Massachusetts Long-Term Supports Systems Transformation

Introduction

The Commonwealth of Massachusetts has moved steadily over the past several years to make long-term supports in the community available, affordable, and accessible alternatives to institutional care. The Commonwealth has made great strides in achieving this aim and can point to many areas of excellence. However, our transformation is not yet complete. This Systems Change grant will afford the Commonwealth the opportunity to build on the strengths of these areas of excellence, focus on developing areas that are still deficient, and weave efforts together to form an integrated, coherent, person-centered system of long-term supports. We intend to focus our proposed grant activities on areas that are not sufficiently addressed or well-coordinated within our current system so that we can better meet the needs and preferences of elders and persons with disabilities in Massachusetts. At the conclusion of the grant period, Massachusetts will be successful in addressing gaps within the current long-term supports infrastructure to provide an array of effectively managed, long-term support choices, and the opportunity for individuals within the Commonwealth to exercise those choices.

The University of Massachusetts Medical School, Center for Health Policy and Research (UMMS/CHPR) is applying for this grant in partnership with the Executive Office of Health and Human Services (EOHHS) and the Executive Office of Elder Affairs (EOEA). For the following narrative, this collaboration will be referred to as the "EOHHS, EOEA, UMMS/CHPR long-term supports Partnership" or simply the "Partnership." For organizational charts depicting EOEA, EOHHS, UMMS/CHPR, as well as the structure of the Partnership arrangement, please see Appendix F. The Partnership includes all of the Executive Branch human services agencies serving people of all ages with diverse disabilities. The Partnership has involved these agencies as well as a diverse consumer, advocacy, and provider group representation in the development of this proposal to ensure cross-disability and inclusive collaboration. Built on the success of previous Systems Change grants, this process has garnered stakeholders' commitment to work actively with the Commonwealth on the design and implementation of grant activities. For a description of the inclusive process utilized to develop this proposal and a list of drafting partners, please see Appendix G.

The Commonwealth is ready to build upon many accomplishments already in existence within the long-term support system. The narrative below articulates the Commonwealth's progress in the six major components related to long-term supports systems transformation. After completing a preliminary Readiness Assessment during the planning phase of proposal development, it became evident that the Commonwealth has progressed in all six areas, but that further transformation in the areas of quality management, finance and diversion, and housing is required. In addition, the Commonwealth is committed to the successful integration and coordination of initiatives across the six transformation components to ensure a comprehensive, well-managed system that is seamlessly unified to participants.

Part 1: Systems Readiness Assessment

1. Political and State Agency Leadership.

Governor Mitt Romney, EOHHS (including the Secretary, Budget Director, Medicaid Director, and other agency leadership), and EOEA are united in their support for systems transformation to enhance community living options. Since the inception of the Personal Care Attendant service in 1974, the Commonwealth of Massachusetts has implemented many initiatives focused on ensuring that elders and persons with disabilities can access high quality long-term support services in the community. Commitment is evident in the implementation of the three home and community-based services (HCBS) waivers supporting frail elders, people with mental retardation, and people with traumatic brain injury. Since the implementation of these waivers, a few of the Commonwealth's accomplishments include:

- enhancements of the HCBS waiver programs and state-funded programs serving frail elders and persons with disabilities;
- development of an affordable housing registry;
- implementation of new nursing home screening and transition activities;
- implementation of multiple systems change grants; and
- introduction of electronic eligibility processes through a web-based system.

EOHHS and EOEA Re-organization

With buy-in from the legislature, Governor Mitt Romney developed a plan for re-organization of EOHHS and EOEA in 2003 to better integrate services and supports for elders and persons with disabilities reinforced the Commonwealth's commitment to systems transformation. The reorganization initiated a critical phase of reform in relation to the design and delivery of long-term supports. Implementing the consolidated agency structure required in the reorganization was a major challenge at all levels of state government. Staff in the various agencies within EOHHS and EOEA faced many cultural and structural barriers as the different philosophies, approaches, and constituencies were blended into the new organizational structure in order to streamline service delivery and increase access to available services. Through this process, the Commonwealth has made great strides to ensure that elders and individuals with disabilities have the opportunity to live in the most integrated community setting appropriate to meet their needs and preferences, exercise meaningful choices, and obtain quality services consistent with their preferences and priorities.

As a result of the reorganization, Medicaid-covered long-term supports are now overseen by the newly created Office of Disabilities and Community Services within EOHHS (ODCS/EOHHS), in collaboration with EOEA. The ODCS/EOHHS brings together the key departments that support people with disabilities including the Department of Mental Retardation, Massachusetts Rehabilitation Commission, Commission for the Blind, Commission for the Deaf and Hard of Hearing, and the two Soldier's Homes. ODCS/EOHHS and EOEA jointly oversee policy related to Medicaid-covered long-term support services administered through EOEA. ODCS/EOHHS and EOEA also coordinate closely with sister agencies including the Office of Health Services (including the Department of Mental Health), the Office of Medicaid, and the Office of Children, Youth, and Family Services. Cross-agency coordination is managed

through routine meetings of leadership across each of the Offices, their respective state agency commissioners, and Medicaid staff. As noted previously, organization charts is found in Appendix F.

Level of Support

Upon the reorganization of EOHHS, EOHHS and EOEA formed one mission and Strategic Plan to better serve people in need. Through the strategic planning process, EOHHS, under the guidance of Governor Mitt Romney, enacted a "Community First" policy. The over-arching premise of the Community First policy is to make home and community-based services more available to elders and individuals with disabilities to ensure they no longer find institutional settings to be their only or most readily available option. In addition to support from the Governor and the Secretary of EOHHS, the Community First policy has the full support of the Secretary of EOEA, the Budget Director, and the Medicaid Director. ODCS is charged with implementation of the Community First policy in coordination with EOEA. For more information on Community First and a list of initiatives developed under this policy, please see Appendix H.

In addition to commitment of state agency leadership, there is significant support for increased community-based options within the Legislature. In July, 2004, the legislature passed budget language that required the Commonwealth to seek an expansion of the Frail Elder HCBS waiver by expanding financial criteria up to 300 percent of the federal poverty level. EOEA was successful in this effort and expansion is effective as of July 1, 2005. In addition, support from key legislators is evident as outlined in letters of support provided by State Senate Majority Leader, Frederick E. Berry; Senate Chair of the Health Care Financing Committee, Richard T. Moore; Senator and participant in the Massachusetts Long-Term Care Policy Academy Team, Michael R. Knapik; and Chair of the Elder Affairs Committee, Senator Sue Tucker (found in Required Attachment E).

The support for transformation provided by Governor Romney is essential for sustainable systems change. Also crucial to systems transformation, the support for community-based options, consumer choice, and consumer control is evident among the Secretaries and Commissioners of all of the state agencies serving elders and people with disabilities and key legislative leaders representing both political parties. Please see Required Attachment E for letters of support from Governor Romney as well as Executive and Legislative leadership.

Competing Priorities

Both political and state agency leadership recognize that individuals must be made aware of long-term supports and how to access them. Political and state agency leadership also agree that it is important to increase the availability of more individualized, and community-based services, as well as delivery approaches in order to maximize the number of persons who are able to remain living in the community. While there is consensus on the need to streamline information and improve access to community-based models of support, other programs simultaneously being implemented by the Secretariats may compete for the time, resources, and funding that can be focused on this effort. For example, a key goal of the Governor is to increase the number of individuals with private health insurance coverage and decrease reliance

on state and federally-funded health care coverage. Another competing priority is the desire to develop statewide use of health information technology. The availability of funding through this CMS grant will provide additional resources to ensure that other priorities, important as they are, do not distract attention from transformation of the long-term support system. These resources will supplement the staff resources available within EOHHS and EOEA and will assist to provide a clear focus for policy makers in the various state agencies, the legislature, and the consumer and provider communities.

Areas of Consensus and Non-consensus

There is strong consensus among Executive and Legislative leadership that individuals should be able to choose community-based supports rather than institutional supports. However, fiscal constraints and a lack of data supporting innovative approaches to community support make it difficult to achieve increased funding for community options. By using grant funds to better integrate and monitor the delivery of community supports and to measure the effectiveness of innovative approaches, the Partnership hopes to provide increased evidence that supports the increased financing of flexible community-based supports. In addition, the Partnership is committed to analysis and broad dissemination of the results of existing initiatives and improvement in the Commonwealth's infrastructure to ensure informed decision-making.

2. Stakeholder Support and Mediation.

The Commonwealth is a national leader in meaningfully involving stakeholders in the design of policy. Numerous consumer and other stakeholder involvement activities in existence prior to the Systems Change grants are evidenced by activities related to Olmstead planning, the Department of Education Statewide Improvement grants, and other transition planning activities. Even so, the implementation of the CMS grants has spearheaded a transformation in the level of consumer and stakeholder involvement in planning, implementing, and evaluating long-term supports by creating systematic and inclusive processes to involvement. Although new methods have been successful, Massachusetts can do more to be inclusive and transparent in its policymaking.

Defining Stakeholders and Conflicting Views

The state recognizes that there are many different groups of stakeholders representing various ages, disabilities, cultural perspectives, and experiences. These groups include people receiving services, family and other informal caregivers, advocates, and paid providers. Differences are often manifested in diverse and sometimes conflicting views and expectations for service delivery systems. Consumers, supportive of independent living and the right to fail, report that quality should be defined by the consumer, not the provider of services and the Commonwealth. Consumers and family members also feel that services and supports can be used more efficiently in the hands of consumers rather than providers. Providers' perspectives are also varied and frequently differ from those of consumers and advocates. For example, some traditional home care providers feel that self-directed supports should have the same if not more restrictive training, background checks, and quality oversight requirements. People representing the nursing home industry frequently remind policy makers that nursing home supports are, and should continue to be, a valuable part of

the long-term care system. Home health providers report that more needs to be done to increase the capacity of agency-based services in preparation for the aging baby-boomer population. As stakeholders have become more involved in the design of policy, it is evident that sensitivity to stakeholders' different values is important and requires a lot of time and resources to ensure meaningful and effective involvement to attain consensus whenever possible.

Level of Involvement, Support, and Mediation Tactics

Each of the state agencies serving elders and people with disabilities has agency-specific methods for obtaining stakeholder input into the design, implementation, and evaluation of programs. The level of stakeholder involvement varies among agencies and has generally been focused on advisory committees or consumer councils related the specific sub-populations served by the respective agencies. State agencies continue to strengthen methods of consumer involvement to ensure the needs of constituents drive the development of services. The Commonwealth's attempt to involve stakeholders in cross-disability discussions has seen significant changes over the past few years. The state's Olmstead Advisory Group, established in 2000, was the first step toward such a cross-disability, cross-state agency mechanism for input. Subsequently, the funding from CMS grants acted as a catalyst to a more meaningful, integrated and systematic approach to involving consumers in public policy decisions.

The first Real Choice Community Forum in January 2003 marked a turning point in the relationship between state policy makers and stakeholders. This coincided with the change in administration and initiation of the reorganization of EOHHS and EOEA. Delays in establishing a consumer group for the Real Choice grant frustrated consumers. During the Forum, consumers pressed for the establishment of a consumer group to guide the grant. Consumer advocates appointed a nominating committee to seek and appoint representation. Soon afterward, the nominating committee appointed the Consumer Planning and Implementation Group (C-PIG). The C-PIG took time to learn more about the grant, met with state partners, and requested to be a part of the decision-making process for the grant. State partners agreed to this and the C-PIG and state partners each designated five members to participate as equal partners on a Collaborative Team. Since then, state policy makers and elder and disability advocates representing diverse populations meet monthly to drive the activities of the Real Choice and Independence Plus grants and to provide input on other policy initiatives.

When there are disputes among team members, the Collaborative Team makes decisions utilizing a consensus model. State and consumer partners have developed a strong rapport and recognize that all Collaborative Team members are acting in the best interests of the Commonwealth, elders, and people with disabilities. Once consensus is reached on decisions, both consumer and state partners are responsible for communicating decisions made to their respective groups. Participants are enthusiastic about the level of involvement this process affords them and consider the approach a success. Grant staff, consumer advocacy leadership, and state policy makers have presented this collaborative model as a national model of an effective practice numerous times at statewide and national conferences, including the CMS Systems

Change Conferences. For more information on this model and how it evolved, and a list of presentations, please see Appendix I.

Similar models for stakeholder involvement have been incorporated into most of the Systems Change grants, as well as into other policy design and implementation activities across the Secretariats. In addition, the Commonwealth's Systems Change grants involve stakeholders in meaningful ways through integrated subcommittees and public forums. To ensure meaningful involvement, Systems Change grants provide a stipend for consumer involvement and access to accommodations including transportation; documents in alternate format such as Braille, tapes, disks, large print; CART providers, and American Sign Language interpreters. Please see Appendix J for a more detailed list of lessons learned on consumer involvement prepared by Real Choice grant staff in collaboration with consumer partners.

In regard to systems change initiatives, disability advocates have voiced that change needs to happen quickly and that grant funds should be used to implement change rather than simply study problems. Disability advocates have also been clear that effective transformation of long-term supports cannot happen without their presence. For letters of support from stakeholders, please see Required Attachment E.

Interactive Discussions

Over the past year, the Commonwealth has begun to bring providers, consumers, advocates, and families together to attempt to find common ground and build consensus toward systems change. Massachusetts and Connecticut held a joint "Day of Dialogue" in November 2004 to begin a value-based discussion of key topics noted within this section. The following month, the Commonwealth held its first "Connecting the Dots" meeting, bringing together partners on all the Systems Change grants to identify linkages with the state's strategic planning process. As the Commonwealth continues to move towards an approach to policy making that is inclusive of and responsive to stakeholders, expanding the dialogue to include all stakeholders is critical. The lessons learned from previous grant activities in involvement strategies, consensus building, and communication, as well as the inclusive process used in the writing of this grant will help the Commonwealth to foster an open and trusting dialogue among consumers, families, advocates, providers, and state partners.

3. Developing a Shared Vision.

The Commonwealth has implemented numerous activities over the past five years to create a shared vision among state policy makers, persons with disabilities, advocates, and providers. The shift from a top-down approach to a truly collaborative one is evident in the evolution of these processes over the past few years. In 2001, the Commonwealth's Olmstead Commission, a group of advocates, providers, and state partners appointed by the Governor hosted cross-disability listening sessions across the Commonwealth to seek input on barriers to community living. Those sessions led to the development of four subcommittee reports outlining recommendations for changes to long-term care policy. State agency representatives reviewed the subcommittee reports in the spring of 2002 and developed an initial plan which prioritized and limited the scope of the recommendations based on feasibility and consistency of the work directed

by the Executive Branch at the time. The Commonwealth's action plan was documented in "Enhancing Home and Community-Based Services (ECBS): A Massachusetts' Plan" issued in August 2002. The Plan outlined specific tasks each state agency was responsible for accomplishing to enhance supports in the community. Please refer to Appendix K for a copy of the Executive Summary of the ECBS Plan.

The inadequacy of the consensus-building process in developing the plan resulted in the plan being "dead on arrival." Several months after the ECBS Plan was released, advocates joined to develop and release their own plan, "The People's Plan," which reinforced the full set of recommendations from the Olmstead Commission. Many felt that the ECBS Plan fell short of identifying progressive methods to increase options for people to live independently in the community. For a copy of the January 2003 "People's Plan," which includes all four subcommittee reports, please see Appendix L. Soon after the release of the People's Plan, frustrated by the lack of active involvement in the planning of supports, disability advocates strongly voiced their dissatisfaction during the first Community Forum held in January 2003.

As noted above, these events coincided with the transition of a new administration which allowed for revisiting the process and the issues. The Governor immediately began the Executive Branch reorganization, and EOHHS and EOEA initiated the development of a new vision for long-term supports that was built on both evidence-based practices and the preferences expressed by consumers. The initial vision and guiding principles were documented in the "Transforming Long-Term Supports" report issued in December 2003, a report drafted by UMMS/CHPR in collaboration with EOHHS and EOEA. It was refined with input from various stakeholders, including elders and people with disabilities. In addition to the long-term support vision and guiding principles, the report also outlined recommendations for enhancing community-based options for elders and people with disabilities. For a full copy of this report, please see Appendix M.

While this report was in development, EOHHS was concurrently developing an agency-wide strategic planning process through the use of cross-agency committees. The committees identified planning activities for the key areas of human services policy including long-term supports. In the fall of 2004, strategic planning activities were outlined in a report entitled "Forging the Future." For the list of long-term supports planning activities as outline in the report, please see Appendix H.

Most recently, EOHHS and EOEA received assistance from the National Governor's Association to develop a stakeholder process and revisit the mission and goals for the future. A modified mission statement was reviewed and revised by consumers at the third annual Community Living Forum on June 16, 2005 and by a broader group of providers, consumers and advocates at a statewide stakeholder meeting on June 20, 2005. The recommended vision, still under discussion, is:

> Our vision is for citizens to be empowered to live with dignity and independence in their communities through access to person-centered, integrated systems, supports and choices.

The meetings noted were the subsequent step in a renewed dialogue on how members of the elder and disability communities can work with one another and with the state

more effectively to further the Community First goals. The progress the Commonwealth has made in involving stakeholders to establish a shared vision has assured that the Partnership is ready to drive continued systems transformation in Massachusetts.

4. Improving Access to Services.

Massachusetts offers a rich Medicaid state plan including personal care attendant services, adult foster care, adult day health, medical transportation, in addition to three key home and community-based services waivers serving elders, persons with mental retardation, and persons with traumatic brain injury. The Commonwealth also offers many innovative state-funded programs to increase the availability of home and community-based supports. For a sample of key services and supports available within the Commonwealth, please see Appendix N.

Long-term supports are only as good as the access to such supports. Although generous and innovative, access to EOHHS and EOEA supports can be difficult due to complicated and fragmented systems, as well as rigid eligibility criteria of multiple funding sources. EOHHS and EOEA leadership are aware that a system difficult to navigate can lead to underutilization of services as well as inefficient and costly service provision once services are finally accessed. EOHHS and EOEA leadership understand the importance of strong community networks to ensure individuals have access to the supports in a timely manner. The following is a sample of the networks working diligently to ensure access to community-based supports:

- *Independent Living Centers*- The Massachusetts Rehabilitation Commission contracts with eleven Independent Living Centers (ILCs) to provide direct services such as intake support, peer counseling, skills training, individual advocacy, and service coordination. The ILCs also provide community services such as outreach, public information, community involvement, and systematic advocacy.
- *Aging Services Access Points*- EOEA contracts with twenty-seven Aging Service Access Points (ASAPs) to serve as one-stop shopping portals for individuals sixty years of age and older. ASAPs also provide community supports through the Elder Home Care Program to approximately 33,000 individuals a year and administer Frail Elder HCBS waiver services to approximately 6,000 individuals per year.
- *1-800 Age Info*- EOEA, in partnership with Mass Home Care, funds 1-800 Age Info to provide an internet and telephone-based information and referral system designed to assist consumers, caregivers, and professionals seeking information and resources on eldercare services. The site lists information on approximately 40,000 services and programs in Massachusetts for elders. For more information on 1-800 Age Info, please see Appendix O.
- *Shine Program*- EOEA administers the Shine Program, allowing benefit counselors to provide information and assistance regarding health insurance and benefits to elders, disabled Medicare beneficiaries, family members, and professional caregivers. Annually, the Shine program assists approximately 40,000 Massachusetts Medicaid beneficiaries.
- *Comprehensive Service and Screening Model*- In 2004, EOEA implemented a new nursing home screening initiative in which community care managers from ASAPs conduct face-to-face screenings of individuals who are seeking nursing home care

or who were recently admitted to a nursing facility. For more information on this model, please see Section 8 of this Readiness Assessment.

- *Aging Disability Resource Centers*-Through a 2003 Aging and Disability Resource Centers (ADRC) grant, Massachusetts is testing the "no-wrong-door" approach to ensure that individuals will learn about all opportunities available to them regardless of age or which agency they contact. The enthusiasm for the model in those regions has prompted an exploration of expansion to other areas of the state. For more information on ADRC, please see Section 12 of the Readiness Assessment.
- *Mental Health Recovery Learning Centers*- Mental Health Recovery Learning Centers are currently being developed through the 2003 Mental Health Transformation grant to increase access to information for people with psychiatric illnesses who need long-term supports and to increase capacity of consumer advocates. For more information on Recovery Learning Centers, please see Section 11 of the Readiness Assessment.
- *Mass Acess Housing Registry*- The Mass Access Housing Registry is a comprehensive web-based database of accessible housing in Massachusetts. More information on this registry is located in the Section 9 of this Readiness Assessment.
- *Virtual Gateway*- The Virtual Gateway is a major Massachusetts' effort to streamline access to programs and services available through EOHHS for consumers and providers by providing consumers one place retrieve information about EOHHS services and contracted providers. It is a single access point on the Internet for a wide variety of EOHHS programs. As the Virtual Gateway is fully implemented, it will be used as a method to connect all of the access models above as well as additional systems. More information on the Virtual Gateway is located in Section 7.

Although there continues to be a need for streamlined information and access related to long-term supports, it is evident that the Commonwealth is devoting significant resources to address this need. EOHHS and EOEA continue to build the bridges among the multiple networks and service delivery systems already in place as well as the new initiatives currently being piloted. Such efforts document the Commonwealth's progress toward a one-stop, no-wrong-door approach to providing long-term supports for people regardless of age or disability.

5. Consumer-Directed Services through All Funding Streams and the Use of Individual Budgets.

Since the inception of the Personal Care Attendance program in the 1970's, Massachusetts has been a national leader in the development of consumer-directed options for people with disabilities. The following is a list of consumer-directed programs currently available in Massachusetts:

The Medicaid State Plan Personal Care Attendant Program (EOEA-Medicaid)

The Commonwealth's self-directed Personal Care Attendant (PCA) Program, currently supporting approximately 9,000 individuals, has been in existence for over thirty years and has experienced significant growth over that time. Within this program, people who have two or more hands-on unmet needs related to activities of daily living hire, train, and even fire their own personal care attendants. Participants receive training on the program and worker management from their PCA agency (often the local

Independent Living Center or Aging Services Access Point). Individuals who want support in managing their PCAs can appoint a surrogate.

Services within the Elder Home Care Program (EOEA- Medicaid and State Funded)

Additional consumer-directed services are available with the Elder Home Care Program administered by EOEA. Individual ASAPs have utilized Home Care funding to allow a small number of consumers to hire, fire, and train their own workers. Small pockets of flexible funding are also available for home modifications and caregiver support through Older American's Act funding.

The Supported Living Program (MRC- State Funded)

The Supportive Living Program provides consumer-driven case management support to individuals who require support directing their own services. Case managers are available to provide support in areas the individual requests assistance with (i.e. financial management, hiring workers, and coordinating medical appointments). Consumers are given the opportunity to appoint and change their case management provider during and annual "open enrollment period".

Individual and Family Supports (DMR- Medicaid and State Funded)

The Department of Mental Retardation received a Self-Determination grant from the Robert Wood Johnson Foundation in the 1990s to test the concepts of consumer direction in the lives of persons with mental retardation. This model of consumer direction assumes individuals can determine important aspects of their lives even if they are not able to fully self-direct on their own. Participants receive an individual budget that is established through a developmental process. This budget can then be used to purchase services and supports in the community. The program's success is evident in Massachusetts' decision to sustain the model with state funds beyond the grant period. Thousands of families receive an array of flexible supports through this program.

Intermediary Service Organizations (DMR- State Funded)

The Intermediary Service Organization ("ISO") program is a DMR initiative that was initiated with Robert Wood Johnson Foundation grant funds and was designed to provide consumers with greater choice in the design of their individual service plan through the development of individual budgets. Essential to this goal is the enhancement of service and provider choice, since the ISO program allows consumers greater flexibility when determining needed services and supports as well as selecting providers to deliver those services-supports.

In addition to the consumer-directed services already available within the Commonwealth, EOHHS and EOEA are working with stakeholders to develop and implement the additional consumer-directed initiatives funded by three of the existing CMS grants (Real Choice, Independence Plus, and C-PASS). Please see Section 11 of this Readiness Assessment for additional detail. The Commonwealth has a history of implementing successful models of self-direction utilizing both Medicaid and non-Medicaid funding. Even so, the Massachusetts experience with designing individual budgets is primarily focused on the work of DMR. As a continued leader in the development of innovative self-direction models, Massachusetts is beginning to venture

out in new areas within self-direction and flexible service delivery. To be successful in this area, the Commonwealth will need to further explore the use of individual budgets that can be created regardless of disability and be utilized across long-term support services.

6. Development of Quality Management Systems for Long-Term Supports.

A comprehensive, integrated, quality management system for long-term supports is an essential component to systems transformation. To date, the Commonwealth has implemented several quality management systems within agencies, but has yet to create an effective, comprehensive system to ensure quality long-term supports across funding streams, state agencies, providers, and services. The following is a review of quality management systems that have been successfully implemented within the Commonwealth:

Quality Management within the Department of Mental Retardation (DMR)

DMR has been nationally recognized for its Quality Management and Improvement system which reviews quality from the perspectives of the individual, provider, and overall system. Through 17 different components, the DMR system ensures discovery and remediation of participants' health, safety and quality of life. In addition, there is an extensive outcome-based licensure and certification process for providers. Finally, DMR fully utilizes all data gathered to identify and implement improvements through its number of quality assurance processes and through public dissemination of quality assurance reports. The reports outline both positive aspects of services and supports as well as areas needing improvement. Quality Councils, comprised of individuals receiving supports, families, providers, and DMR staff analyze the reports and make recommendations for service improvement targets. Participation in the National Core Indicators Projects allows DMR to benchmark its performance on key indicators of quality against national averages. Through a 2003 CMS Quality Assurance and Quality Improvement grant, discussed in Section 11 of this Readiness Assessment, DMR has been able to build on these efforts and work with other New England states to identify and implement more health-related quality indicators for persons with mental retardation.

Quality Management within the Department of Mental Health (DMH)

DMH engages in quality improvement activities with community service providers, private and DMH-operated psychiatric inpatient services, and other DMH-operated services. Many programs conduct self-evaluations that are approved by DMH. The programs track the outcomes from these assessments on a regular basis. DMH identifies in its current Strategic Plan a need to operate in a manner that is more quality and data-driven. To ensure consumer involvement in quality management, Massachusetts Behavioral Health Partnership (the Medicaid behavioral health carve-out provider) contracts with Consumer Quality Initiatives (CQI) to design, conduct, and interpret qualitative data for mental health services provided to individuals receiving publicly funded care. CQI is an organization that is governed and operated by individuals who are current and former mental health service consumers, and its employees bring a unique perspective to the work they do with individuals with

disabilities. CQI is also conducting an evaluation of consumer satisfaction with participants in the Real Choice pilot.

Although Massachusetts has been a national leader in developing quality improvement systems for persons with mental retardation and persons with mental illness, EOHHS and EOEA have been less successful to date in developing effective quality management across long-term support delivery systems. Effective approaches do not exist for all populations utilizing long-term supports. There are no consistent standards for measuring and managing quality of long-term supports across agencies. Also, when reviewing CMS' new quality expectations for HCBS waivers, it is evident that more resources are needed to develop effective quality management systems for two of its waivers, the frail elder waiver and the traumatic brain injury waiver. EOHHS and EOEA have identified the need to develop an integrated approach to measuring and monitoring quality across the agencies serving elders and persons with disabilities. This is evident in the strategic planning priorities set forth by EOEA and many of the agencies within EOHHS. To ensure a true and transparent, continuous quality improvement system, the Commonwealth is dedicated to developing a system that is driven by the needs and preferences of the consumer, enables consumers to play a central role in monitoring and reporting on quality, shares data results with all stakeholders, and creates strategies for improvement at all levels of the delivery system and across programs.

7. Developments of Information Technology that Support Transformation.

The Commonwealth has worked for the past several years on refining its information technology systems to better support service delivery. Significant resources have been devoted to information systems enhancements including the following:

- development of technology to unify the various service eligibility and intake processes among the agencies serving elders and persons with disabilities;
- implementation of telephonic and web-based information and referral systems that can be accessed by providers, agency staff, consumers, and families; and
- development of electronic billing, recordkeeping, and data systems that will yield more reliable and useful information for policymakers.

Below is a list of current initiatives supporting this charge:

Virtual Gateway

The Virtual Gateway is a major Massachusetts effort to streamline consumer and provider access to EOHHS programs and services. Through a streamlined Internet portal, the Virtual Gateway provides consumers with information on a wide variety of EOHHS services in one location. The Virtual Gateway is also a central place for contracted providers to conduct business with EOHHS. One prominent feature of the Virtual Gateway is the screening and common intake tool. This tool, launched in 2004, allows applicants working with registered providers to enter client information into one on-line form and electronically submit applications for several EOHHS programs such as Medicaid services, Food Stamps, and Women, Infants, and Children services and supports. In summer of 2005, the screening and common intake tool will be expanded to include community services and long-term supports for persons with disabilities, elders, and veterans. The expanded tool will address one of the current challenges

facing individuals seeking long-term supports, namely, that they must complete and submit multiple applications before they know whether there is an agency or program that can provide assistance. The Resource Information Locator, to be added in early 2006, will assist hospital and nursing home discharge planners, as well as individuals and their families to locate community services to support individuals to remain in or transition into the community. This will also improve access to information and eligibility determination so that individuals can receive benefits and services sooner.

Mass Network of Information Providers (MNIP also known as New England INDEX)

The MNIP is a web-based network of information on providers of services and supports for people with disabilities. It is available to organizations and individuals who are seeking information about provider agencies serving individuals in Massachusetts. The MNIP is being expanded and linked into the Virtual Gateway to assure that individuals who are seeking long-term supports can quickly find available providers in their areas. For more information on MNIP, please see Appendix P.

Mass Access Housing Registry

In 1995, the Commonwealth developed the Mass Access Housing Registry. Mass Access is a comprehensive web-based database of accessible housing in Massachusetts that also includes a list of vacancies. Funded in part by the U.S. Department of Housing and Urban Development, the Registry has served as a model for other states and is promoted on the CMS website as a promising practice. Mass Access has been an effective tool with over 800 vacancies reported annually. See Appendix Q or www.massaccesshousingregistry.org for more information.

Rewarding Work Website

The Rewarding Work campaign and its related website were developed initially in Massachusetts to support provider agencies seeking to hire direct support workers. The website has now been expanded to feature personal assistance services and to allow individuals who hire their own workers to search the website to find workers who meet their needs. Rewarding Work is a national model featured as a CMS promising practice and is now in active use in Massachusetts, Connecticut, and New Jersey. Other states are exploring options for joining the campaign. For more information on Rewarding Work, please see Appendix R or visit www.rewardingwork.org.

Data Warehouse

Massachusetts is in the process of developing a data warehouse to house extensive historical information on services provided by Medicaid and state programs. The initial warehouse has been developed to support Medicaid claims and eligibility data and is organized to facilitate data extraction that will support internal policy analysis and planning purposes. The data is available on a password-protected basis and access to personally-identifiable information is limited to a narrow set of users. Non-identifiable data will be extremely important in the modification of program policies, the design of quality management systems, as well as other key government purposes. As the warehouse information is expanded to include state-funded programs, the ability to

link Medicaid and state-funded expenditures will greatly enhance the Commonwealth's ability to plan for and oversee services to support elders and people with disabilities.

The Commonwealth recognizes the importance of accessible and integrated information technology to the transformation of long-term supports. Because of this, the Commonwealth has implemented these initiatives to increase the capacity and functionality of our information technology system. With these enhancements, information technology is being utilized to support information sharing, eligibility determination, and access to resources in order to serve people in need of supports in a more efficient and timely manner. EOHHS and EOEA will continue to devote significant resources to the enhancement of information technology to ensure new technology is beneficial to the transformation of long-term supports.

8. Status of Rebalancing Funding Efforts between Institutions and Community-Based Services over the Past Five Years.

In "Transforming Long-Term Supports in Massachusetts" (Appendix M), EOHHS documented the Commonwealth's high rate of nursing facility utilization compared with the national average (72 beds per 1000 elders in Massachusetts vs. 54 per 1000 nationally). However, recent data reflects a shift in the balance of spending from nursing facilities to community-based services. The annual number of Medicaid nursing facility days in Massachusetts dropped from 13 million in 1999 to just over 11 million in 2004. As of 2003, 47 percent of long-term care spending in Massachusetts was for community-based long-term supports.

Diversion and Transition Efforts. In recent years, Massachusetts has developed many initiatives to shift the emphasis from institutional toward home and community-based services. Maintaining open enrollment into the home and community-based services waivers has been one strategy. The following is a sample of the Commonwealth's existing diversion and transition initiatives:

Transition Support Provided by ILCs

ILCs support approximately one hundred individuals a year in transitioning from institutional to community-based settings. As a strategy to increase diversions, MRC provided each ILC with a goal for transitions in 2005 while utilizing existing staff and resources. Due to tight resources, diversion and transition activities conducted by ILCs are limited. Many feel that additional resources are necessary to ensure diversion and transition support can be provided to meet the transition goals.

Comprehensive Service and Screening Model

As already noted in Section 4 above, Massachusetts introduced a new screening and diversion approach in 2004. Rather than the review of paper screening tools generated by hospital discharge planners with incentives to move individuals to the easiest setting to coordinate (generally nursing homes), ASAPs now conduct face-to-face screening activities with individuals shortly after admission to a nursing facility. This provides an opportunity for individuals to learn about all of the community-based options available to them before a short-term nursing home stay becomes a long-term stay. The effectiveness this screening model is hampered by the fact the EOHHS and

EOEA are not informed when individuals are admitted to nursing facilities or rehabilitation beds. There is currently no requirement that hospitals report all discharges to nursing facility or rehabilitation beds to the State nor must the nursing facilities report any admissions that are not Medicaid-financed.

There are multiple screening and diversion strategies currently in existence within the Commonwealth. For a list of current strategies, please see Appendix S. EOHHS and EOEA have yet to be successful in integrating approaches and ensuring screening, diversion, and transition strategies are available to support individuals in community settings, regardless of their age, disability, insurance, or level of support required.

Rebalancing Efforts. In addition to screening and diversion strategies, there are also initiatives underway to support the rebalancing of funding between institutional and community settings. These initiatives include:

Rebalancing for Elders

A significant development in rebalancing was the inception of the Community Choices component to the elder Home Care program. Community Choices has allowed individuals at imminent risk of nursing facility placement to receive enhanced service packages to remain in the community through the 1915c Frail Elder waiver. The program began in November 2002 and has been growing steadily ever since. The Commonwealth has also recently received approval from CMS to modify financial eligibility for the Frail Elder waiver from 100 percent of the federal poverty level to 300 percent of the Social Security Income level to reach individuals who, without the support of the waiver, may enter a nursing home to quality for Medicaid supports.

Rebalancing Support for People with Significant Mental Health Disabilities

Massachusetts was an early leader in the reduction of capacity of intermediate and continuing care psychiatric inpatient beds, and continues to shift resources from inpatient to community services. In the coming year, DMH will complete the discharges of 260 individuals into newly created community placements from these inpatient beds, while preparing to decrease adult inpatient capacity from 900 beds to 740. The percentage of DMH spending on community services has exceeded spending on inpatient care for many years, and the balance will continue to tip on the side of the community. One barrier to this interest is the CMS Institution for Mental Diseases (IMD) Exclusion. This exclusion prohibits Medicaid reimbursement from being offered to inpatient facilities providing a majority of care for mental health conditions and thus eliminates the option of the developing a waiver as an alternative to such institutions. UMMS/CHPR is also currently conducting a study of individuals admitted to nursing homes who have been screened under the Preadmission Screening Resident Review (PASARR) process. Such efforts may reveal new opportunities for targeting resources and flexible funding models to help such individuals avoid nursing home placement. This work may influence the design of future consumer-directed long-term supports in Massachusetts and across the nation.

Barriers. Despite the efforts to increase access to community-based supports within the Commonwealth, there has been a continued bias in eligibility rules and procedures that favor institutional models of service delivery. A few additional known barriers include:

- *Time-Consuming Processes for Seeking Community-Based Supports-* Consumers have indicated that the amount of time required to arrange and acquire approval for community-based services, including PCA, often makes it difficult for many to avoid a nursing home placement.
- *Silo Funding Allowing Money to Follow the Provider-* One additional challenge to community-based options is the reality that the Commonwealth currently operates on a line item approach to long-term supports that segregates dollars by providers, not consumers. This compartmentalization of funds by provider type makes it impossible for consumers to carry support dollars with them to alternate settings as their needs change. There are also no incentives in the current reimbursement system for facilities to assist individuals to transition from facilities to community settings.
- *Inconsistent Eligibility Rules-* Although the Commonwealth has initiated methods to rebalance funding between institutional and community-based settings utilizing waivers, financial eligibility rules still allow individuals to quickly meet eligibility for Medicaid coverage in nursing facilities when they cannot qualify for community services. High institutional costs count toward medical "spend-down" rules and enable Medicaid-eligible nursing facility residents to convert from Medicare coverage to Medicaid coverage for their nursing facility stay, while this same conversion to Medicaid coverage of community-based long-term supports is usually precluded due to the institutional bias of Medicaid financial eligibility rules.

A review of current legislation and budget practices is necessary to identify further barriers to allowing budgets to follow an individual from and institutional setting to a community setting. Developing an implementation plan to address noted barriers will be critical in the transformation of long-term supports.

9. Status of Joint Initiatives between State Housing and Service Agencies.

As in many states, housing is a major challenge for elders and people with disabilities who choose to receive support in the community. Joint initiatives among state housing and service agencies are essential to ensure successful transformation of long-term supports. Using state and federal resources, the Department of Housing and Community Development (DHCD), its affiliated quasi-public agencies, more than 250 local and regional housing authorities, and a wide array of private and non-profit housing developers and owners engage in activities to create or find affordable housing options. Each year, more than one billion dollars of federal, state, and quasi-public funds are spent to build, renovate, preserve, and subsidize affordable housing in Massachusetts. Appendix T includes a supplemental list of recent housing initiatives and availability within the Commonwealth along with current housing collaborative initiatives to address barriers related to housing for elders and people with disabilities.

DHCD has demonstrated support and leadership in developing housing capacity for individuals with long-term support needs through several financing programs as outlined in the Affordable Housing Guidebook produced by the Citizens Housing Planning Association (CHAPA). This Guidebook was designed to inform legislators of

housing programs for elders and people with disabilities. For information from this Guidebook, please see please see Appendix U. In addition, further support is demonstrated in the objectives for the 2005-2009 Consolidated Plan developed by DHCD. These objectives include: developing and maintaining an adequate supply of safe, affordable, accessible housing; expanding homeownership opportunities for low, moderate, and middle income families; reducing chronic and family homelessness by providing a viable continuum of care; ensuring that residents with long-term support needs have access to appropriate services and accessible, community housing options that maximize consumer choice; and ensuring full and fair access to housing for all residents.

In fall 2004, the Massachusetts Rehabilitation Commission (MRC) implemented a housing survey in response to recent legislation charging MRC to develop integrated housing models for people not eligible for DMR or DMH services. As of April 2005, over 1000 people diverse in disabilities and geographic locations responded to the survey. According to the findings, many respondents want to live alone or in a shared apartment with one or two roommates. Many respondents also indicated a significant interest in homeownership. Additionally, nearly half indicated a need for assistance with shopping and/or housekeeping. The findings of the MRC survey are consistent with previous surveys conducted by other state agencies, which have emphasized the need for a diverse range of options of housing for elders and people with disabilities. For additional results from MRC's survey, please see Appendix V.

Even though DHCD collaborates with the various human services agencies to make accessible public housing units available to elders and people with disabilities, there continues to be individuals who are institutionalized primarily due to a lack of affordable, accessible housing and individualized services. EOEA, MRC, as well as other state agencies such as DMH and DMR have identified increased access to housing and supportive services and increased coordination among agencies focusing on housing initiatives as a strategic priority during the Commonwealth's strategic planning process. The lack of accessible and affordable housing is the most significant barrier to transforming long-term supports within the Commonwealth.

10. Current Level of State Collaboration: Progress and Remaining Challenges.

As a result of the major reorganization noted in Section 1of this Readiness Assessment, EOHHS, as the single state agency for Medicaid, is now charged with fully integrating MassHealth[1] with 17 other human service offices and departments as well as with EOEA. EOHHS and EOEA are committed to streamlining access to services and supports and addressing the silo-based approaches that currently dominate the service delivery system. Within EOHHS, the Office of Disabilities and Community Services, under the direction of Assistant Secretary Gerry Morrissey, Jr. is responsible for the coordination of long-term support policy across the Secretariat and for managing the nexus between policies for elders and policies for non-elderly persons with disabilities. Secretary Jennifer Davis Carey of EOEA, in close collaboration with Assistant Secretary Morrissey, is responsible for policy and service delivery for elders.

[1] MassHealth is Massachusetts' Medicaid Program

The new relationships within EOHHS have brought opportunities for valuable synergies associated with managing the delivery of long-term supports for elders and people with disabilities. For the first time, policy, program, fiscal, and advocacy activities related to long-term supports are aligned within a core group of agencies under common leadership. This new structure recognizes the unique and common needs among these diverse groups of consumers. As with any new system of coordination, it has taken time for state policy makers, providers, consumers, and advocates to understand how the re-organization influences day-to-day activities and the service delivery approaches of individual state agencies.

State agencies have worked diligently to coordinate across the multiple Systems Change grants and emerging initiatives to enhance community-based options for elders and people with disabilities through “Connect the Dots” forums. With assistance from the National CMS Technical Assistance Exchange, EOHHS and EOEA have been able to coordinate the efforts of the grants and identify continued opportunities to foster collaboration through these forums. For information on the “Connect the Dots” forums, please see Appendix W. These forums have proven to be a successful approach, allowing grantees and partners to communicate, identify areas for future collaboration, and discuss sustainability. Even so, the resources required to follow-up and maintain coordination and collaboration above and beyond the work of the individual grants have proven to be a challenge.

11. Real Choice Systems Change Grants, Their Progress, and Barriers.

Massachusetts has been awarded eight Systems Change grants since 2001. The following details the progress and barriers related to each grant. Appendix X contains a chart that provides more detail on the grants awarded to Massachusetts.

- The Real Choice grant (2001) is piloting the Flexible Supports and Services project to test the use of flexible funding to increase participants’ quality of life and independence. Time has been this grant’s most recent barrier as significant time was spent securing sustainable funding prior to enrolling participants.
- The Nursing Home Transition “Bridges to Community” grant (2001) is designed to identify and address service gaps, systemic barriers, and challenges facing individuals with disabilities in transitioning from nursing homes to the community. The grant provided full case management support and transition funds to assist 17 persons to move back to the community from institutions. There were three major service gaps identified as barriers to persons returning to the community: lack of comprehensive and coordinated discharge planning, affordable and accessible housing, and case management. As a result of this grant, the groundwork is being laid for including transition services under the home and community-based waiver.
- The Independence Plus grant (2003) focuses on the systems needed to support a waiver application that ensures an Independence Plus option that builds on the PCA program, the Real Choice pilot, and other self-directed models already in place. Grant funds are also supporting the development of a continuous quality improvement system and a support brokerage system. Transitions among key state agency leaders was an initial barrier to progress, but has since been addressed.
- The Community Personal Assistance Services and Supports (C-PASS) grant (2003) is designed to build state capacity to provide consumer driven personal supports.

Mini-projects and a statewide marketing and outreach strategy will be implemented that will include traditionally underserved and un-served racial/ethnic minorities in systems change. One barrier for this grant is working with consumer and state partners to identify alternate methods to self-direction beyond the Cash and Counseling method being implemented within Independence Plus.

- The Community-Based Treatment Alternatives for Children (CTAC) grant 2003 funds a feasibility study to explore the use of HCBS waivers to provide community-based supports for children with serious emotional disturbances that are currently in and out of home placement. Information has been collected on the range of Psychiatric Residential Treatment Programs across the Commonwealth. Initial contracting problems delayed start-up, but the project is now proceeding on schedule.
- The Mental Health Systems Transformation grant (2004) aims to develop the infrastructure needed to support and sustain effective recovery oriented, consumer-directed mental health services in Massachusetts through the development of a state level, consumer-directed Recovery Center of Excellence Transformation Center. The Center will provide training and technical assistance to consumer operated programs and mental health providers. The primary barriers to implementation are competing priorities and the need to change the mindset of professionals to support consumer-direction and recovery approaches.
- The Quality Assurance and Quality Improvement grant (2004) represents a six state effort to establish a set of quality standards, indicators, measures, and benchmarks for state Mental Retardation/Developmental Disability systems, with a focus on health indicators that will be used to enhance the National Core Indicators. Differences in state systems and definitions have been a barrier that the project is attempting to overcome.
- The Family-to-Family Health Care Information and Education Center grant (2004) is geared to increasing families' knowledge of supports and services, eligibility of services, as well as access to training, leadership, and peer support opportunities to enable their children to be active participants in the community. Limited staffing due to the small size of the grant has been one of the greatest challenges.

12. All Other Pertinent System Reform Grants Awarded: Progress and Barriers

The following is a list of other Massachusetts' systems reforms efforts:

- The Medicaid Infrastructure and Comprehensive Employment Opportunities (MI-CEO) grant (2004) is working to increase the number of people with disabilities who are employed while improving the quality of jobs. This grant builds on the work of the previous 2001 Medicaid Infrastructure grant and is defining employment services outcomes by working with the EOHHS Strategic Task Force on Employment.
- The Aging and Disability Resource Center grant (2003) uses funds to create a "No Wrong Door" coordinated system of information and access for all persons seeking long-term services and supports, regardless of age, disability, or income. One challenge noted in this grant is that ASAPs and ILCs have different approaches even within their own networks. This will make coordinating the efforts among all ASAPs and ILCs challenging when the Commonwealth seeks to implement statewide.
- The Massachusetts Commission for the Deaf and Hard of Hearing and EOHHS completed a three year federally funded Elder Caregiver Resource Center Grant.

This project served as a model to reach elders who are hard of hearing or deaf and their caregivers, and connect each with information, assistance, and resources for living safely and independently.

- Massachusetts received a 2004 grant from the National Governors' Association to support strategic planning related to long-term supports. This grant funded the convening of a stakeholder group to develop consensus on a long-term care vision and goals. The barriers faced by this group are all of the challenges noted above, particularly the difficulty of bridging the differences in philosophy and language related to long-term support issues among diverse stakeholder groups.

13. Other Barriers that Might Delay Systems Change Efforts.

One barrier that may delay systems change efforts is the lack of available direct support workers. Individuals wishing to receive community-based services must often wait for workers to be located before moving to the community. Even though Massachusetts has been an innovator in recruitment strategies, availability of workers continues to be a major challenge. Consumer leaders in collaboration with the Department of Mental Health are preparing a process to develop training and certification of mental health consumers who wish to become service providers. It is believed that individuals who become certified peer support workers through this process will add a new source of direct care workers and that these individuals will have a commitment to, and understanding of, the work that will be unique.

Another barrier is that there continues to be a lack of awareness among hospital medical staff and other providers pertaining to the broad range of community-based services and supports available to elders and people with disabilities. This lack of awareness also exists with consumers and caregivers. Over the past year EOHHS and EOEA have been exploring options for conducting a public awareness campaign to inform consumers, families, and providers about available options.

14. Plans to Overcome Current Barriers to Hiring Readily Available State and Contractual Staff to Work on Systems Transformation Grant.

EOHHS, EA, and UMMS/CHPR have already identified a significant number of personnel, technical assistance, and subcontracting resources available to be implemented once the award is received. Project Management staff have also been identified and will be available October 1, 2005. Additional technical assistance and subcontracting resources will be identified once the Strategic Plan is drafted and goals, objectives, and strategies for transformation are confirmed. We are expecting that the unique partnership between the Commonwealth and UMMS/CHPR, will enable us to readily hire staff to drive systems transformation and this issue will not be a barrier.

15. Increases and Reductions in Medicaid Spending Over the Past Five Years.

The following is a list of Medicaid expansion activities over the past five years:

- In 2002, the HCBS waiver for people with mental retardation/developmental disabilities added the following services to the menu of options: day habilitation supplement (extended state plan), individual and community habilitation, family support and community habilitation, personal agent services, assistive technology,

and transitional services. These services were added to the existing menu of respite care, residential habilitation, supported employment services and transportation.

- In 2002, EOEA implemented the Choices program within the HCBS waiver for frail elders to provide higher rates of reimbursement based on acuity and specific at risk clinical conditions.
- In 2004, the HCBS waiver for frail elders added skilled nursing (extended state plan), home-based wandering services, and transitional assistance to the existing menu of homemaker, home health aide services, respite care, adaptive housing services (environmental adaptations), transportation, chore services, companion services, supportive day program, grocery shopping, laundry, and home delivered meals.
- In 2004, Senior Care Options was implemented to provide a capitated Medicare and Medicaid benefit package for elders to offer innovative long-term services and coordination.
- Effective July 1, 2005, the Commonwealth will expand the HCBS frail elder waiver to elders whose income is up to 300 percent of the SSI standard. Using this expansion strategy, the goal is to offer HCBS waiver services coordinated with the full array of Medicaid state plan services to approximately 1,800 more frail elders in 2005 and 2,100 more frail elders in 2006.

The following is a list of Medicaid reductions over the past five years:

- reduction of some acute care benefits such as eyeglasses and dentures; and
- reduction in orthotics and prosthetics for most individuals. This benefit was later restored, but not to the full complement of benefits it was prior to the cut.

16. State's History and Ability to Implement Components to Scale.

Massachusetts has a solid history of implementation of many initiatives statewide, particularly as they relate to our Medicaid population. A sample of initiatives include:

- expansion for new Medicaid populations through an 1115 research and demonstration waiver in 1996. Approximately 300,000 additional people now receive MassHealth coverage including those members served under CommonHealth, a Massachusetts Buy-In program for working disabled;
- recent statewide implementation of the Comprehensive Service and Screening Model noted in Section 8;
- statewide expansion of financial eligibility criteria for the frail elder HCBS waiver; and
- statewide implementation of Senior Care Organizations in 2004 now serving approximately 1,500 elders.

17. Documentation of Laws and Regulations.

Laws and regulations that have been implemented to further Systems Change efforts include:

- budget language to develop Choices within the HCBS frail elder waiver;
- budget language to expand financial eligibility for the HCBS frail elder waiver;
- regulations to implement the Comprehensive Service and Screening Model;
- regulations to ensure transition support in frail elder and MR/DD HCBS waivers; and
- modified regulations to enhance screening and improve service to the consumers with mental retardation or developmental disabilities in need of long-term supports.

Part Two: Current Level of Transformation

Massachusetts has witnessed achievements within many components of effective transformation. Based on our Readiness Assessment, we are in the "advanced" stage of transformation. Even so, the Commonwealth exhibits some traits of the "mid-range" stage since many of our initiatives are in implementation phase and outcomes have not yet been assessed. The higher of the two phases has been chosen as requested in the solicitation. As such, Massachusetts is in the "advanced" stage based on the following:

The Commonwealth has Made Great Strides in the Transformation to Date

As noted in the Readiness Assessment, the Commonwealth has implemented numerous reform activities in an attempt to off-set the institutional bias present in the traditional system while providing more choice and control for people seeking long-term supports. Transformation activities have taken place to increase access to community-based supports, develop new opportunities for consumer-direction, and create information technology to support transformation efforts. More work is needed to create a comprehensive system of quality management, alternative financing mechanisms for diversion, and flexible and supportive housing options.

The Commonwealth is Implementing Reform across Multiple Agencies

Since the reorganization in 2003, the Commonwealth has formed a system of coordination through the consolidation of state agencies into four separate EOHHS clusters. The reorganization of EOHHS agencies into clusters has allowed state agencies to better plan and implement policy reform across agencies serving diverse populations. All clusters are involved in a systematic strategic planning process to increase consumer choice, control, and independence while ensuring that services provided are cost-effective and high quality. Since the re-organization, EOHHS and EOEA have implemented reform across multiple agencies through the strategic planning process, the National Governors' Association planning grant, multiple systems change grants, and the roll out of the data warehouse. Although the reorganization has increased coordination within the clusters, more work is needed to build bridges across clusters, allowing for systems of support to be seamless regardless of age or disability.

The Commonwealth has been Successful in Planning Reform across Population.

As already noted, the reorganization of EOHHS has allowed for policy makers within each of the agencies to routinely communicate, plan, and implement cross-disability initiatives. Cross-age and cross-disability initiatives already implemented include the Comprehensive Service and Screening Model and the Virtual Gateway portal. Other initiatives currently in design phase include the Aging and Disability Resource Centers and Independence Plus. In addition, EOHHS and EOEA are reviewing methods to meet the needs of diverse disability populations prior to nursing home placement in order to divert or delay placement. Because many reform activities are currently in the planning and implementation phases across multiple populations, outcomes related to reform have yet to be realized.

History of Sustainability
Despite financial limitations that the Commonwealth continues to face, many generous Medicaid and State funded programs have remained intact while new and innovative methods of service delivery have been created and sustained. For example:

- Enhancement of three HCBS waivers serving frail elders, people with traumatic brain injury, and people with mental retardation and other developmental disabilities.
- The Home Care Program, a State-funded program providing community-based support to people 60 years and older, has been in existence for over 30 years and serves approximately 40,000 people.
- EOHHS and EOEA assured sustainability for the Real Choice pilot participants for three years after grant funds are depleted through a multi-agency partnership and pooled funding. The model will be sustained through an 1115 waiver.
- The MassHealth Personal Care Attendant program started as a pilot over 30 years ago and now serves over 9,000 people statewide under the State Plan.
- The Medicaid buy-in program, commonly known as CommonHealth, has been in existence since 1996 and currently serves approximately 12,000.

Innovation
Massachusetts is known for its development of cutting edge service delivery systems. In addition to the innovative models of their time, the PCA Program and the CommonHealth Program, Massachusetts implemented Programs for All-Inclusive Care for the Elderly (PACE) and Senior Care Organizations (SCOs). PACE is an intense medical and social support model that pools Medicare and Medicaid funding for medically complex elders who choose to live in the community. In 1994, the Commonwealth expanded to six PACE programs. More recently, Massachusetts developed the SCO model, a model that integrates Medicare and Medicaid funding in an innovative managed care system. This model allows nurse practitioners to visit people in their homes and has a demonstrated ability to reduce health care costs and provide quality care for people with complex needs.

Massachusetts has Implemented Components of Reform in Multiple Areas
After completing the Readiness Assessment, it is evident that Massachusetts has initiated reform activities across multiple agencies and across disability populations in many of the reform areas identified in the solicitation. For example, stakeholder input mechanisms to seek involvement in policy design reach across disability agencies and populations as evidenced in the many community forums held as well as the numerous integrated subcommittees, coordinating councils, and management teams. Access to services is evident through the many networks available as well as the coordination of these networks through the ADRC grant and the Virtual Gateway. Methods to ensure consumer choice and control are evident in the statewide self-directed Personal Care Attendant Program, the development of an Independence Plus option, and additional self-directed models utilized in the delivery of state funded services. The development of the Virtual Gateway and the data warehouse has allowed for information sharing and streamlining of functions. Transformation within these components has prepared the Commonwealth for success in further transforming long-term supports.

Part Three: Transformation Goals and Outcomes

Goal One (Goal Three in Solicitation): Development of Comprehensive Quality Management Systems

(a) Rationale for choosing this goal

As noted above, Massachusetts provides a rich array of long-term support services funded through the Medicaid State Plan, long-term support programs of solely state funds, and its three HCBS waiver programs. Although community-based supports are widely available from multiple state agencies, these delivery systems are not well-coordinated with one another. Consequently, these agencies lack a coherent vision for how to conduct quality management. Given the disjointed nature of their quality management approaches at the agency and program levels, the existing quality management systems vary in their scope, depth, maturation, and comprehensiveness.

Unmet Need

The HCBS waiver for persons with mental retardation has had a long history of engaging in state and national quality initiatives. However, no comparable effort, up to date, exists to galvanize the state's other waiver programs into a more prospective quality management approach. With the release of the CMS' HCBS waiver guidance and draft application, a new sense of urgency has been created in Massachusetts to enhance its quality management strategies in all its waivers. While CMS emphasis on outcomes will ensure that all waivers within the state satisfy a threshold for quality, the state can and should do more to implement a comprehensive quality management approach. For example, beyond meeting basic assurances, waiver program data must also be available to design system improvements that impact the outcome of services.

The state has not developed quality indicators to comprehensively measure the quality of most long-term support programs or services. For example, within the EOEA, programs such as group adult foster care, protective services, assisted living, PACE, and Senior Care Options, have implemented some degree of quality management. However, the scope and sophistication of the quality management approaches vary widely among these programs. In some programs, quality data is routinely collected, but is not systematically and consistently utilized to foster improvements. Nor has there been Secretariat-level collective action to develop and implement common strategies for measuring quality or collecting data, at the program level, or at the individual level. Systematic processes for routinely measuring quality and using quality data for improving the quality of service delivery are key elements of an effective long-term support system.

Readiness

The re-organization of EOHHS has resulted in a single office having policy and operational oversight of the delivery of long-term support services that are administered by a cluster of agencies. This re-organization further supports our goal for a more effective, overarching quality management approach. Most importantly, it allows for the creation of an accountable entity with functional responsibility for quality management of

long-term supports. This leadership in turn has the potential to adopt standardized measures across waivers, coordinate or consolidate discovery methods, and develop shared quality improvement strategies for common problems. The grant will build on systems already in place whenever possible. Of special note, many consumers of long-term supports have expressed the desire to see the Commonwealth implement more effective strategies for measuring and reporting consumer-driven quality of long-term supports, and seek to participate in the design of such an approach.

Within the Office of Disabilities and Community Services, the Department of Mental Retardation (DMR) represents one agency that has successfully created a comprehensive and effective quality management strategy, particularly for its HCBS waiver for persons with mental retardation. One of DMR's key design strategies was to include consumers in the ongoing quality measurement and improvement process. DMR's experience with effective quality management system design can help guide the design of an approach to quality management for long-term supports that spans agencies, delivery systems and HCBS waiver programs.

Building upon CMS' HCBS framework, the Commonwealth's approach would likely entail working with the Systems Transformation Steering Committee and a sub-committee dedicated to developing and implementing strategies to:

a. Identify quality goals
b. Identify quality standards (existing research in Massachusetts and elsewhere regarding goals and standards for long-term support service measurement will be used)
    - System level (likely a small core set of common goals)
    - Program level (program-specific)
    - Provider level (provider-type-specific)
    - Individual level (defined by the individual)
c. Identify a mechanism for measuring performance against standards (system, program, provider, individual)
d. Delineate an approach for using performance measurement routinely to:
    - Identify opportunities for improvement (system, program, provider, individual)
    - Collaborate with providers and consumers to make improvements
    - Set annual quality improvement goals based on findings (system, program, provider, individual)
    - Re-measure to assess performance against standards and improvement goals to confirm quality improvement (system, program, provider, individual)
e. Present recommendations on the proposed goals, standards, and plans to implement the quality measurement and improvement approach to executive and senior agency staff in the two Secretariats for modification and adoption
f. Oversee of the implementation of the quality management system

The State now has the organizational structure within EOHHS, the will, and the support of consumers to design and implement such an approach, as well as the data collection, analysis, and report dissemination mechanisms that will support it.

Barriers

The long-term support services and HCBS waiver programs administered by EOHHS and EOEA have multiple funding streams, utilize different staffs, and in some cases, target different populations. Historically, opinions of what constitutes "quality" and how best to measure it frequently varies, sometimes dramatically, depending on the population served. The state faces a significant though worthy challenge: To review each quality management approach--across the delivery systems and waiver programs-for measuring and monitoring quality and to design a new and coherent mechanism that can integrate existing approaches, with the ongoing input of consumers.

Defining and tracking measures of consumer-driven quality and designing improvement strategies will be complicated by the competing perspectives on how quality is defined particularly in self-directed services. It will be critical to include individuals receiving services, service providers, and state staff in defining "quality" and selecting quality indicators and quality measurement approaches to ensure that the quality management system captures "quality" from these diverse perspectives. This may create tensions that will need to be addressed, particularly in the selection of quality measures for consumer-directed services. The Steering Committee and quality management sub-committee, along with the designated quality management staff, will facilitate a constructive dialogue to obtain the state, consumers, and providers' perspectives on quality and to reach consensus on the most appropriate quality measures. In the selection of quality indicators, a balance will be sought between individual's preferences and rights to self-determination and the state's concerns for the health and welfare of consumers of its long-term support services. . Lastly, it has long been a challenge for states to find ways to solicit input about quality of services from some consumers, particularly frail elders, who fear that their criticisms could lead to loss of service. It will be necessary to work closely with these consumers and family members to develop new and "safe" space for them to provide honest critiques.

Another challenge once the quality measures and measurement approaches have been determined will entail the collection of data. This may be a particular challenge with respect to the collection of quality measurement information from providers who may not be sophisticated or familiar with reporting information.

Assets

As noted in the Readiness Assessment, the Commonwealth will leverage its expertise in quality measurement and improvement. For example, the DMR expertise in managing their quality system, as noted earlier, will be tapped. The agency has established an approach that links consumer outcomes to quality indicators and specific measures. On a regular and systematic basis, it tracks and reports quality outcomes and uses the quality data to shape quality improvement strategies. DMR has also created the necessary infrastructure to ensure the routine monitoring of providers. Consumers are actively involved in quality councils established around the state, and DMR has a well-developed orientation program to assist them to serve as team members on licensure and certification reviews. The agency has been repeatedly commended by CMS in the past for its effective quality management approach. For information on DMR's quality management system, please see Appendix Y.

As with any program, it has both strengths and weaknesses and not all participants agree on these. However, given that it is one of the most mature quality management approaches in place within the Secretariat, DMR's basic operational approach to quality management will provide a good starting point upon which the state can build the cross-agency, multi-level quality management approach envisioned. It should further be noted that while DMR's quality management operational experiences would be drawn on heavily, the DMR-specific goals and measurement strategies will not be imposed on other agencies.

Several other agencies have implemented some degree of quality measurement and management. The ODCS has already begun to catalog what each agency has implemented with respect to quality management and will build on this collective experience in moving forward. In addition to the activities of the EOEA and EOHHS agencies, the Commonwealth also has the opportunity to build on the knowledge in existence at UMMS/CHPR. UMMS/CHPR has supported the Office of Medicaid in the evaluation of MassHealth services, including the services provided through the 1115 MassHealth Waiver. In addition to UMMS/CHPR's extensive involvement in measuring the quality of existing MassHealth services, UMMS/CHPR also administers the 2003 Independence Plus grant, which includes a review of quality management systems in self-directed services. UMMS/CHPR is also working with an integrated workgroup of consumer and state partners to identify quality components essential for assuring health and welfare under an Independence Plus waiver. This same work group is reviewing methods for evaluating quality from the consumer standpoint. Through the work of this grant, UMMS/CHPR has utilized the CMS HCBS Quality Framework, and the CMS Participant Experience Surveys.

Technical Assistance

To ensure the effectiveness of the strategic planning and implementation of activities under this goal, the grant team will engage consultants with expertise in the development and implementation of quality management systems for long-term supports. Experienced consultants that will be considered include:

- Human Services Research Institute
- University of Maine, Muskie School of Public Service
- Bailit Health Purchasing, LLC
- Consumer Quality Initiatives, a consumer-run mental health participatory research organization

We have enclosed letters of support from these entities in Required Attachment E that also describe their expertise in the quality management area.

Integration with Other Transformation Efforts

As one of the major responsibilities of the Steering Committee, members will continuously work to ensure that efforts within all three goal areas are integrated with one another as well as with other transformation components for which funding is not requested. The quality work described above will drive the quality measurement and evaluation strategies to measure the impact of both the finance and diversion strategies (example: the impact of diversion strategies on individuals' quality of life) as well as the

housing strategies (example: people have choice and control over the type of housing support they receive) as outlined within the remaining sections of this proposal.

In addition to the transformation components highlighted within the goal areas of this proposal, the quality system developed with the assistance of transformation grant funds will be integrated with other transformation efforts such as the creation of a one-stop access and delivery system (example: methods are in place to improve information and access based on input received), self-directed support delivery system (example: individuals are able to define, measure, and evaluate the quality of the services they are directing), and efforts to enhance information technology (example: information is accessible to individuals seeking information regardless of disability).

(b) Preliminary strategies proposed to meet objectives

Objective 1: Develop and implement a comprehensive quality management strategy consistent with the state's transformation of its long-term support system.

We propose to design a comprehensive and integrated approach to ensuring quality of long-term supports delivered by the EOHHS cluster of agencies and EOEA. With this effort we will ensure that the state's HCBS waiver programs and its other long-term support programs will routinely identify quality issues and take actions to address these issues. The design and implementation of this quality system will entail several steps, which may be implemented simultaneously:

1. The first step is to identify the quality management system for each HCBS waiver and non-HCBS waiver program and the components that need improvement.

2. The second step is to assess the quality management implementation in each agency providing long-term supports and any of its waiver and non-HCBS waiver programs.

3. The third step entails identifying a manageable number of quality goals and measures to assess service delivery processes and correlate these process measures with outcome measures for select service delivery elements. Service delivery elements will be selected from the system, program, provider, and individual levels. Rather than attempt to develop new measures and standards, the group will look to the wealth of research that has already been conducted to develop and validate quality measures. This includes a review of nationally noted outcomes, indicators, measures, and methods for collecting, monitoring, and organizing data including web-enabled systems, remediation approaches including positive approaches and sanctions, and quality improvement strategies such as Quality Councils, reports, provider profiles, etc. (The group will use the CMS Framework as the starting point, use the group process to identify core measures across systems (maybe 1-2 per Framework area) and select more detailed measures at the program level).

4. The fourth step entails designing a coherent system of quality management for all long-term support service agencies and programs. This includes a determination of those existing approaches that should remain intact and a way to integrate them into the new, larger system. We are aware that other states, such as Wisconsin, have already begun to develop a quality management strategy that spans services for elders and persons with disabilities in multiple agencies. As part of this step, we will identify states that are farther along than Massachusetts and reach out to them to learn from their experiences.

At the outset of the strategic planning activity related to this goal, the Steering Committee will convene a subcommittee to work on the Strategic Plan and ultimately, the implementation of the initiative. The quality sub-committee will include consumers and other stakeholders and will be charged with ensuring involvement of other consumers and stakeholders not represented on the sub-committee. In implementing the steps outlined above, the following activities will be undertaken:

1. Assess the strengths of the activities that are currently in place within and across agencies and their long-term support programs. This includes:

- Assessing existing discovery systems to detect problems and evaluate their performance using measures; determining consistency and timeliness of data collection; and identifying review processes for analyzing and acting on existing data.
- Reviewing decision-making processes for evaluating findings of discovery methods, priorities-setting and developing quality interventions within and across agencies and with external stakeholders. It is likely that this will be an iterative process. The Steering Committee and related sub-committee might focus on developing quality interventions to ensure that the HCBS quality management systems are affected in the strategic planning portion of the grant period. In addition, the Steering Committee may consider adding a few approaches for measuring and monitoring performance of non-HCBS waiver programs each year of the remaining four grant years. It should be noted that we are aware that just ensuring an effective waiver program quality management approach is a significant undertaking. Focusing on perhaps 3-5 indicators per year regarding non-HCBS programs may be a reasonable goal.
- Identifying all the elements requisite for a quality management system (e.g. defined responsibility and authority, measures, discovery systems, remediation methods, priority setting techniques, and improvement strategies).
- Determining the roles and responsibilities of staff necessary to effectively implement a system-wide quality management approach. This will include a delineation of responsibilities for measuring performance of the HCBS waivers against the CMS measures and a management plan for coordinating quality management across the Secretariat for waiver and non-waiver programs. Infrastructure options to support the overarching quality management aim will be explored. For example, it is likely that the idea of creating a unit within the ODCS cluster for quality measurement and management, with some core functions conducted centrally and others remaining within the respective program areas will be considered. The role of consumers in

different parts of the quality management process will also be clearly defined and a process for ensuring continuous consumer involvement will be developed.

2. Review CMS' HCBS waiver assurances and requirements to determine whether and what evidence is currently collected on level of care, individual plan, performance of qualified providers, health and welfare, administrative accountability and financial accountability across all three of the state's HCBS waivers. With this information, the Steering Committee and related sub-committee will identify areas of weakness in the state's efforts to meet the HCBS waiver assurances and design and implement methods for improving these processes.

3. Develop and implement processes for linking and improving the existing data systems utilized for quality management.

   Standardized systems and adequate staff resources to collect, manage, and analyze data will be necessary to ensure an integrated, comprehensive system of quality management. Data collection standards will be defined to ensure consistent methods allowing for comparability across systems, as applicable. Existing data collection and management systems will be integrated into the larger, cross agency approach. In some cases, this will entail processes by which data may be extracted from one system to be integrated into the data analysis and reporting of all. A data collection and data analysis plan will be developed. It will include direction on the level of analysis associated with the system, program, provider, and individual level measures of quality. A process for report utilization, identification and communicating the issues identified, and the development and implementation of improvements will also be established.

   The systems implemented will have to be prepared to handle data from many different sources including consumer surveys, incident and mortality reports, administrative data, and assessment data. Once the new system is designed and implemented, the Steering Committee will facilitate the creation of an ongoing committee of consumers and stakeholders to provide ongoing input regarding the effectiveness of the new quality management system. The committee will include representation from state agencies providing long-term supports, individuals served, service providers, and other quality experts. This committee will review methods to sustain and continuously improve the system. While it will be the state staff's responsibility to develop and implement quality management tools and processes, the Steering Committee and related sub-committee will provide ongoing feedback about the development and implementation of these processes to help ensure that the state follows through on timely reporting and the implementation of recommended quality improvement initiatives.

4. Implement a process for ensuring ongoing consumer and stakeholder involvement.

   Involvement of stakeholders, including but not limited to consumers of services, family members, and providers, is key to ensuring that quality is defined and measured in a way that is inclusive of all participants in the HCBS waiver and other long-term support programs. Consumer and provider involvement will be ensured through the Steering Committee and sub-committee process. These groups

will also develop mechanisms for engaging and periodically soliciting the input of other consumers and providers who are not represented on these committees. Potential strategies for ongoing inclusion of consumer input once the quality management strategy is implemented may include the development of quality review teams, like the DMR quality councils, which include consumers of services, as well as state survey and certification staff. Enabling consumers to play a central role in monitoring and reporting on the quality of supports will greatly strengthen Massachusetts' approach to quality.

Objective 2: Develop and routinely disseminate quality management reports to key entities and other stakeholders, including but not limited to state and local agencies, participants, families, other interested parties, and the public.

Once the quality measures have been selected, the Steering Committee and related sub-committees will work with regulatory agencies, provider groups, participants, families, the staff of a new quality management unit or function, and other stakeholders to design the layout and content of reports and the plan for dissemination. In determining the report content, the group will first discuss how consumers and providers wish to use reported information. Grant staff will develop prototypes of reports and report formats for testing with representatives of these groups. The format of report(s) will be designed to be understood by diverse audiences and may need to be modified to meet the needs of the different populations and funding sources. Once the report formats are created, they will be piloted. The piloting process will be utilized to ensure the report(s): 1) are accessible and easy to read; 2) provide the desired information and level of specificity.

Grant staff will modify the reports based on feedback. It is likely that some report dissemination will begin to occur by the end of the second grant year. It should be noted that the Department of Mental Retardation (DMR), as part of a CMS grant focusing on the health outcomes of persons with mental retardation in the DMR HCBS waiver, will be piloting provider profiles. The intent is to make provider-specific information public to help individuals and families make service decisions. The results of the pilot will be extremely useful to the Steering Committee for use in the development of additional quality reports, including profiles of other long-term supports provider.

The Steering Committee and Quality Management sub-committee will also develop and implement a process in which regular feedback on the report utility can be provided. Reports will be assessed for 1) timeliness, 2) the extent to which they help consumers make informed decisions about their supports; 3) the extent to which state policy makers use them for strategic planning purposes; and 4) the extent to which providers use them to improve service delivery. Once the overarching quality management infrastructure is implemented, staff charged with report dissemination, will have a process for receiving the feedback and suggestions for report modification and discussing with the Steering Committee to determine whether changes are desirable or necessary.

Objective 3: Periodically evaluate the quality management strategy.

To sustain the comprehensive quality management system, infrastructure will be put in place to evaluate and continuously improve the system. As noted, a Quality Management subcommittee will be established to ensure that the state follows through on commitments to restructure in support of the integration and implementation of the comprehensive quality management system. This committee's activities will be overseen by the Steering Committee. To ensure that committee members are able to participate actively, all participants will be offered training in basic continuous quality improvement theory and practice, and thoroughly briefed on the design of the quality management structure.

At the inception of the Quality Management committee, the Steering Committee members will assist the Quality Management committee with setting goals and timeframes for evaluating the efficacy of the quality management strategy. The committee will also develop processes for assessing the efficacy of the strategy which will most likely focus on the timeliness and effectiveness of the processes implemented. For example, if the Strategic Plan for this goal calls for the creation of a quality management unit within ODCS and an integrated data collection process, the committee will measure whether and how well these plans are achieved.

(c) Grant outcomes

1. By the end of the grant period the state will have in place a comprehensive and effective approach for measuring and reporting program and provider-level quality for its three HCBS waiver programs and will have the foundation for a comprehensive system that will oversee quality management for its other EOHHS and EOEA long-term support programs. Specific measures and indicators will be identified during the strategic planning process. Areas that will be measured, reported, and addressed include the following:
   - Documentation of level of care: the state will assess the processes it has implemented for evaluating and reevaluating level of care need; will identify any problems with the process, such as the consistency of the application of level of care determination criteria among assessment staff (i.e., inter-rater reliability).
   - Assessment of individual plan adequacy: the state will develop an effective mechanism for evaluating whether plans of care are adequate to meet consumers' needs and whether the services prescribed are delivered in a manner satisfactory to consumers, and for developing appropriate interventions to improve the individual plan implementation process when concerns are raised.
   - Adequacy of providers: the state will ensure that it has implemented an effective mechanism for ensuring that HCBS agency providers are qualified, that their performance is evaluated periodically, that information on their performance is provided to them routinely and that the state has a process to work with providers to assist them in improving care delivery.
   - Health and welfare of HCBS waiver participants: the state is currently implementing an approach for ensuring effective measurement of the health and welfare of waiver participants within its DMR waiver. The DMR approach will be

explored for applicability for use with the state's other two HCBS waiver populations. The quality management staff will ensure that data on waiver participants' health and welfare will be adequately captured in any future approach.
- Designated quality management staff will also assume the responsibility for:
  1. assessing the state waiver administration based on its approved Medicaid waiver application,
  2. working closely with the state's Office of Medicaid staff to ensure that a system for ensuring financial accountability of the waiver programs is established, and
  3. assessing and documenting that the state meets the Medicaid HCBS waiver assurances.

Areas that will comprise the comprehensive quality management system for the non-HCBS waiver programs will be selected and agreed upon as described above, by the Steering Committee and the related sub-committee.

2. As noted, one of the outcomes of the implementation of strategies will be the development and routine dissemination of quality management reports to program staff, consumers, providers, and other stakeholders. The initial reports will be tested and modified, as necessary, before dissemination. The state will implement a process for periodically evaluating with all report recipients the usefulness and accessibility of the reports and will develop improvements pursuant to suggestions for change.

3. Also noted earlier, the state will identify staff responsible for the oversight of the implementation of the quality management infrastructure changes described in this grant application. These staff, along with the Steering Committee and Quality sub-committee, will be responsible for developing and implementing a process for evaluating the extent to which the new quality management infrastructure is effective. It is likely at a minimum, two assessments will occur: 1) an annual progress report on the infrastructure implementation and 2) an assessment of the level of cross-agency integration and coordination in quality management activities. The latter assessment will most likely entail surveys of agency staff and participating long-term support providers. The strategic planning process will identify the timeframe and key entities for the evaluation.

(d) Defining key stakeholders

As noted in the Readiness Assessment and Strategic Planning sections of this document, this transformation opportunity will be driven by a Steering Committee of state and consumer partners. During the strategic planning process, the Steering Committee will ensure that the workgroup responsible for reviewing this goal includes a diverse group of stakeholders, such as consumers with various disabilities, state agency representatives from the various agencies providing long-term supports, state quality representatives, individuals implementing current quality initiatives (such as DMR quality representatives, CMS quality grant staff, and non-profits specializing in quality),

entities that will be impacted by change in policy, other disability specific community-based organizations, legislators, and other stakeholders to be named during the strategic planning process. In addition to implementing a work group to initiate this goal, stakeholder input on this goal will be requested during two Community Forums hosted during the strategic planning phase.

Goal Two (Goal Five in Solicitation): Diversion and Alternative Financing Mechanisms

(a) Rationale for choosing this goal

Although Massachusetts has a broad availability of long-term supports in facility and community settings, public funding for long-term support services is tied to settings and provider groups rather than to the needs and preferences of individuals seeking long-term support services. Furthermore, different Medicaid financial eligibility rules exist for institutional versus community-based services, with eligibility rules favoring access to institutional placement over community-based long-term supports. Consequently, nursing facilities have residents who may prefer to live in the community and may be supported in the community.

Unmet Need

The Commonwealth has had minimal opportunity to date to explore the use of alternative funding mechanisms as tools to strengthen nursing facility diversion and transition efforts. Successful transformation of long-term supports must include the creation of alternate financing mechanisms to allow funds to support individuals in the setting of their choice. In addition, sufficient resources must be devoted to assist individuals to avoid, delay, or transition from an institutional setting. Thus, it is essential that EOHHS and EOEA work with state partners, consumer partners, and other stakeholders to identify and implement new payment mechanisms to promote institutional diversions and transitions into the community. Successful innovation will allow for long-term support funds to be expended in the least restrictive setting of the person's choice.

As noted in the Readiness Assessment, Massachusetts has developed and implemented a number diversion and transition strategies over the past few years to identify persons seeking or needing institutional care, to inform them of their options, and to assist them in accessing community-based alternatives. These approaches, addressed in the Readiness Assessment within Section 8, have helped many people avoid or leave institutional settings. Despite diversion and transition activities in place within the Commonwealth, many people who could live in the community with supports are instead institutionalized. Many are unaware of their community-based options, do not have access to community-based supports, and/or do not have support to avoid or transition from an institution. This is because many of the current strategies target specific geographic locations and/or disability populations. In addition, minimal funding is available to provide the intense support required by many to transition back home. Furthermore, the strategies are being implemented by different state agencies with little coordination among them.

Because of the reasons mentioned above, it is essential that EOHHS, EOEA, state partners, consumer partners, and other stakeholders review current diversion and transition strategies and identify ways to coordinate and improve them. Furthermore, the state will need to augment these diversion and transition strategies with innovative new funding mechanisms that will enhance the effectiveness of such diversion and transition programs.

Readiness

The Commonwealth is ready to develop a system that more effectively allocates the funding resources for long-term supports. The reorganization of EOHHS and the new "Community First" policy present the state with a heightened opportunity for the Partnership to identify and/or create new financing options for more elders and persons with disabilities to receive public funding for community-based long-term supports. Such funding options include moving funds from facility-based support to community-based support and making Medicaid-covered community-based waiver services available to more persons—persons who might otherwise enter a nursing facility.

Representatives from the multiple state agencies within EOHHS and EOEA providing long-term supports to elders and people with disabilities recognize the need to redistribute long-term support funding across settings and to allow for increased consumer control and choice in services and support. These state agency staff also note the need for implementing a mechanism for cross-agency coordination for the purposes of 1) creating innovative funding models that will promote access to long-term supports in the community, and 2) building on and linking current diversion and transition strategies to ensure a coherent and well-integrated approach for identifying and assisting persons to remain in or transition back into a community setting, regardless of their age or disability. We intend to accomplish this systems transformation by focusing on two objectives as described below.

Barriers

The Commonwealth's barriers to using alternate financing mechanisms to promote diversion and transition include:

- Funding is tied to settings and providers rather than individuals;
- Medicaid eligibility guidelines are more rigid/stringent for community support than institutional support;
- Availability of supports to divert and/or transition individuals from nursing facilities differs by geographic locations and disability populations; and
- Policy makers continue to have concerns of a potentially costly "woodwork effect" (i.e., that the expenditures on the community-based services will far outstrip what would have been expended on institutional care if no changes were made to funding mechanisms. Therefore, it may be necessary to implement this part of the strategy gradually to enable careful monitoring of utilization and to ensure that an effective formula and methodology that protect against the "woodwork effect" are created and implemented.

Assets

EOHHS and EOEA will build on many current assets. For example, EOHHS and EOEA will access and analyze current state-agency data of the individuals they serve and the cost of current services in order to fulfill this charge. In particular, EOHHS and EOEA can analyze and utilize information from at least three data sources: 1) flexible financing approaches currently used by the DMR home and community-based waiver program, 2) the information already gathered and analyzed in its Independence Plus and Real Choice grant programs, and 3) the state's "data warehouse". Staff at

UMMS/CHPR will assist in identifying and analyzing costs related to alternate financing mechanisms and diversion and transition strategies. Furthermore, the implementation of the state's new, centralized, web-based intake and eligibility system will further link several regional entities. These entities will also be integrated—through future grant activities-- in their outreach, information and referral, and case management for persons with long-term support needs.

Last, the state has a rich resource of matched Medicaid and Medicare claims and access to extensive reports. The UMMS/CHPR can use this dataset to project costs under different scenarios. For example, costs can be projected to verify waiver program budget neutrality or to estimate the impact of increased access to community-based supports on the need for institutional care. EOHHS and EOEA will also call upon technical assistance partners to assist in reviewing Massachusetts barriers to alternate financing as well as potential solutions.

Technical Assistance

To ensure the effectiveness of the strategic planning and implementation of activities under this goal, the grant team will engage consultants with expertise in guiding state development and implementation of alternative financing mechanisms for long-term supports. Experienced consultants that will be considered include Bailit Health Purchasing, LLC and Community Living Technical Assistance Exchange at the Center for State Health Policy, Rutgers University. We have enclosed letters of support in Required Attachment E from these entities that also describe their expertise in the finance and diversion area.

Integration with Other Transformation Efforts

As noted in the previous goal section, one of the major responsibilities of the Steering Committee will be to continuously work to ensure that efforts within all three goal areas are integrated with one another as well as with other transformation components for which funding is not requested. Finance and diversion efforts will be integrated with the quality system developed through the previous goal. For example, quality indicators related to the impact of individual budgeting and diversion strategies will be developed, implemented, and evaluated across long-term support systems. Also, housing activities outlined in the next goal section will be directly funded through mechanisms identified through the work of this goal.

In addition to the transformation components highlighted within the goal areas of this proposal, the finance and diversion strategies developed with the assistance of transformation grant funds will be integrated with other transformation efforts already in progress such as the development of a one-stop access and delivery system (example: diversion strategies will include the utilization of one-stops), self-directed support delivery system (example: many people who choose to transition into the community may choose to direct their own services), and information technology (example: the data warehouse will be used to design individual budgets and the virtual gateway will be the web-based portal for one-stops).

(b) Preliminary strategies proposed to meet objectives

Objective 1 (Objective 2 in Solicitation): Develop and Implement More Effective Payment Methodologies to Promote Institutional Diversion and Transitions into the Community.

In order to effectively implement EOHHS and EOEA's "Community First" policy, it is essential to identify strategies for making public funding for community-based services available to persons prior to their receiving supports in an institution. Over the five grant years, Massachusetts seeks to explore, develop, and implement alternative financing mechanisms that will promote diversion and transition activities. Strategies to meet this objective will be finalized during the strategic planning process involving state partners, consumers, advocates, legislators, and other stakeholders. A sample of activities EOHHS and EOEA will undertake to address this goal may include:

1. Understanding the Target Population.

   A. Analysis of demographics of individuals currently served in institutions.

   B. Identification of key predictors of institutionalization.

2. Understanding Barriers to Financing and Potential Solutions.

   A. Review of Medicaid law and state regulations to identify barriers to transferring Medicaid funding and potentially other funding sources from institutional settings to community settings or to individuals.

   B. Review of Medicaid law and state regulations to identify barriers to community funding for people in institutional settings that Medicaid does not support, particularly for individuals with mental health conditions served in Institutions for Mental Diseases (IMDs).

   C. Review of institutional settings currently utilized within the Commonwealth and their sources of funding.

   D. Review of best practices in other states related to pooling of funding and methods to allow funds to follow an individual from one setting to the next. States to be reviewed may include:

   - Washington and Oregon, which have for years implemented a single long-term care budget that permits the seamless allocation of funds between institutional and community settings, based upon consumer needs.
   - Vermont's use of Act 160 permits the state to reallocate any savings from nursing facility spending that was less than the projected eight percent annual increase to community services.
   - Wisconsin's method to reallocate institutional funds to the community by using a variation on the "cold-bed" rule and funding new HCBS waiver slots for

individuals who move into the community from a nursing home that is downsizing or closing.

- Texas' legislation allowing money to be transferred into the community when an individual leaves an institution.

E. Examination of innovative approaches other states have developed to finance diversion and transition of people with significant mental health disabilities and often more complicated transition needs.

3. Identifying and Implementing Innovative Approaches to Financing.

A. Identify mechanisms for converting Medicaid institutional funding into community-based service funding and explain the statutory authority necessary to do so. Strategies to be applied may include:
    - Developing a method to convert the cost of an institutional stay into an available pool of funds for community-based supports. In the development of such a method, a variety of questions will need to be answered, including:
        - How will utilization of institutional funds be linked to utilization of community-based long-term supports to ensure rebalancing?
        - How would the re-allocation of funds work in instances with more than one funding stream?

- Attaching funding for long-term supports to an individual's need rather than to specific providers. Questions that will need to be answered will include:
    - How will the cost of an institutional stay be converted to an appropriate amount available for community-based long-term supports?
    - How often would re-determination of eligibility and a person's community supports allocation amount be conducted?
    - How will the state ensure funds are spent in a fiscally responsible manner and budgeted over time instead of being expended all at once?
    - Who will manage the funds? How will this be coordinated with the Independence Plus grant currently being used to develop self-directed flexible supports and services utilizing a Cash and Counseling model?
    - How would emergency institutional stays be funded?
- Developing a method to pool funding for long-term supports across settings. This might be accomplished through an HCBS or Research and Demonstration waiver, as DMR's individual supports services are authorized.
- Exploring the use of institutional funds to make access to Medicaid-covered personal assistance services timelier in order to avoid institutional placement or allow for quicker transition.

B. Educate policy makers and legislators on alternative models for financing and diversion strategies.

- Create fact sheets and/or other forms of reports to share information, reasons for creating alternative financing models, current barriers, and potential solutions.
- Hold educational forums on alternative financing models, current barriers, and potential solutions.

C. Develop a plan to implement innovative financing strategies and to design new waivers or waiver amendments, as necessary, and evaluate progress.

Objective 2 (Objective 3 in Solicitation): Target high cost individuals and services to more effectively manage delivery of long-term supports to promote their option of community living.

Massachusetts has implemented several mechanisms for identifying persons seeking nursing facility or other institutional placement to assist them to understand their community-based alternatives and how to access them. As noted, at present, these programs and activities are not well coordinated with one another. In order to most effectively implement new financing options to promote community-based services, we believe it is critical to better align and improve these programs and activities to maximize the number of persons receiving of information and assistance to access community supports.

Therefore, we propose to use a portion of the grant funds allocated to this goal to improve the infrastructure, integration and scope of the state's multiple diversion and transition activities over the next five years. Strategies to meet this objective will be finalized during the strategic planning process involving state partners, consumers, advocates, legislators, and other stakeholders. A sample of activities EOHHS and EOEA will undertake to address this goal may include:

1. Present a snapshot of promising practices in screening, diversion, and transition across disability populations within the Commonwealth as well as in other states.

   A. Review current screening, diversion, and transition strategies within the Commonwealth.

      As noted in the Readiness Assessment Section 8, multiple screening, diversion, and transition activities are already implemented in the Commonwealth. Examples include the Pre-Admission Screening and Resident Review Process (PASRR), the Comprehensive Service and Screening Model (CSSM), Independent Living Center transition activities, development of Aging and Disability Resource Centers, Massachusetts Rehabilitation Commission's supportive living model, Department of Mental Health's recovery center model and Department of Mental Retardation's Individual and Family Supports model. UMMS/CHPR is currently conducting a study of these activities to assist EOHHS and EOEA to identify opportunities to build upon or improve these initiatives.

   B. Review methods used in other states to screen and divert individuals from institutional settings for system-wide application. A few examples may include:

   - Maine requires pre-admission screening and periodic reassessment for all nursing home residents, regardless of the source of payment. The state hires a private contractor that utilizes nurses equipped with laptops to conduct face-to-face interviews to make the clinical assessments. In 2002, this contractor assessed 15,849 individuals at an average cost of $157.59 per assessment.

- Oregon requires preadmission screening for individuals, including private pay patients, who seek Medicaid-funded nursing facility services and "those whose financial status would appear to make them eligible for Medicaid within 90 days of nursing home admission." These screenings are performed by case managers from Oregon's "single entry points," which are usually Area Agencies on Aging. These case managers use laptops loaded with Oregon's Client Assessment and Planning System (CA/PS) system software and assign the individual to their respective place within Oregon's seventeen level priority system. Although they receive a less detailed assessment by a hospital (private pay patients) or state contractor, private pay patients are required to receive an assessment, unlike Massachusetts.
- In Washington, state-employed case managers must contact and assess new Medicaid nursing home residents within 7 days of admission. In addition to new Medicaid residents, case managers can also work with individuals who are likely to become Medicaid eligible within 180 days and long-term Medicaid residents. Each of Washington's six regions has nursing home caseload reduction targets with monthly statistics tracking caseload trends.

C. Identify other states with innovative models to support individuals with mental health conditions served in institutional settings.

2. Identify Populations to be targeted for transition or diversion.

A. Identify scenarios that cause people to enter or remain in a nursing facility and identify current diversion and transition activities to address such scenarios.

B. Identify persons who are currently targeted by the state's diversion and transition initiatives and those who could benefit from community-based supports but are not currently served by the above initiatives. Examples include:

- Those who are initially paying privately or through a Medicare benefit for institutional care. The state is not routinely informed of such admissions and therefore most of the state's programs that provide outreach to Medicaid recipients in institutional settings do not target these individuals.
- Those who are residing in nursing facilities for an extensive period and who may wish to return to the community. These individuals may not know the available community resources to assist them to transition back into the community or how to access these services.

C. Identify new populations to target for diversion or transition.

The Partnership would likely focus on developing or expanding the existing models to target underserved groups through enhanced outreach or case management. These populations include persons:

- with chronic care needs and with a high or potentially high likelihood of entering a nursing facility. These individuals may not currently require an institutional level of care, and therefore don't qualify for certain Medicaid-covered long-term supports;
- in chronic rehabilitation hospitals on administratively necessary days;

- living at home with aging parents; and
- residing in institutional settings because of a lack of community-based supports to address unmet needs related to significant mental health disabilities.

3. Identify and implement strategies that support the successful transition of individuals from institutional to community settings.

   Samples of potential strategies include:

   A. Utilize the nursing home Minimum Data Set (MDS) data to identify those who are interested in transition. At present, the state has access to data on residents who wish to return to the community. The state does not currently have the infrastructure to analyze and utilize this information to target persons and to help them transition back to community settings. Massachusetts proposes to use this data to target these persons who could reside in alternate settings. Outreach to such persons could be conducted through regional collaborations between Aging Services Access Points, Independent Living Centers and other community-based organizations that are familiar with the needs of various populations. The Commonwealth would need to develop the process within the state agency structure where the collection and analysis of the MDS data would occur.

   B. Seek other ways to identify populations that could benefit from diversion assistance. For example, several states have legislation that requires hospitals to notify the state of any person being discharged to a nursing facility. Such an obligation could also be imposed through a state's hospital licensure regulations. The Steering Committee would explore the mechanics and relative merits of these sorts of requirements, such as to whom hospitals might report and how the information would be used by the entities conducting diversion activities.

   C. Evaluate the potential for strengthening the role of PASRR in assisting individuals with mental health disabilities to remain in or transition to community-based settings.

   D. Explore potential of developing a Medicaid 1115 waiver that would allow for alternative uses of institutional funds as well as some options for how certain targeted populations might be given the option to access Medicaid-covered long-term support services. For instance, Medicaid-covered community-based services could be made available to certain persons not currently receiving Medicaid-covered services but who are at imminent risk of institutional care based on their clinical and financial profile.

   E. Design a system to screen every nursing home admission regardless of income and disability to ensure every individual is aware of community-based options.

   F. Examine how currently successful models of support, such as the Department of Mental Retardation's Individual and Family Supports, Massachusetts Rehabilitation Commission's Supportive Living Program, and targeted case

management strategies, etc. can assist individuals to avoid an institutional placement or to transition from an institutional setting.

G. Identify how best to integrate and expand the existing activities statewide while building on the capacity of consumer-driven community-based organizations such as Independent Living Centers, newly formed Mental Health Recovery centers, and provider networks such as Aging Services Access Points.

H. Create cultural, linguistic, and disability competency standards for providers performing screening, diversion, and transition activities to ensure providers can truly “reach” those whom they are serving or might serve. This includes coverage for American Sign Language interpreters and Communication Access Real-time Translation Services for individuals who are deaf or hard of hearing.

I. Work with the Massachusetts Medical Society and hospital medical directors to identify methods to inform medical professionals with referral responsibilities about the community-based providers and options available to assist persons in need of long-term supports. Medical professionals themselves, particularly physicians, who lack knowledge of community-based options, are frequently contributing to consumers’ lack of awareness of these options and therefore steer their patients toward institutional settings.

J. Identify methods to implement case management and other coordination strategies to support individuals to successfully transition to or divert from nursing facilities or other institutions.

K. Assess the best mechanism within the EOHHS/EOEA infrastructure for overseeing and coordinating future diversion activities at the regional or local level.

<u>(c) Grant outcomes</u>

At the conclusion of the grant period and attainment of this goal, state and consumer partners will be reviewing the results of implementing innovative methods for converting institutional funding into community support funding, after reviewing barriers, identifying promising models in other states, and educating policy leaders and legislators. By the end of the five year grant, we anticipate the development of the following:

- Transparent, reliable, and valid approach to converting institutional funds to community-based services funds for individuals interested in moving from an institutional to community setting;
- Systematic process for targeting individuals who might be eligible for such a financing approach;
- Systematic and integrated approach to ensuring that people in institutions and acute settings, particularly those with chronic care needs and high service utilization and

their families, and the medical professionals who work with them, are aware of community-based long-term supports and alternatives to institutional care;
- Systematic and integrated approach to identifying, screening, and supporting individuals who want to transition from an institutional setting to the community; and
- Process for making individuals in the community aware of their community-based alternatives and how to access them at critical junctures. These individuals will include individuals who are elderly or persons with disabilities without Medicaid but who are likely to qualify for Medicaid shortly after entering a nursing facility.

Success will be measured through the identification of baseline and subsequent benchmarks. We also plan to identify how the Medicaid budget is impacted by the implementation of the identified strategies. A few indicators will include:
- Proportional increase in Medicaid spending on community-based long-term supports compared to spending on institutional services (overall as well as population specific);
- Rate of Medicaid long-term support spending compared to national average;
- Number of institutional beds and Medicaid waiver slots; and
- Number of persons funded through Medicaid waiver slots.

(d) Defining key stakeholders

As noted in the Readiness Assessment and Strategic Planning sections of this document, this transformation opportunity will be driven by a Steering Committee of state and consumer partners. During the strategic planning process, the Steering Committee will ensure that the workgroup responsible for reviewing this goal and recommending an action plan includes a diverse group of stakeholders, including consumers with various disabilities, state agency representatives from the various agencies providing long-term supports, state finance representatives, individuals implementing current screening, diversion, and transition strategies (such as Aging Service Access Points, and Independent Living Centers), entities that will be impacted by change in policy (such as nursing facilities, acute hospital discharge planners, and home care and home health agencies), other disability specific community-based organizations (such as multi-service head injury centers), legislators, and other stakeholders to be named during the strategic planning process. In addition to implementing a work group to initiate this goal, stakeholder input on this goal will be requested during two Community Forums hosted during the strategic planning phase.

Goal Three (Goal Six in the Solicitation): Long-term Supports Coordinated with Affordable and Accessible Housing.

(a) Rationale for choosing this goal

To ensure effective transformation of long-term supports, it is essential that the Commonwealth address the serious deficit in housing options for elders and people with disabilities. Like most states, Massachusetts has an insufficient stock of affordable and accessible housing. The lack of housing is exacerbated for elders and persons with disabilities in Massachusetts who often need residential modifications or supports in order to live in their community. "Accessibility" reaches beyond physical barriers to include additional supports and services that enable individuals to live healthier lives in the community and prevent or delay institutional placements, unnecessary emergency room visits, and acute care hospitalizations. The need for accessible and affordable housing reaches across the diverse populations of people with disabilities, including people who are elderly, have physical disabilities, have cognitive disabilities, and have significant psychiatric disabilities. Housing is not one size fits all. Some individuals have existing homes that need to be modified in order to accommodate reduced mobility; some reside in institutions and are not able to transition because of the lack of affordable and accessible housing options in the community; and others are homeless due to limited housing options and services to meet their needs in the community.

A variety of models exist in which housing and services are bundled or provided separately, and consumer preferences for these models vary. A significant number of individuals who need housing would prefer that services are "unbundled" from the housing in order to obtain individualized long-term support services, such as consumer control over the time and manner in which the service is delivered. It is essential that a flexible and integrated housing stock with multiple housing options is created to ensure consumer choice and control in community living. As referenced in the Readiness Assessment, Section 9, most state agencies providing long-term support to elders and people with disabilities have collaborated with the Department of Housing and Community Development, provider groups, and local agencies to develop and implement strategies to increase the capacity of housing support for people they serve. Nevertheless, state agencies and consumer partners continue to identify the need for housing as a top priority to assist people to transition back to, or remain living within their own communities.

Unmet Need

Through housing assessments and reports identified in the Readiness Assessment Section 9, EOHHS and EOEA have identified multiple unmet needs that intensify the lack of access and availability of effective housing options. The Commonwealth will include the following strategies to address these unmet needs:

- Program designs that are flexible and responsive to the changing needs of individuals;
- Increased housing capacity by redesigning current unit configurations, building in concepts of universal design or visitability in new housing developments, and adding community spaces to existing housing stock;

- Coordination across multiple agencies to solidify new partnerships between housing and service providers, and to provide training and technical assistance as needed;
- Efforts to integrate the current initiatives with future activities, including tenancy preservation designed to eliminate homelessness for individuals with disabilities;
- Comprehensive assessment and planning to assist individuals to identify and address housing needs;
- Consumer education and information on home modification resources and available housing options, including physical accessibility, the quality of the building and setting, availability of public transportation, proximity to supports and stores, availability of onsite supports, etc.; and
- Increased home ownership among persons with disabilities.

Readiness

With the adoption of its Community First policy, the state has already begun to focus on linking housing, health care, and supportive services--recognizing this collaboration to be an important component to allow many individuals to remain in or return to the community. The recent Massachusetts Rehabilitation Commission housing survey has confirmed the need for a diverse range of housing options. All key human services agencies have identified enhanced coordination, and increased access to housing and services as strategic priorities, and under the Governor's leadership there is a strong commitment to move forward.

Barriers

Multiple barriers to affordable and accessible housing have already been identified by state and consumer partners through review of current programs and surveys as outlined in the Readiness Assessment, Section 9. Barriers fall into the following categories:

- Multiple, uncoordinated funding sources for the development of housing options leads to a very complicated financing process.
- Housing and long-term support services each have their own set of program, regulatory, and eligibility requirements. Because there are different requirements, people cannot rely on obtaining community-based long-term supports when or if they are able to obtain housing. For example, a person's income may be low enough to qualify for public housing, but not low enough to qualify for Medicaid coverage of community-based services.
- There is a lack of data on individuals served in existing housing bundled with services and the service needs of these individuals. Without this information, it is difficult to project what levels of reimbursement are appropriate for providers of housing with supports nor can we project what oversight regulations are necessary to adequately protect consumers in these settings.

EOHHS and EOEA will work with state and community partners during the strategic planning process to continue to identify barriers to providing affordable and accessible housing options to elders and people with disabilities.

Assets

The Commonwealth has many assets within the partnerships among the various state agencies to address this issue. State assets that will lead to successful systems change through this goal include an informed group of stakeholders from the consumer, provider, advocacy and policy networks already established through previous initiatives and community-based service access points such as Aging Service Access Points and Independent Living Centers. Other resources include experienced real estate developers in the for-profit and non-profit sectors, financing programs for capital costs, a large and varied portfolio of existing housing options, experienced service providers, and Medicaid home and community-based waivers and state plan services which complement the Personal Care Attendant program and a large state home care program. Building on the partnerships and assets already in place, and with the support of EOHHS and EOEA's Community First policy, the Commonwealth is ready and committed to creating accessible and affordable housing options to allow people to transition to or remain in their own communities.

Technical Assistance

Massachusetts has a great deal of in-state expertise on housing issues as well as out-of-state housing colleagues. The Citizens' Housing and Planning Association (CHAPA) is a statewide non-profit organization that represents all interests in the housing field including developers, homeowners, tenants, government officials and others. They recently released "Affordable Housing Guidebook for Legislators" that identifies the needs in Massachusetts and current state and federal programs. We expect to partner with CHAPA in the strategic planning process and the implementation of the grant.

The Center for Housing and New Economics (CHANCE), based at the Institute on Disability at the University of New Hampshire, and a partner with the ILRU Technical Assistance Center, will also be a source of technical assistance on options that enable consumers to purchase or rent their own homes. Jay Klein, the Director, and Cathy Ludlum, a consumer with extensive experience on housing issues, have been partners in other activities, and will offer important expertise as Massachusetts moves forward. We have enclosed letters of support in Required Attachment E from these entities that also describe their expertise in the housing area.

Integration with Other Transformation Efforts

As noted in previous goal sections, the Steering Committee will continuously work to ensure efforts within all three goal areas are integrated with one another as well as with other transformation component for which funding is not requested. In order to evaluate the effectiveness of the implementation of the identified housing strategies, quality measurements will need to be developed. In particular, developing quality indicators and measurements for housing with services programs, i.e. supportive housing, can be coordinated through the strategies developed in the quality goal section. In addition, finance and diversion strategies are closely tied to housing since diversion will only be successful with the availability of housing. The financing of housing with supports may be funded by sources previously funding institutional support. Also, if a waiver is developed to increase the number of people transferring

institutional funds to the community, housing capacity will need to be increased to support individuals as they transition into the community.

In addition to the transformation components highlighted within the goal areas of this proposal, the housing strategies developed with the assistance of transformation grant funds will be integrated with other transformation efforts already in progress such as development of a one-stop access and delivery system (example: information on new housing options will be incorporated into available information), self-directed support delivery system (example: enhanced housing options will be available regardless of whether or not someone chooses to direct their services), and information technology (example: availability of accessible and affordable housing will be documented and tracked on the virtual gateway).

(b) Preliminary strategies proposed to meet objectives

EOHHS and EOEA will pursue an integrated housing system that allows for multiple options for housing and supports to meet the needs of individuals with diverse disabilities. We propose to use grant funds to 1) improve the coordination of long-term supports with affordable housing across the state agencies that develop and manage housing and support programs, and 2) develop and implement strategies to ensure that there is increased awareness of, and access to, affordable and accessible housing with long-term supports. Grant funds will provide an important infusion of funds and resources to bolster the state's efforts at expansion and coordination of these activities, and guide the creation of new innovations to provide more community-based housing options.

Objective 1 (Objective 2 in Solicitation): Improve the Coordination of Long-Term Supports within Affordable Housing.

The purpose of this objective will be to develop a system to provide the needed long-term support services to individuals residing in affordable housing in a reliable, cost-effective, person-driven, and timely manner. Housing providers, while having expertise in property management, do not have the knowledge to successfully coordinate long-term supportive services for individuals. Building partnerships between housing and service providers can improve access and utilization of community resources and strengthen the local infrastructure needed to support service delivery. Strategies to meet this objective will be further refined during the strategic planning process. Potential strategies include:

A. Build on existing accomplishments in housing to develop a comprehensive system of support while coordinating housing strategies across funding sources and populations. Examples include:

- Establish an agreement between the Department of Housing and Community Development, EOHHS, and EOEA to address the need to create and preserve affordable and accessible housing stock and to provide supportive services in a variety of settings. This agreement and related activities would then be noted in the strategic plans of the respective agencies.

- Develop agreements for coordination between Public Housing Authorities and units within state agencies and their programs that support transition, diversion, housing development, and supportive living.
- Require substantiated partnerships between local housing and service providers as a requirement in state-issued procurements for service contracts.
- Identify "cutting edge" practices for increasing housing options within Massachusetts and other states and share information with partners.
- Provide technical assistance in planning and designing supportive housing in naturally occurring retirement communities to maximize access to community supports.
- Expand tenancy preservation programs in state housing courts, based on a very successful model tested in Springfield, MA to help prevent evictions of persons with disabilities and low incomes.
- Explore creative methods for linking financial eligibility for services with eligibility for housing supports to enable individuals in publicly-funded housing to qualify for supports when needed.
- Create a system to ensure coordination across housing initiatives that includes collection and analysis of housing data.
- Ensure housing models address specific linguistic and cultural needs of persons of various disabilities.

B. Create a designated housing support function at Aging Service Access Points and Independent Living Centers that is coordinated at the state level and spans EOHHS agencies and EOEA. This strategy would include:

- Providing training and support for service coordinators in the various state agencies and contracted providers in housing options, service planning, tenancy preservation, and other best practices related housing and supports.
- Providing technical assistance and resources to community-based service providers to establish service coordinators in affordable and accessible housing and to collaborate with real estate developers to produce more effective housing models.
- Ensuring coordination with other community-based organizations providing information and supporting the needs of diverse disability populations, such as Aging Disability Resource Centers and Mental Health Recovery Learning Centers, local housing specialists, etc.
- Piloting a model that employs trained housing specialists to work with skills trainers and consumers at one or more Independent Living Centers while ensuring coordination with other community-based organizations supporting people with disabilities.

C. Ensure that the individual service planning process includes assisting individuals with the identification of any unmet needs related to housing and long-term supports and developing a plan for finding the requisite housing and supports. Potential strategies include:

- Developing and piloting a housing needs assessment module that can be added to assessment tools already in use by community organizations and providers assisting individuals to avoid admission to or transition from institutional settings.

- Developing and piloting a housing needs and preferences tool for use by the 11 Independent Living Centers), Mental Health Recovery Learning Centers, and other community-based organizations to be identified.

Objective 2 (Objective 3 in Solicitation): Increase Access to Affordable Housing with Long-term Supports.

We envision two key strategies to meeting this objective. The first focuses on increasing awareness of available affordable housing and housing with supports options. The second focuses on the accessibility of affordable housing. It will entail the creation of a mechanism to increase both the supply of housing that is accessible and/or can be reconfigured to meet individual needs, and access to financing assistance to aid in the rental or purchase of housing. Approaches to implementing these strategies are described below.

A. Expand and improve of Mass Access, the Commonwealth's housing registry. Consumers have expressed concern that Mass Access lacks the capability of newer online resources, and there is a desire for Mass Access to be improved, expanded, and better coordinated with the state's system of long-term supports. For example, currently, Mass Access provides a list of available units but housing seekers or their advocates must call the housing development or Housing Authority to get the application for the unit. With grant funds, other similar access barriers related to Mass Access can be identified and possible solutions or innovations can be identified. Examples include:

- Identify and implement strategies to enable Mass Access to become a web-based single point of entry for housing for elders and people with disabilities. Potential methods include allowing applications to be downloaded or completed online, allowing applications to be tracked online, creating methods to inform individuals of openings (such as Section 8), etc.
- Provide information about available housing with on-site services in Mass Access.
- Identify and implement methods for Mass Access to be coordinated with other registry-type systems. For example, a database is currently being developed to track units targeted to homeless persons. It is envisioned that the Mass Access registry could be linked with this or any other similar type registry that might be developed to ensure that users of Mass Access are made aware of all housing options for elders or persons with disabilities.
- Identify methods for using Mass Access to ensure that accessible units or units with particular features are matched with, and occupied by, persons requiring the design features the units offer. Guidelines for housing managers posted on the website may be beneficial.
- Link Mass Access to the Virtual Gateway.

B. Conduct Education and Outreach about Home Modification.
The Commonwealth of Massachusetts has worked strategically to develop a variety of resources that elders and people with disabilities can use to make their homes accessible. These include state-funded low- and no-interest rate deferred payment

loan programs as well as grants through local governments and low-interest loans from private banks and Mass Housing, the state's housing finance agency. In addition, the Commonwealth has developed a new Assistive Technology Loan Program that can assist a household to purchase equipment needed in their home. Combined with any needed home or personal care services, all of these programs assist elders and people with disabilities to remain in their homes rather than feel forced into institutional settings. Despite the availability of these resources, service coordinators and other staff within Aging Service Access Points, disability organizations, Councils on Aging, hospitals, and nursing and rehabilitation settings remain unaware of many of the programs available to provide home access modifications and technology. Potential strategies for addressing this issue include the following:

- Host an annual one-day conference on Home Modification and Assistive technology. The purpose of the conference would be to identify strategies to address gaps in legislation, existing programs, education, and outreach. Information on available resources could also be shared.
- Assemble information about available home modification programs by city or town. This could include the development of product lists of the various types of home modifications that are available to meet the needs of diverse disability populations. The information would be made available broadly in a written manual, on-line, and in alternative formats.
- Develop outreach and education materials which would be disseminated to key organizations directly and through organization conduits such as Mass Home Care, State Independent Living Council, Mass Advocates Standing Strong, Arc of Massachusetts, local Community Development Corporations, Association of Councils on Aging, and Mass Hospital Association. Materials would be designed in a manner that is sensitive to the needs of diverse populations including persons of color and immigrant communities and would also be available in alternative formats and multiple languages.
- Develop and implement a plan to broadly disseminate the resource information.

C. Retro-fit existing housing to enable better service provision and accessibility.
As noted in the Readiness Assessment Section 9, some current housing models are underutilized because they do not meet the needs of elders and people with disabilities who are transitioning from institutional settings or who are homeless. Retro-fitting existing housing to better meet the needs of elders and individuals is essential in increasing the capacity of housing and coordination with services. Potential strategies include:

- Identify promising housing models and underutilized models from surveys and studies conducted to date.
- Explore the costs and infrastructure change needs associated with funding a process for retro-fitting existing units to make them more accessible.
- Explore whether or not it is feasible to expand the congregate model to additional populations not currently served with this model.

- Identify financing mechanisms for modifications to existing entities such as the installation of elevators in garden style apartment complexes, breakthroughs in undersized units, providing on-site support services, and other retro-fitting models.
- Explore methods to convert some units of congregate housing into transition apartments, an approach that has been successfully implemented in the northeast region of the state.
- Explore the option of renovating and modifying the rest home program to meet the individualized needs of consumers and allow for Medicaid funding for services.

D. Develop strategies to enable more persons to purchase or rent a home or apartment.
   Although some people request housing that is coordinated with support services, others are seeking opportunities to purchase their own home or rent their own apartment so they can hire their own supportive services as needed. Potential strategies to meet this need include:

- Pursue creative financing mechanisms to assist individuals and families in gaining access to financing such as developing revolving loan funds with foundations or banks.
- Offer Transitional Housing Programs that promote independence and include assistance for first and last month's rent and security deposits.
- Build linkages with private landlord associations to expand inventory of affordable, accessible units and to provide information to landlords about services that may be available to assure successful tenancy.

(c) Grant outcomes

At the end of the five year period we envision a system of affordable housing and long-term supports that is well coordinated at the state and local level. We expect that the identified strategies will lead to the design and development of an infrastructure that supports elders and people with disabilities in their chosen setting. The success of this grant goal will be documented in a benchmarking report that answers the following questions:

A. Has the capacity of affordable and accessible housing coordinated with long-term supports increased? Potential measurements include:
   1. Number of new models providing housing with long-term supports in community settings.
   2. Overall capacity of housing with long-term supports.
   3. Number of individuals receiving long-term supports in affordable housing compared to the number before implementation.
   4. Number of individuals with disabilities who were homeless prior to implementation who are no longer homeless.

B. Has access to affordable and accessible housing with supports improved? Potential measures include:
   1. The utilization rate for Mass Access before and after implementation.

2. The number of accessible units available on the registry.
3. Consumer and provider survey results pertaining to the reliability of the housing registry before and after implementation.
4. Activities performed by newly appointed housing coordinators and data on progress in assisting individuals to locate and move into housing.
5. Development of Memoranda of Understanding between housing and supportive service providers.
6. Development and dissemination of outreach and educational materials.
7. Development of assessment module and planning tool.
8. Utilization rates and feedback on the assessment module and planning tool.

C. Has affordable and accessible housing where individuals are receiving long-term supportive services proven to be a cost-effective and quality alternative to institutionalization? Potential measurements include:
  1. Number of individuals who have transitioned from nursing facilities.
  2. Survey of individuals who have transitioned to identify level of satisfaction with their new housing.
  3. Survey level of satisfaction of individuals within new models of affordable and accessible housing.
  4. Measurement of quality indicators based on process created within the quality goal of this grant to determine effectiveness of various housing models coordinated with services.
  5. Number of evictions that were successfully avoided through tenancy preservation programs.
  6. Rate of nursing facility admissions and/or or average length of nursing facility stay for Medicaid waiver clients.
  7. Nursing home cost data.
  8. Housing models cost data.

(d) Defining key stakeholders

Stakeholder involvement for the entire management of the grant has been previously discussed in other sections of this application. Consumers in addition to other stakeholders will sit on the Steering Committee for this grant and identify methods to ensure that consumers and other stakeholders are involved in all aspects of planning, implementation, and evaluation of grant activities. In addition, the Citizens Housing and Planning Association has two identified work groups, one focusing on disabilities and housing policy and the other on elderly housing. These work groups, which include consumers, advocates, providers, and state policy makers, in coordination with the Steering Committee members, will be instrumental in carrying out the identified strategies.

Part Four: Process for Developing the Strategic Plan for Systems Transformation

Massachusetts has created the infrastructure, programs, and services to better meet the needs of elders and individuals with disabilities in the community. This transformation opportunity provides the necessary resources to increase efforts within certain transformation components as well as the overall effort to bring all of the Commonwealth's activities together into an efficient, well-connected system. The following outlines the process for developing the Strategic Plan for our Systems Transformation efforts.

A. Process to be used to develop the Plan.

Once informed of the award, the Partnership will commence the grant strategic planning process while building on planning already initiated within EOHHS and EOEA. Strategic planning will be a systematic and transparent process inclusive of people receiving services, legislative leaders, executive leaders, program administrators of existing programs, advocates, providers, caregivers, current Systems Change grant staff, and other stakeholders to be identified. The Commonwealth will utilize the unique partnership between UMMS/CHPR and state agencies to build a comprehensive Strategic Plan while ensuring a multifaceted stakeholder involvement process.

Responsibility for Producing the Plan

As the Office charged with strategic policy planning for long-term supports in the Commonwealth, ODCS/EOHHS, under the leadership of Assistant Secretary Gerry Morrissey, Jr., will be responsible for implementing the strategic planning process and for producing the Strategic Plan document. Deputy Assistant Secretary (and Co-Principle Investigator), Laurie Burgess of ODCS/EOHHS and Assistant Secretary (Co-Principle Investigator), Ellie Shea-Delaney of EOEA will coordinate the efforts of their respective Secretariats and ensure cross-agency and diverse consumer involvement in the development of the Strategic Plan.

Support in the Strategic Planning Process and the Development of the Plan

In lieu of a Strategic Planning contractor, UMMS/CHPR will assist EOHHS and EOEA to plan for and implement the strategic planning process using the guidelines set forth in this proposal. As an academic research and policy center with a focus on applied social policy, UMMS/CHPR has the required expertise and knowledge related to strategic planning principles and planning processes required to perform effective strategic planning. UMMS/CHPR has successfully assisted state agencies in strategic planning for the past five years. This is well documented through the following projects (for more information on these processes, please see Appendix H):

- UMMS/CHPR Long-Term Care Policy Unit assisted the new Elder Affairs, Office of Long-Term Care within EOEA to develop its vision, mission, and Strategic Plan after the recent reorganization.
- UMMS/CHPR Research Design and Methods Unit assisted ODCS to develop its strategic priorities related to employment.

- UMMS/CHPR State Health Policy Unit assisted DMH in the development of its Strategic Plan.

In addition to UMMS/CHPR's expertise, Laurie Burgess has extensive experience in strategic planning and long-term support design as a consultant to other states including Maryland, Minnesota, New Hampshire, Texas, and Indiana. Ellie Shea-Delaney also has extensive experience with the strategic planning process through her work in policy design at EOEA and her involvement in many strategic planning activities utilizing external funding including the recent National Governors' Association grant.

Organizational Structures to Ensure a Comprehensive Process.

The organization structure created under this grant will ensure cohesion of grant activities within this grant, other Systems Change grants, and additional long-term support initiatives to ensure a comprehensive approach to the transformation of long-term supports. ODCS/EOHHS, EOEA, and UMMS/CHPR will follow a comprehensive process to strategic planning for which the ground work has already been laid. Please see Appendix Z for a chart depicting the strategic planning process. The following structures will be created to ensure a comprehensive process:

Steering Committee: EOHHS, EOEA, and UMMS/CHPR will build on partnerships already in existence under current Systems Change grants and will outreach to new stakeholder groups to establish the Systems Transformation Steering Committee. The Steering Committee will include representation from state agencies, legislators, existing Systems Change initiatives, consumers of services and other key stakeholders. This Steering Committee will be charged with ensuring an inclusive and comprehensive process for strategic planning, implementation, and evaluation of grant activities.

The Steering Committee will oversee the development of the vision statement, mission statement, goals, objectives, strategies, implementation plan, technical assistance plan, evaluation plan, and methods for involving stakeholders. The Steering Committee will ensure the Strategic Plan is built upon strategic planning initiatives already implemented through support from the National Governor's Association. Consumer representatives will receive needed accommodations, transportation, respite, personal assistance, and stipends to enable them to attend and actively participate in Steering Committee meetings. UMMS/CHPR will provide a facilitator and document the progress of the Steering Committee. UMMS/CHPR will also provide a Project Director to manage implementation activities.

Unlike more traditional models of grant design and implementation, consumers of services will be at the decision-making table through their representation on the Steering Committee. During the strategic planning process, the Steering Committee will determine whether to appoint a smaller Collaborative Team (consistent with models in other grants) to facilitate timely decision-making and/or a consumer subgroup to provide additional opportunities for consumers to discuss and process grant-related information.

Grant Management Team: The Grant Management Team will consist of the Co-Principle Investigators from UMMS/CHPR, ODCS/EOHHS, and EOEA along with the Project Director. The Grant Management Team will be responsible for day-to-day grant activity operations such as the creation and refinement of the strategic plan, the

development and oversight of work plans, and the administration of subcontracts for technical assistance and evaluation. The Grant Management Team will be accountable to the Steering Committee, Assistant Secretary Gerry Morrissey, Jr. of ODCS/EOHHS, and Secretary Jennifer Davis Carey of EOEA.

In partnership with the Steering Committee, the Grant Management Team will plan the first Community Forum. State agency leadership, legislators, program administrators, provider networks, advocates, self-advocates, family members, and caregivers will be invited to attend the Forum. The Forum will provide an opportunity to inform the public about this new initiative, the strategic planning process, the three priority areas (quality, diversion using alternative financing models, and housing), and methods for stakeholder involvement. During the Forum, the Steering Committee will seek consensus on the vision statement, mission statement, and the strategic planning process as well as seek input on the three priority areas and the stakeholder involvement mechanisms. Modifications will be made based on the input received.

Upon the drafting of the Strategic Plan, the Steering Committee and Grant Management Team will plan a second Forum to seek input on the draft document. A draft of the document will be disseminated prior to the second Forum, and will then be modified based on the input received during the Forum. Forums will continue annually during the implementation phase as a method to inform the public of the progress of the grant as well as to seek additional stakeholder involvement and input. Forum participants will have access to alternative formats and accommodations. Limited transportation funds will be available for those who could not attend the Forum otherwise.

Priority-Specific Subcommittees: After the initial Community Forum, integrated subcommittees in the area of quality, alternative finance mechanisms for diversion, and housing will be established by the Steering Committee with support from the Grant Management Team for each of the three priority areas set forth in this proposal. At least one representative from the Steering Committee and Grant Management Team will sit on each of the subcommittees. Subcommittees will include a diverse representation of program administrators, consumers of services, legislators, provider networks, and other stakeholders to be determined. Project-specific subcommittees will be responsible for developing a stakeholder input process to inform their strategic planning process as well as the refinement of priority goals, objectives, strategies, implementation work plan, and outcome measures. Each subcommittee will have the support of a strategic planning facilitator. Progress will be documented by UMMS/CHPR and representatives will provide timely updates and recommendations for objectives and activities to the Steering Committee. Consumer representatives on the sub-committees will receive needed accommodations, transportation, respite support, personal assistance, and stipends to allow them to attend and fully participate in meetings.

Once the Strategic Plan is finalized and CMS has approved the document, the Grant Management Team will be responsible for implementing day-to-day activities as described in the implementation plan, under the direction of the Steering Committee, Assistant Secretary Gerry Morrissey, and Secretary Jennifer Davis Carey of EOEA. The Grant Management Team will be responsible for implementing and monitoring the implementation plan, the technical assistance plan, the evaluation plan, and convening

stakeholder subcommittees. The implementation plan will include strategies for additional stakeholder involvement mechanisms for the implementation phase of the grant. The necessary staff support and subcommittees will be appointed in each of the three priority areas to ensure work plan timelines are met. The priority-specific subcommittees involved in the strategic planning process will likely evolve into implementation sub-committees responsible for driving activities defined during the strategic planning process. These sub-committees may include new membership and will ensure the involvement of stakeholder groups in the implementation and evaluation of transformation activities.

B. Involving Agency Executives, Legislators, and Advocates.

Methods for involving agency executives, legislators, and advocates have been detailed in the section above. The Partnership will ensure a comprehensive and systematic process for involving state agency representatives, legislators, and advocates to ensure expertise is utilized to its fullest potential and buy-in is sought to ensure sustainability of effective strategies. State agencies that will be involved include:

- The Executive Office of Health and Human Services
- The Executive Office of Elder Affairs
- Office of Medicaid
- Office of Disabilities and Community Services
- Office of Health Services
- Department of Mental Retardation
- Massachusetts Rehabilitation Commission
- Massachusetts Commission for the Deaf and Hard of Hearing
- Massachusetts Commission of the Blind
- Department of Mental Health
- Department of Housing and Community Development

Legislative representation will be requested prior to the start of the strategic planning process. Representation may include the following in addition to others to be identified at a later date:

- Fredrick E. Berry, Senate Majority Leader
- Richard T. Moore, Senate Chair, Health Care Financing Committee
- Sue Tucker, State Senator and Chair of the Elder Affairs Committee
- Michael R. Knapik, State Senator and participant in the Massachusetts Long-Term Care Policy Academy

Advocate Representation will be requested prior to the start of the strategic planning process as well as throughout grant implementation. Representation may include:

- Mass Home Care Network and individuals ASAPs
- Statewide Independent Living Council and individuals ILCs
- Home Health Providers
- Disability-Specific Advocacy Organizations
- Peer Support Advocacy and Self-Advocacy Networks
- Nursing Home and Other Institutional Representation

C. Involving Consumers who will be directly impacted by the Goals chosen and the Strategic Planning Process.

The Partnership's success in creating inclusive methods of involvement is evident in previously implemented Systems Change grants. UMMS/CHPR, ODCS/EOHHS, and EOEA have administered multiple successful Systems Change initiatives. More specifically, the 2001 Real Choice Grant utilizes a collaborative decision-making model presented during two CMS Systems Change Conferences that includes the involvement of five separate state agencies serving elders and people with disabilities and five representatives from a larger consumer group. Since this model's inception, similar models have been adopted in the Commonwealth's 2003 and 2004 Systems Change grants, including all of the grants administered by UMMS/CHPR. As requested during the consumer input process while drafting this proposal, this grant will utilize a similar collaborative approach to decision-making.

To ensure an inclusive and transparent process, extensive time and resources will be devoted to informing various consumers diverse in disability, culture, and age of this new initiative prior to extensive planning. As already noted, EOHHS and EOEA will ensure the creation of a Steering Committee that will include representation from each of the stakeholder groups, including consumers of services, that will drive the strategic planning process. Please see the organizational structure section above to learn more about the specific structures to be utilized to ensure consumers of services are directly involved. To ensure meaningful consumer and stakeholder involvement in transformation of the long-term supports continues beyond the life of the grant, the Partnership will review strategies to sustain this method of involvement.

D) Methods for Formative Learning.

Within each of the goal areas outlines in Part Three of this proposal, specific outcomes and outcome measures have been identified. The identification of desired outcomes and outcome measures as well as methods for data collection, analysis, and interpretation are essential to ensuring effective systems transformation. Upon award of this grant, the Steering Committee will review potential evaluators and choose an evaluator experienced in measuring and evaluating systems change activities.

The Steering Committee, with support from the Grant Management Team, will establish an Evaluation Committee. The Evaluation Committee, facilitated by the evaluation subcontractor, will include grant management staff, consumer, and state representation. The Committee will work with each of the three subcommittees to drive the development of both formative and outcome evaluation methods. The Committee will ensure measurable outcomes are identified for each of the three goal areas as well as for the overall progress of the grant. The Committee will be responsible for ensuring methods for information gathering, analysis, and evaluation are feasible and relevant to the goals, objectives, and measurable outcomes of the grant. The Committee will also be responsible for creating a system that ensures information on effective and non-effective processes is gathered in a timely manner and communicated to the Steering Committee. The Steering Committee will then be responsible for ensuring modification in strategies responsive to information received through the evaluation. Consumer representatives on the Committee will receive needed accommodations, transportation, respite support, personal assistance, and stipends in order to attend meetings.

Part Five: Budget Presentation

The University of Massachusetts Medical School, Center for Health Policy and Research (UMMS/CHPR) is applying for the 2005 Systems Transformation grant on behalf of the Office of Disabilities and Community Services within Executive Office of Health and Human Services (ODCS/EOHHS) and the Executive Office of Elder Affairs (EOEA) in partnership with state agencies providing long-term supports to elders and people with disabilities. UMMS/CHPR, ODCS/EOHHS, and EOEA will collaborative with a diverse representation of advocates, self-advocates, family members, provider groups, legislators, and other stakeholders to perform systems transformation. UMMS/CHPR is requesting **$3,479,266** to administer this grant during a 5-year period to allow for effective planning, design, and implementation of the Commonwealth's transformation of long-term supports for elders and people with disabilities.

Massachusetts has exceeded the 5 percent match requirement through in-kind contributions totaling **$975,367** or 28.03 percent of the total grant funds requested. In-kind contributions are provided by UMMS/CHPR, ODCS/EOHHS, EOEA, Massachusetts Rehabilitation Commission, Department of Mental Retardation, and the Department of Mental Health. In-kind contributions from UMMS/CHPR include 20 percent of the salary for the Co-Principle Investigator, Dee O'Connor, Ph.D. and a biostatistician from UMMS/CHPR's Research, Design, and Methods Unit. In-kind contributions from ODCS/EOHHS, EOEA, MRC, DMR and DMH include:

- Laurie Burgess (20 percent), Co-Principle Investigator and Deputy Assistant Secretary of ODCS;
- Ellie-Shea Delaney (20 percent), Co-Principle Investigator and Assistant Secretary of EOEA;
- Maggie Dionne (20 percent), Director of Housing for EOEA;
- Sandy Tocman (10 percent), Director of Quality for EOEA;
- Lisa McDowell (10 percent), Director of Institutional, Residential, and Day Services for EOEA;
- Karen Langley (10 percent), Director of the Supportive Living Program for MRC;
- Lisa Sloane (10 percent), housing consultant for MRC;
- Margaret Chow-Menzer (10 percent), Assistant Commission of DMR;
- Gail Grossman (10 percent), Director of Quality Management for DMR; and
- Michael O'Neill (10 percent), Director of Operations for DMH.

Massachusetts has devoted $2,011,186 of the budget to staff resources to ensure grant activities are completed and $147,520 to meetings to ensure involvement of stakeholders. $550,000 or 15.7 percent of total grant funds has been allocated for subcontractors and consultants to be named during the strategic planning process. Of this total, $120,000 has been earmarked for subcontracts within each of the three goal areas (quality, alternative finance mechanism for diversion, and housing). An additional $90,000 has been earmarked for technical assistance for all three areas. $100,000 has been earmarked for pilot funds to be allocated for projects during the strategic planning process. Massachusetts has also allocated $100,000 (2.87% of total grant funds) for the evaluation component of this grant. UMMS/CHPR has applied an 18% indirect rate for a total of $461,100 in indirect costs. A breakout for the 5 year budget and the 9 month strategic planning process is provided as an additional attachment.