis, and must be determined necessary for the participant to remain in the community, as documented in the participant's service plan.

(B) Nonpayable Services. Homemaker, home health aide, personal care, adult companion, individual support and community habilitation, and supportive home care aide services, in combination are limited to no more than 84 hours per week. The MassHealth agency or its designee may grant exceptions to the limit on a 90-day basis in order to maintain a participant's tenure in the community, to provide respite to a caregiver who lives with the participant, to facilitate transitions to a community setting, to ensure that a participant at risk for medical facility admission is able to remain in the community, or to otherwise stabilize a participant's medical condition. Exceptions may also be granted for participants awaiting transition to a residential waiver. Exceptions to the 84 hours per week limit must be included in the participant's waiver plan of care.

(C) Recordkeeping. In addition to the requirements of 130 CMR 630.441, the provider must maintain records that include detailed descriptions of individual support and community habilitation services provided and documentation of all units of services.

630.424: Laundry

(A) Conditions of Payment. Laundry services are covered when participants require assistance with washing, drying, and folding.

(B) Nonpayable Services. Laundry services may not be provided at the same time when Homemaker services that include laundry assistance are being provided.

630.425: Orientation and Mobility Services

(A) Conditions of Payment. Orientation and mobility services are covered to provide participants who are diagnosed with a vision impairment or legal blindness training in how to move or travel safely in their home and community.

(B) Nonpayable Services. Travel time is not covered.

630.426: Peer Support

(A) Conditions of Payment. Peer support services are covered up to a maximum of 16 hours per week when the services:

(1) are instructional and not counseling; and

(2) enhance the skills of the participant to function in the community.

(B) Recordkeeping. In addition to the requirements of 130 CMR 630.441, the provider must maintain documentation in the participant's record that demonstrates the benefit of this service to the participant.

630.427: Personal Care

(A) Conditions of Payment.

(1) Personal care services are covered when the participant requires a range of assistance with ADLs related to independent living and when the personal care service enables the participant to function with greater independence within the participant's home and community. Personal care services under an HCBS waiver may include supervision and cuing of participants. Personal care services may also include assistance with IADLs. Personal care services provided under an HCBS waiver may not duplicate personal care services provided under the state plan.

(2) MassHealth authorizes the following types of payments to Direct Care Workers providing self-directed waiver personal care services to MFP-CL waiver participants:

(a) holiday rate determined in accordance with 101 CMR 309.00: *Rates for Certain Services for the Personal Care Attendant Program* and 101 CMR 359.00: *Rates for Home and Community-based Services Waivers* for activity time performed at the times and on the holidays authorized pursuant to 101 CMR 309.00 and 130 CMR 422.000: *Personal Care Attendant Services*.

(b) completed new hire orientation payment in accordance with 101 CMR 309.00 and 101 CMR 359.00 and pursuant to a collective bargaining agreement effective in accordance with M.G.L. c. 118E, § 73, and c. 150E.

(B) Nonpayable Services. Homemaker, home health aide, personal care, adult companion, individual support and community habilitation, and supportive home care aide services, in combination are limited to no more than 84 hours per week. The MassHealth agency or its designee may grant exceptions to the limit on a 90-day basis in order to maintain a participant's tenure in the community, to provide respite to a caregiver who lives with the participant, to facilitate transitions to a community setting, to ensure that a participant at risk for medical facility admission is able to remain in the community, or to otherwise stabilize a participant's medical condition. Exceptions may also be granted for participants awaiting transition to a residential waiver. Exceptions to the 84 hours per week limit must be included in the participant's waiver plan of care.

630.428: Prevocational Services

(A) Conditions of Payment.

(1) Prevocational services are covered when the participant requires habilitative or rehabilitative services, rather than explicit employment training, as specified in the participant's service plan. Prevocational services may be provided one-to-one or in a group format. Prevocational services may be provided as a site-based service, in community settings, or in a combination of these settings and must include integrated community activities that support development of vocational needs.

(2) The amount, duration, and scope of prevocational services provided to a participant is based on the participant's pre-employment needs that arise as a result of their functional limitations and condition, including services that enable the participant to acquire, improve, retain/maintain, and prevent deterioration of functioning consistent with the participant's interest, strengths, priorities, abilities and capabilities.

(B) Nonpayable Services.

(1) Prevocational services will not be covered on the same day as waiver *per diem* day services are covered but are allowable on the same day as partial *per diem* day services.

(2) Day services, community-based day supports, supported employment, and prevocational services, in combination, are limited to no more than 156 hours per month, with each day of day services considered to be six hours. The MassHealth agency or its designee may grant individualized exceptions to the limit on a 30-day basis in order to maintain a participant's tenure in the community, to facilitate transitions to a community setting, or to otherwise facilitate the participant's successful engagement in community-based waiver services. Exceptions to the 156 hours per month limit must be included in the participant's waiver plan of care.

630.428: continued

(C) Recordkeeping. In addition to the requirements of 130 CMR 630.441, the provider must have documentation in the participant's file that the service the participant received is not available under a program funded under § 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401), and the provider must maintain records that include detailed descriptions of prevocational services provided and documentation of all units of services.

630.429: Residential Habilitation

(A) Conditions of Payment. Residential habilitation is covered solely when authorized in the participant's service plan. Residential habilitation is covered when a participant requires ongoing services and supports delivered to a participant in a provider-operated 24-hour staffed residential setting.

(B) Nonpayable Services. Residential habilitation is not covered for participants who live with their immediate family unless the immediate family (for example, grandparent, parent, sibling, or spouse) is also eligible for residential habilitation and, if applicable, has received prior authorization from the MassHealth agency or its designee for residential habilitation. The following waiver services are not available to participants receiving residential habilitation: assisted living, shared living – 24-hour supports.

(C) Payer for Residential Habilitation. DDS is responsible for payment to providers for residential habilitation.

630.430: Respite

(A) Conditions of Payment. Respite care is covered solely to provide temporary relief to non-paid caregivers when the participant requires assistance with activities related to independent living.

(B) Nonpayable Services.

(1) Respite care is not covered for the purpose of compensating relief or substitute staff for a paid service provider.

(2) Respite care is not covered for any time period during which other assistance with activities related to independent living is available to a participant.

630.431: Shared Home Supports

(A) Conditions of Payment.

(1) Shared home supports provide daily structure, skills training and supervision, but do not include 24-hour care.

(2) The shared home supports provider must match a participant with a shared home supports caregiver. The caregiver must live with the participant at the residence of the caregiver or the participant.

(3) Shared home supports include supportive services that assist with the acquisition, retention, or improvement of skills related to living in the community. This includes such supports as: adaptive skills development, assistance with ADLs and IADLs, adult educational supports, and social and leisure skill development.

(4) The shared home supports provider must provide regular and ongoing oversight and supervision of the caregiver.

(5) Shared home supports may be provided to no more than two participants in a home.

(6) In the event the shared home supports caregiver is temporarily unavailable or unable to provide care, the shared home supports provider may bill for short-term alternative shared home support days in accordance with all applicable guidance issued by the MassHealth agency or its designee, during which time the staff qualifications and site requirements remain the same.

(B) Nonpayable Services.

(1) Shared home supports are not available to participants who live with their immediate family, unless the immediate family member is also eligible for shared home supports and had received authorization in their service plan for shared home supports.

630.431: continued

(2) Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.
(3) Payment is not made for short-term alternative shared home support days not billed in accordance with all applicable guidance issued by the MassHealth agency or its designee.
(4) Shared home supports may not be billed on the same day as short-term alternative shared home support days.

630.432: Shared Living – 24-hour Supports

(A) Conditions of Payment.
(1) Shared living – 24-hour supports is a residential service that provides 24-hour, seven-days-per-week supportive services.
(2) Shared living – 24-hour supports integrates the participant into the usual activities of the caregiver's family life. In addition, there will be opportunities for learning, developing and maintaining skills including in such areas as ADLs, IADLs, social and recreational activities, and personal enrichment.
(3) The caregiver lives with the participant at the residence of the caregiver or the participant. Shared living agencies recruit caregivers, assess their abilities, coordinate placement of participant or caregiver, train and provide guidance, supervision and oversight for caregivers and provide oversight of participants' living situations. The caregiver may not be a legally responsible family member.
(4) The shared living – 24-hour supports provider must provide regular and ongoing oversight and supervision of the caregiver.
(5) Shared living – 24-hour supports may be provided to no more than two participants in a home.
(6) In the event the shared living caregiver is temporarily unavailable or unable to provide care, the shared living agency may bill for short-term alternative shared living – 24-hour support days in accordance with all applicable guidance issued by the MassHealth agency or its designee, during which time the staff qualifications and site requirements remain the same.

(B) Nonpayable Services.
(1) Shared living – 24-hour supports 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 shared living – 24-hour supports and had received prior authorization, as applicable, for shared living – 24-hour supports.
(2) The following waiver services are not available to participants receiving shared living – 24-hour supports: assisted living and residential habilitation.
(3) Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement.
(4) Payment is not made for short-term alternative shared living – 24-hour support days not billed in accordance with all applicable guidance issued by the MassHealth agency or its designee.
(5) Shared living – 24-hour supports may not be billed on the same day as short-term alternative shared living – 24-hour support days

(C) Payer for Shared Living – 24-hour Supports. DDS is responsible for payment to providers for shared living – 24-hour supports.

630.433: Skilled Nursing

(A) Conditions of Payment. Skilled nursing services listed in a participant's service plan must be provided within the scope of the State's Nurse Practice Act at M.G.L. c. 112 and regulations at 244 CMR 3.00: *Registered Nurse and Licensed Practical Nurse*.

630.433: continued

(B) Nonpayable Services.

(1) Skilled nursing services are limited to one skilled nursing visit per week per participant. The MassHealth agency or its designee may authorize an exception to the limit on a temporary basis to facilitate transitions to a community setting, to ensure that a participant at risk for medical facility admission is able to remain in the community, or to otherwise stabilize a participant's medical condition.

(2) Skilled nursing services are not covered when duplicative nursing services are provided to the participant.

630.434: Specialized Medical Equipment

(A) Conditions of Payment. Covered specialized medical equipment includes devices, controls, or appliances that enable a participant to increase their ability to perform daily living activities or to perceive, control, or communicate with the environment or to perceive or communicate with other people; medical equipment necessary to address physical conditions or participant functional limitations; and ancillary supplies and equipment necessary for the proper functioning of specialized items. This service may also include evaluation, customization, maintenance or repairs, temporary replacement, and training for the participant or caregiver in the use of the equipment. Specialized medical equipment must:

(1) meet applicable standards of manufacture, design, and installation; and

(2) have been examined or tested by Underwriters Laboratories (or other appropriate organization), and comply with Federal Communications Commission regulations, as appropriate.

(B) Nonpayable Services.

(1) Items that are not of direct medical or remedial benefit to a participant are not covered.

(2) Specialized medical equipment must not be covered under 130 CMR 406.000: *Pharmacy Services* or 130 CMR 409.000: *Durable Medical Equipment Services*.

(3) Items available to a participant through Medicare are not covered.

630.435: Supported Employment

(A) Service Limitations. When supported employment services are provided at a work site where persons without disabilities are employed, MassHealth payment is made only for the adaptations, supervision, and training required by participants as a result of their disabilities.

(B) Nonpayable Services.

(1) Payment for supported employment does not include incentive payments, subsidies, or unrelated vocational training expenses including, but not limited to, the following exclusions:

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

(b) payments that are passed through to users of supported employment programs; or

(c) payments for training that is not directly related to a participant's supported employment needs.

(2) Supervisory activities performed as a normal part of the business setting are not covered.

(3) Supported employment services are not covered when provided in settings that are solely comprised of individuals with disabilities, also known as sheltered workshops.

(4) Supported employment services will not be covered on the same day as waiver per diem day services are covered, but are allowable on the same day as partial *per diem* day services.

(5) Day services, community-based day supports, supported employment, and prevocational services, in combination, are limited to no more than 156 hours per month, with each day of day services considered to be six hours. The MassHealth agency or its designee may grant individualized exceptions to the limit on a 30-day basis in order to maintain a participant's tenure in the community, to facilitate transitions to a community setting, or to otherwise facilitate the participant's successful engagement in community-based waiver services. Exceptions to the 156 hours per month limit must be included in the participant's waiver plan of care.

630.435: continued

(C) Recordkeeping. In addition to the requirements of 130 CMR 630.441, each provider of supported employment services must maintain documentation in each participant's file that the service is not available under a program funded under § 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401). The provider must also maintain records that include detailed descriptions of supported employment services provided and documentation of all units of services.

630.436: Supportive Home Care Aide

(A) Conditions of Payment. Supportive home care aide is covered when a participant needs assistance with ADLs and IADLs, in addition to providing emotional support, socialization, and escort services to participants with Alzheimer's Disease/Dementia or behavioral health needs.

(B) Nonpayable Services.

(1) Supportive home care aide services are not covered when a waiver participant is receiving Independent Living Supports or Shared Home Supports.

(2) Homemaker, home health aide, personal care, adult companion, individual support and community habilitation, and supportive home care aide services, in combination are limited to no more than 84 hours per week. The MassHealth agency or its designee may grant exceptions to the limit on a 90-day basis in order to maintain a participant's tenure in the community, to provide respite to a caregiver who lives with the participant, to facilitate transitions to a community setting, to ensure that a participant at risk for medical facility admission is able to remain in the community, or to otherwise stabilize a participant's medical condition. Exceptions may also be granted for participants awaiting transition to a residential waiver. Exceptions to the 84 hours per week limit must be included in the participant's waiver plan of care.

630.437: Occupational Therapy, Physical Therapy, and Speech Therapy

(A) Occupational Therapy.

(1) Conditions of Payment. Occupational therapy is covered when:

(a) authorized and included in the participant's service plan;

(b) appropriate and necessary for the participant to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired or reduced as a result of acute or chronic medical conditions, congenital anomalies or injuries; or required to maintain or prevent the worsening of function;

(c) the participant's needs are of such a level of complexity and sophistication that the judgment, knowledge, and skills of a licensed occupational therapist are required;

(d) performed by a licensed occupational therapist, or by a licensed occupational therapy assistant under the supervision of a licensed occupational therapist; and

(e) when the service is not covered under 130 CMR 403.000: *Home Health Agency*, 130 CMR 432.000: *Therapist Services*, 130 CMR 430.600: *Rehabilitation Center Services*, 130 CMR 435.000: *Chronic Disease and Rehabilitation Inpatient Hospital Services*, or 130 CMR 410.000: *Outpatient Hospital Services*.

(2) Nonpayable Services. Services that are not of direct medical or remedial benefit to a participant are not covered by MassHealth.

(B) Physical Therapy.

(1) Conditions of Payment. To be covered, physical therapy must

(a) be authorized and included in the participant's service plan;

(b) be appropriate and necessary for the participant to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries; or required to maintain or prevent the worsening of function;

(c) the participant's needs are of such a level of complexity and sophistication that the judgment, knowledge, and skills of a licensed physical therapist are required;

(d) be performed by a licensed physical therapist, or by a licensed physical therapy assistant under the supervision of a licensed physical therapist; and

630.437: continued

(e) when the service is not covered under 130 CMR 403.000: *Home Health Agency*, 130 CMR 432.000: *Therapist Services*, 130 CMR 430.600: *Rehabilitation Center Services*, 130 CMR 435.000: *Chronic Disease and Rehabilitation Inpatient Hospital Services*, or 130 CMR 410.000: *Outpatient Hospital Services*.

(2) Nonpayable Services. Services that are not of direct medical or remedial benefit to a participant are not covered by MassHealth.

(C) Speech Therapy.

(1) Conditions of Payment. Speech therapy is covered when:

(a) authorized and included in the participant's service plan;

(b) appropriate and necessary for the participant to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries; or required to maintain or prevent the worsening of function;

(c) the participant's needs are of such a level of complexity and sophistication that the judgment, knowledge, and skills of a licensed speech/language therapist are required;

(d) be performed by a licensed speech/language therapist; and

(e) when the service is not covered under 130 CMR 403.000: *Home Health Agency*, 130 CMR 413.000: *Speech and Hearing Center Services*, 130 CMR 432.000: *Therapist Services*, 130 CMR 430.600: *Rehabilitation Center Services*, 130 CMR 435.000: *Chronic Disease and Rehabilitation Inpatient Hospital Services*, or 130 CMR 410.000: *Outpatient Hospital Services*.

(2) Nonpayable Services. Services that are not of direct medical or remedial benefit to a participant are not covered by MassHealth.

(D) Maintenance Program.

(1) The MassHealth agency pays for the establishment of a maintenance program and for the training of the participant, the participant's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service.

(2) In certain instances, the specialized knowledge and judgment of a licensed therapist may be required to perform services that are part of a maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the participant's medical condition. At the time the decision is made that the services must be performed by a licensed therapist, all information that supports the appropriateness and necessity for performance of such services by a licensed therapist, rather than a non-therapist, must be documented in the manner and format designated by the MassHealth agency or its designee.

630.438: Transitional Assistance Services

(A) Services and Expenses Included under Transitional Assistance Services. Transitional assistance consists of the following items, when appropriate and necessary for the participant's discharge from a nursing facility or hospital and safe transition to the community:

(1) assistance with housing search and housing application processes;

(2) security deposits that are required to obtain a lease on an apartment or home;

(3) assistance arranging for and supporting the details of the move;

(4) essential personal household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;

(5) set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water;

(6) services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy;

(7) moving expenses;

(8) home accessibility adaptations; and

(9) activities to assess need, arrange for, and procure resources related to personal household expenses, specialized medical equipment, or community services.

630.438: continued

(B) Conditions of Payment. To qualify for payment as transitional assistance services, expenses must be:

(1) authorized and included in the participant's service plan;

(2) incurred within 180 days before a participant's discharge from a nursing facility or hospital or another provider-operated living arrangement or during the period following discharge from the facility; and

(3) necessary for the participant's safe transition to the community.

(C) Nonpayable Services and Expenses. Transitional assistance services does not include expenses:

(1) for monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for pure diversion or recreational purposes;

(2) for furnishing living arrangements that are owned or leased by an HCBS waiver provider where the provision of these items and services is inherent to the service being provided;

(3) that are not necessary for the participant's safe transition to the community; or

(4) for devices that the participant has received through the Assistive Technology service.

(D) Payer for Transitional Assistance Services. MRC is responsible for paying providers for transitional assistance services.

630.439: Transportation

(A) Driver and Vehicle Requirements.

(1) All drivers must have a valid driver's license, appropriate for the type and class of vehicle used to transport HCBS waiver participants.

(2) All vehicles must be insured and documentation of vehicle and liability insurance must be provided.

(3) Transportation providers must provide written certification of:

(a) vehicle maintenance;

(b) age of vehicles; and

(c) passenger capacity of vehicles.

(4) Transportation providers must be duly registered with the Massachusetts Registry of Motor Vehicles and must meet all safety and inspection requirements of the Registry.

(5) All accessible vehicles specifically equipped to carry one or more persons who are mobility-impaired or using a wheelchair must be equipped with applicable safety equipment to secure a wheelchair and all drivers must be trained in the use of vehicle lifts and safety equipment.

(6) All vehicles must be maintained in such a manner as to ensure the safety and comfort of the passengers being transported. Such vehicles must be clean, sanitary, vermin free, and protected against motor-exhaust fumes. The vehicle must carry no more than the number of passengers for which it was designed, in accordance with local town or city regulations where the vehicle is licensed.

(B) Conditions of Payment. Transportation services are covered only to the extent that they enable a waiver participant to gain access to waiver and other community services, activities, and resources, as specified in the participant's service plan.

630.440: Vehicle Modification

(A) Conditions of Payment.

(1) Vehicle modifications, to an automobile or van which is the participant's primary means of transportation, are covered when such adaptations or alterations are:

(a) made in order to accommodate the special needs of the participant;

(b) necessary to enable the participant to integrate more fully into the community; and

(c) required to ensure the health, welfare, and safety of the participant.

(2) The need for vehicle modification must be documented in the participant's service plan, subject to MRC requirements and approved for payment by MRC.

630.440: continued

(B) Nonpayable Services. The following are specifically excluded vehicle modifications:
(1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant.
(2) Adaptations or improvements to a vehicle that is owned or leased by an entity providing services to the participant.
(3) Purchase or Lease of a Vehicle. However, payment for adaptations to a new van or vehicle purchased or leased by a participant or family can be made available at the time of purchase or lease to accommodate the special needs of the participant.
(4) Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the adaptations.
(5) The cost of modifications cannot exceed the cost limit for the service as provided under the HCBS waiver in which the participant is enrolled.
(6) Modifications to a paid caregiver's vehicle or provider agency vehicle are excluded.

(C) Payer for Vehicle Modification Services. MRC pays providers for vehicle modification services.

630.441: Location Requirements for HCBS Waiver Providers

(A) Any location where HCBS waiver services are provided must comply with applicable site requirements established by DDS or MRC for the provision of HCBS waiver services. In addition, the location must be integrated in and support full access of participants receiving HCBS waiver services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS waiver services.

(B) Any location where HCBS waiver services are provided must meet all applicable requirements of 42 CFR 441.301(c)(4) (Home and Community-based Settings Rule).

(C) Any location that is owned or operated by an HCBS waiver provider where HCBS waiver services are provided must meet all applicable building, sanitary, health, safety, and zoning requirements.
(1) All HCBS waiver providers must ensure that the location in which HCBS waiver services are provided is clean, environmentally safe, free of vermin and obvious fire and chemical hazards, maintained in accordance with common fire safety practices, and of sufficient size to accommodate comfortably the number of individuals and staff it serves. Any objects or conditions that represent a fire hazard greater than that which could be expected of ordinary household furnishings is not permitted.
(2) All HCBS waiver providers must ensure that the location in which HCBS waiver services are provided is a barrier-free environment in those areas used by persons with substantial mobility impairment, to the extent necessary to permit access to the supports, services, personal, and common areas. A location is deemed barrier free, in whole or part, if it meets the applicable standards of 521 CMR: *Architectural Access Board* as adopted in 780 CMR: *State Board of Building Regulations and Standards*.

(D) Any location where day services are provided must meet the site requirements of 130 CMR 404.000: *Adult Day Health Services* or 419.000: *Day Habilitation Center Services* or the licensure/certification standards of an EOHHS agency for day services (such as Department of Developmental Services requirements at 115 CMR 7.00: *Standards for All Services and Supports* and 115 CMR 8.00: *Licensure and Certification for Providers* or Department of Mental Health requirements at 104 CMR 28.00: *Licensing and Operational Standards for Community Services*: *Subpart B*) or the site requirements established by DDS or MRC for the provision of day services to participants of an HCBS waiver.

(E) Any location where residential habilitation, shared home supports, or shared living services are provided must demonstrate compliance with all applicable licensure requirements at 115 CMR 7.00: *Standards for All Services and Supports* and 115 CMR 8.00: *Licensure and Certification for Providers*.

## 630.442: Personnel Requirements and Responsibilities of HCBS Waiver Providers

The requirements in 130 CMR 630.439 apply to HCBS waiver providers in 130 CMR 630.404(D) that have personnel, including employees, independent contractors, and volunteers, providing HCBS waiver services to participants.

(A) Personnel Hiring Requirements. Each HCBS waiver provider must:

(1) check the candidate's references and job history and ensure that the candidate meets all of the required experience, education, and qualifications before hiring;

(2) conduct a Criminal Offender Records Information (CORI) check and determine whether any offender records may disqualify any personnel from contact with participants;

(3) ensure that all personnel are appropriately trained and managed;

(4) have available at all times a sufficient number of educated, experienced, trained, and competent personnel to provide services to persons with acquired brain injuries;

(5) evaluate personnel annually using standardized evaluation measures; and

(6) maintain a record of each performance evaluation in a separate personnel file for each person.

(B) Hiring Requirements for Personnel Who Provide Hands-on Physical Assistance to Participants. In addition to the personnel hiring requirements in 130 CMR 630.439(A), each HCBS waiver provider must ensure that each person who will provide hands-on physical assistance to participants:

(1) has received a tuberculosis screening upon hire; and

(2) receives a tuberculosis screening every two years.

(C) Personnel Training Requirements. Each HCBS waiver provider must:

(1) provide initial and periodic training to all personnel who are responsible for the care and services to a participant. Records of completed training must be kept on file and updated regularly;

(2) hold an orientation for new personnel within one month of hire. This orientation must include the following topics for all personnel who will have direct contact with participants:

(a) delivery of HCBS waiver services;

(b) written policies and procedures of the HCBS waiver provider;

(c) the requirements of 130 CMR 630.000;

(d) the roles and responsibilities of provider personnel;

(e) best practices for working with participants with brain injuries;

(f) behavioral interventions, behavior acceptance, and accommodations;

(g) cardiopulmonary resuscitation (CPR) and first aid, if such training is required in the licensure or certification standards applicable to the provider type or setting;

(h) infection control and safety practices;

(i) information about local health, fire, safety, and building codes;

(j) privacy and confidentiality;

(k) communication skills;

(l) abuse identification and reporting;

(m) cultural sensitivity and diversity;

(n) universal precautions; and

(o) emergency procedures, including the provider's fire, safety, and disaster plans.

(D) Service Delivery. Each HCBS waiver provider must ensure that each individual who is responsible for delivery of services to a participant must:

(1) be a responsible person who is at least 18 years old, with the ability to make mature and accurate judgments and with no mental, physical, or other impairments that would interfere with the adequate performance of the duties and responsibilities of an HCBS waiver provider;

(2) not abuse alcohol or drugs;

(3) be able to devote appropriate time necessary to provide needed services to the participant to ensure the participant's safety and well-being at all times during which the service is delivered; and

(4) meet all other requirements established by MRC or DDS.

630.443: Withdrawal by an HCBS Waiver Provider from MassHealth

An HCBS waiver provider that intends to withdraw from MassHealth must satisfy all of the requirements set forth in 130 CMR 630.440.

(A) MassHealth Agency Notification.

(1) An HCBS waiver provider electing to withdraw from participation in MassHealth must give written notice of its intention to withdraw to the MassHealth agency. The HCBS waiver provider must send the withdrawal notice by certified or registered mail (return receipt requested) to the MassHealth agency. The notice must be received by the MassHealth agency no fewer than 90 days before the effective date of withdrawal.

(2) If such withdrawal results from a situation beyond the control of the HCBS waiver provider, such as fire or natural or unnatural disaster, the HCBS waiver provider must notify the MassHealth agency or its designee immediately by phone and follow up in writing within three calendar days. The burden of proof to demonstrate an emergency is the responsibility of the HCBS waiver provider.

(B) Notification to Participant and Family.

(1) The HCBS waiver provider must notify all participants, guardians, emergency contacts, and other funding sources in writing of the intended closing date no fewer than 90 days before the intended closing date and specify the assistance to be provided to each participant in identifying alternative services.

(2) On the same date on which the HCBS waiver provider sends a withdrawal notice to the MassHealth agency, the provider must give notice, in hand, to the participants it serves and their authorized representatives. The notice must advise any participant that on the effective date of the withdrawal, the participant must locate another HCBS waiver provider participating in MassHealth to ensure continuation of HCBS waiver services.

(3) The notice must also state that the HCBS waiver provider will work promptly and diligently to arrange for the transfer of participants to other MassHealth-participating HCBS waiver providers or, if appropriate, to alternative community-service providers.

(C) Coordination. The HCBS waiver provider must cooperate and coordinate with the case manager and assist in transferring participants to other programs.

630.444: Recordkeeping Requirements

In addition to the recordkeeping requirements set forth in 130 CMR 450.205: *Recordkeeping and Disclosure*, all HCBS waiver providers must maintain a record for each participant receiving care and services that includes the following information:

(A) the member's name, member identification number, address, sex, age, and next of kin;

(B) the care plan for the specific service being provided, including information about coordination with other services, as appropriate;

(C) complete documentation of all services provided and events that occurred while providing HCBS waiver services;

(D) for products and materials, a copy of the original invoice showing the cost to the HCBS waiver provider, copies of written warranties, and any discounts;

(E) for transportation, the originating location, destination, and mileage of all trips; and

(F) other documentation as may be specified by EOHHS, DDS, or MRC.

REGULATORY AUTHORITY

130 CMR 630.000: M.G.L. c. 118E, §§ 7 and 12.

NON-TEXT PAGE