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**21.01 INTRODUCTION**

The Home and Community Based Benefit (HCB or Benefit) for members with Intellectual Disabilities or Autistic Disorders gives members eligible for this Benefit the option to live in their own home or in another home in the community thus avoiding or delaying institutional services. The Benefit is offered in a community-based setting as an alternative for members who qualify to live in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The Benefit supplements, rather than replaces supportive, natural personal, family, work, and community relationships and complements. It does not duplicate other MaineCare services. This Home and Community Benefit for members with Intellectual Disabilities or Autistic Disorder is not intended to replace Section 29, Support Services for Adults with Intellectual Disabilities or Autistic Disorder.

The HCB Benefit is provided under a Federal 1915(c) waiver that meets Federal standards. MaineCare members may receive covered services as detailed in other sections of the  *MaineCare Benefits Manual*, but can receive services under only one Home and Community Based waiver at any one time.

To be eligible for this Benefit, members must meet medical eligibility requirements and there must be a funded opening. In addition, the planning process includes identifying and documenting the member’s needs in a Personal Plan. The Personal Plan describes certain habilitative, therapeutic and intervention services and supplies with an overall goal of community inclusion.

The Benefit is a limited one. Each year the Department of Health and Human Services (DHHS) must identify the total number of unduplicated members it will provide the benefit to during that year. If there is no funded opening, or if a member is not eligible for a funded opening based on priority, the member is placed on a waiting list as described in this rule.

This rule does not alter or supplant those sections of Maine statute, regulation, or DHHS policy.

**21.02 DEFINITIONS**

**21.02-1 Abuse** means the infliction of injury, unreasonable confinement, intimidation or cruel punishment that causes or is likely to cause physical harm or pain or mental anguish; sexual abuse or sexual exploitation; or the intentional, knowing or reckless deprivation of essential needs as defined in 22 MRSA §3472.

**21.02-2 Activities of Daily Living (ADL) are:**

A. **Bed Mobility**: How person moves to and from lying position, turns side to side, and positions body while in bed;

B. **Transfer**: How person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);

**21.02 DEFINITIONS** (Cont.)

C. **Locomotion**: How person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;

D. **Eating**: How person eats and drinks (regardless of skill);

E. **Toilet Use**: How person uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;

F. **Bathing**: How person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and

G. **Dressing**: How person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

**21.02-3 Administrative Oversight Agency-**is an agency approved by OADS that holds a contract with a Shared Living Provider to provide supervision and monitoring services.

**21.02-4 Agency Home Support** means a Provider Managed Service Location that routinely employs direct care staff to provide direct support services.

**21.02-5 Autistic Disorder** means a diagnosis that falls within the category of Pervasive Developmental Disorders, as defined in Section 299.0-299.80 in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of autism codified in 34-B MRSA §6002 and accompanying rules.

**21.02-6** **Authorized Entity** is the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.

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**21.02-7** **Case Manager** is a person responsible for assuring the timely convening of the service planning team, developing the Personal Plan, monitoring the planned services received by the member, and for insuring that those services meet the requirements set forth in the member’s Personal Plan. This person may also be referred to as an Individual Support Coordinator.

**21.02-8 Correspondent** is a person designated by the Maine Developmental Services Oversight and Advisory Boardto act as a next friend of a person with Intellectual Disabilities or Autism.

**21.02-9 Designated Representative** means the DHHS staff or Authorized Agent authorized by DHHS to perform specified functions.

**21.02 DEFINITIONS** (Cont.)

**21.02-10 Direct supports** are a range of activities that contribute to the health and well-being of the member and his or her ability to live in or be part of the community. Direct support activities may include personal assistance or activities that support personal development, or activities that support personal well-being. Direct support activities are provided as Home Support, Community Support, Employment Specialist Services or Work Support. The emphasis and purpose of the direct support provided may vary depending on the type of service.

Direct support activities include the following:

**Personal assistance** is assistance provided to a member in performing tasks the member would normally perform if the member did not have his or her disability. Personal assistance may include guiding, directing, or overseeing the performance of self-care and self-management of activities.

**Self-care** includes assistance with eating, bathing, dressing, mobility, personal hygiene, and other activities of daily living; assistance with light housework, laundry, meal preparation, transportation, grocery shopping, and assistance with health and nutrition maintenance, including assessing well-being and identifying need for

medical assistance; complying with nutritional requirements as specified in the Personal Plan; administration of non-prescription medication that are ordinarily self-

administered; and administration of prescription medication, when provided by a person legally authorized to assist with the administration of medication.

**Self-management** includes assistance with managing safe and responsible behavior; exercising judgment with respect to the member’s health and well-being; communication, including conveying information, interpreting information, and advocating in the member’s interests; managing money including paying bills, making choices on how to spend money, keeping receipts, and expending funds with the permission of a member’s representative payee. Self-management also includes teaching coping skills, giving emotional support, and guidance to other resources the member may need to access.

**Activities that support personal development** include teaching or modeling for a member self-care and self-management skills, physical fitness, behavior management; sensory, motor and psychological needs; interpersonal skills to cultivate supportive personal, family, work and community relationships; resources and opportunities for participation in activities to promote social and community engagement; participation in spiritual activities of the member’s choice; motivating the pursuit of personal development and opportunities; teaching or modeling informed choice by gathering information and practicing decision making; and learning to exercise.

**21.02 DEFINITIONS** (Cont.)

**Activities that support personal well-being** include directly or indirectly intervening to promote the health and well-being of the member. This may include identifying risks such as risk of abuse, neglect or exploitation; participating in a member’s risk assessment; identifying and reporting to an immediate supervisor changes in health status and behavior; anticipating or preventing unsafe or destructive behavior; and safely intervening against undesirable behavior according to an intervention plan. In the absence of a plan, intervention must be consistent with DHHS’s rule governing emergency intervention and behavioral treatment for persons with intellectual disabilities (14-197 CMR Chapter 5). It may also be necessary to seek emergency medical or safety assistance when needed and comply with incident reporting requirements.

**21.02-11 Employment Setting** foreither Work Support-Individual or Work Support-Groupmust be one with the highest level of integration possible. The job must be one that is available to a non-disabled employee with the same expectations for the member’s job performance and attendance. The member works under similar work conditions as others without disabilities in similar positions; including access to lunchrooms, restrooms, and breaks. The member performs work duties with ongoing interaction with other workers without disabilities, and has contact with customers, suppliers and the public to the same degree as workers without disabilities in the same or comparable occupations. The member cannot be excluded from participation in company-wide events such as holiday parties, outings and social activities. Provider owned/operated businesses are subject to the same integration standards as other businesses. Staff providing employment services at the worksite are not considered non-disabled employees in determining the level of integration. For those agencies that currently operate under an award from AbilityOne (<http://AbilityOne.org>), the federal workforce guidelines associated with this funding source will apply to the services funded by the contract. The member can be on the employer’s payroll or the provider agency payroll.

Members may receive additional employment supports from a provider agency. A member must be supervised in a manner identical to other employees. It is permissible, on a case by case basis to have the support agency offer and provide this supervision as long as the above conditions are met.

**21.02-12 Exploitation** means the illegal or improper use of an incapacitated or dependent member or that member’s resources for another’s profit or advantage as defined in 22 MRSA §3472.

**21.02-13 Family-Centered Support** is a model designed to provide enhanced home support to a member in a family environment, with the family and the member sharing a home that is not owned by the member or member’s family. No more Family Centered

**21.02 DEFINITIONS** (Cont.)

Support will be approved after December 30, 2007. The Family Centered Provider must be a Certified Direct Support Professional (DSP).

**21.02-14 Habilitation** is a service that is provided in order to assist a member to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising the level of physical, mental, and social functioning of a member. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.

**21.02-15 Instrumental Activities of Daily Living (IADL)** include only the following: main meal preparation; routine housework; grocery shopping and storage of purchased groceries; and laundry either within the residence or at an outside laundry facility.

**21.02-16 Intellectual Disability** means a diagnosis of Mental Retardation as defined in Section 317-319 in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 34-B MRSA §5001. The terms “mental retardation” and “intellectual disability” are used interchangeably in these regulations. Use of the term “intellectual disability” in no way alters the criteria for eligibility set forth in s. 21.03-3(B).

**21.02-17 Medical Add On** is a component of Home Support, Community Support, Employment Specialist Services and Work Support and is included in the established authorization (as described in Section 21.04-1). It is not a separately billable activity. Billing may not exceed the Home Support, Community Support, Employment Specialist Services or Work Support authorized units of service. Documentation must clearly identify and support periods of such activity . Refer to Appendix II for more information.

**21.02-18 Member** is a person determined to be eligible for MaineCare benefits by the Office for Family Independence(OFI) in accordance with the eligibility standards published by the OFI in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type and amount of services they are eligible to receive.

**21.02-19 Mental Retardation** means a diagnosis of Mental Retardation as defined in Section 317-319 in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 34-B MRSA §5001. The terms “mental retardation” and “intellectual disability” are used interchangeably in these regulations. Use of the term “intellectual disability” in no way alters the criteria for eligibility set forth in s. 21.03-3(B).

**21.02 DEFINITIONS** (Cont.)

**21.02-20 Neglect** means a threat to an member’s health or welfare by physical or mental injury or impairment, deprivation of essential needs or lack of protection from these as defined in 22 MRSA §3472.

**21.02-21 On behalf Of** is billable activity that is provided for individual members and is not necessarily a direct face-to-face service. On Behalf Of is a component of Home Support, Community Support, Employment Specialist Services and Work Support. It is included in the established authorization and is not a separately billable

activity. Documentation detail must clearly identify and support periods of such activity. Refer to Appendix III for more information.

**21.02-22 Personal Plan** is a member’s plan developed at least annually that lists the services offered under the waiver benefit. The Personal Plan may also include services not covered by the waiver but identified by the member. Only covered services included on the Personal Plan are reimbursable. The Personal Plan may also be known as a person centered plan, a service plan, an individual support plan, or an individual education plan, as long as the requirements of Section 21.04-2 are met.

**21.02-23 Prior Authorization** is the process of obtaining prior approval as to the medical necessity and eligibility for a service.

**21.02-24 Qualified Intellectual Disability Professional (QIDP)** is a person who has at least one year of experience working directly with persons with intellectual disabilities or other developmental disabilities and is one of the following: 1) a doctor of medicine or osteopathy; 2) a registered nurse; or 3) an individual who holds at least a bachelor’s degree as specified in title 42 *Code of Federal Regulations* (CFR) 483.430, paragraph B5.

**21.02-25 Qualified Vendor** is a provider approved by DHHS to provide waiver services to eligible members receiving services under this Section. DHHS requires agencies to provide high quality services that, at a minimum, meet the expectations of the members who utilize those services. DHHS may authorize agencies to provide services under this Section after an application, along with supporting documentation, has been submitted to a Designated Representative for review and approval. The Designated Representative will authorize only agencies that meet DHHS expectations in the areas of organization and operation, operation of individual programs or services, personnel administration, environment and safety, and quality management. Only Qualified Vendors will receive DHHS referrals and authorizations for reimbursement.

**21.02 DEFINITIONS** (Cont.)

**21.02-26 Shared Living** (Foster Care-adult) is a model in which services are provided to a member by a person who meets all of the requirements of a Direct Support Professional with whom that member shares a home. The home may belong to the provider or the member, but the provider must enter into a contractual relationship with an Administrative Oversight Agency in order to provide services under this model. Only one member may receive services in any one Shared Living arrangement at the same time, unless a relationship existed prior to the service arrangement and the arrangement is approved by DHHS. In such case, no more than two members may be served in any one Shared Living arrangement concurrently.

The Shared Living Provider/Direct Support Professional must enter into a contractual relationship with the Administrative Oversight Agency in order to provide services in a Shared Living arrangement. The agency supports the provider in fulfilling the requirements and obligations agreed upon by the DHHS, the Administrative Oversight Agency and the Personal Plan.

**21.02-27 Shared Living Provider** is a provider who subcontracts with an agency to provide direct support to a member, with whom they share a home. The Shared Living Provider must be a Certified Direct Support Professional (DSP) and comply with the Shared Living Handbook provided by DHHS.

**21.02-28 Utilization Review** is a formal assessment of the medical necessity, efficiency and appropriateness of services on a prospective, concurrent or retrospective basis.

Effective

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**21.02-29 Year** Services are authorized on the state fiscal year, July 1 through June 30.

**21.03 DETERMINATION OF ELIGIBILITY**

Eligibility for this benefit is based on meeting all three of the following criteria: 1) medical eligibility, 2) eligibility for MaineCare as determined by the DHHS, Office for Family Independence (OFI), and 3) the eligibility criteria for a funded opening based on priority.

**21.03-1 Funded Opening**

The number of MaineCare members that can receive services under this Section is limited to the number, or “funded openings,” approved by the Centers for Medicare and

Medicaid Services (CMS). Persons who would otherwise be eligible for services under this Section are not eligible to receive services if all of the funded openings are filled.

**21.03 DETERMINATION OF ELIGIBILITY** (Cont.)

#### 21.03-2 Reserved Capacity

The DHHS reserves a portion of the participant capacity of the waiver for specified purposes subject to CMS review and approval in order to:

Meet the needs of incapacitated or dependent adults who require adult protective services to alleviate the risk of serious harm resulting from abuse, neglect and/or exploitation; and

Meet the needs of those individuals who choose to leave an ICF/IID or other institutional setting: and

Meet the needs of members under 21 in out of state residential placements funded by MaineCare or State funds.

The number reserved associated with Section 21.03-2 above is an average based on the DHHS’s data for those in need of adult protective services in recent years. The number reserved for ICF/IID or other institutional residents is based on currently known referrals. The number reserved for members in out of state residential placements is based on the number of current out of state residential placements funded by MaineCare or State funds.

**21.03-3 General Eligibility Criteria**

Consistent with Subsection 21.03-1, a person is eligible for services under this Section if the person:

A. Is age eighteen (18) or older (members who were younger than age 18 and were already receiving services under this Section as of December 30, 2007 may continue to receive benefits under this Section); and

B. Has Mental Retardation as defined by Sections 317-319 in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (American Psychiatric Association) (DSM) IV or Autistic Disorder as defined by Section 299.00 in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition (DSM) IV or Pervasive Developmental Disorder (NOS) as defined by Section 299.80 in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (American Psychiatric Association) (DSM) IV; and

C. Meets the medical eligibility criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) as set forth under the  *MaineCare Benefits Manual*, Chapter II, Section 50; and

**21.03 DETERMINATION OF ELIGIBILITY** (Cont.)

D. Does not receive services under any other federally approved MaineCare home and community based waiver program; and

E. Meets all MaineCare eligibility requirements as set forth in the *MaineCare Eligibility Manual*; and

F. The estimated annual cost of the member’s services under the waiver is equal to or less than two hundred percent (200%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department.

**21.03-4 Establishing Medical Eligibility**

In order to determine medical eligibility, the member and Case Manager must provide to DHHS the following:

A. A completed copy of the assessment form (BMS99) or current functional assessment approved by the Department; and

B. A copy of the member’s Personal Plan developed, approved and signed by the member or guardian and the Case Manager within the preceding six months and any other relevant material indicating the member’s service needs.

Based on review of the Assessment Referral Form and the member’s Personal Plan, a Qualified Intellectual Disability Professional designated by DHHS will determine the member’s medical eligibility for services under this Section.

DHHS shall notify each member or the member’s guardian in writing of any decision regarding the member’s medical eligibility, and the availability of benefit openings

under this Section. The notice will include information about the member’s right to appeal any of these decisions. Rights for notice and appeal are further described in Chapter I of the  *MaineCare Benefits Manual*.

If the member is found to be medically eligible, DHHS must send the member or guardian written notice that the member can receive ICF/IID services or services under this Section. The member or guardian must submit to the Case Manager a signed choice letter documenting the member’s choice to receive services under this section.

**21.03-5** **Calculating the estimated annual cost**

Prior to formal determination of eligibility for services under this section, each applicant and the applicant’s planning team must identify the required mix of

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**21.03 DETERMINATION OF ELIGIBILITY** (Cont.)

services to meet the applicant’s needs and to assure the applicant’s health and welfare. The applicant and the applicant’s planning team shall submit a detailed estimate of the annual budget for services identified in the Personal Plan,

including the specific services and the number of units for each service.

**21.03-6 Priority**

When a member is found to meet MaineCare eligibility and medical eligibility for these services, the priority for a funded opening shall be established in accordance with the following:

1. **Priority 1:** Any member on the waiting list shall be identified as Priority 1 if the member has been determined by DHHS to be in need of adult protective services in accordance with 22 M.R.S.A. §3473 *et seq.*, and if the member continues to meet the financial and medical eligibility criteria at the time that need for adult protective services is determined.

B. **Priority 2:** Any member on the waiting list shall be identified as Priority 2 if the member has been determined to be at risk for abuse in the absence of the provision of benefit services identified in his or her service plan. Examples of members who shall be considered Priority 2 include:

1. a member whose parents have reached age sixty (60) and are having difficulty providing the necessary supports to the member in the family home; or

2. a member living in unsafe or unhealthy circumstances but who is not yet in need of adult protective services, as determined by DHHS Adult Protective Services.

C. **Priority 3:** Any member on the waiting list shall be identified as Priority 3 if the member is not at risk of abuse in the absence of the provision of the benefit identified in the service plan. Examples of members who shall be considered Priority 3 include:

1. a member living with family, who has expressed a desire to move out of the family home;

1. a member whose medical or behavioral needs are changing and who may not be able to receive appropriate services in the current living situation;

**21.03 DETERMINATION OF ELIGIBILITY** (Cont.)

3. a member who resides with family, if the family must be employed to maintain the household but cannot work in the absence of the benefit being provided to the member; or

4. A member who has graduated from high school in the State of Maine, has no continuing support services outside of the school system, but is in need of such services.

**21.03-7 Choosing Whom to Serve Within the Same Priority**

If the number of openings is insufficient to serve all members on the waiting list who have been determined, at the time that any opening is determined to be available, to be within the same priority group, DHHS shall first determine whether each member continues to meet the financial and medical eligibility criteria to be served through this benefit. For those who continue to meet such criteria, the Department will utilize the most current assessment that is entered into the Enterprise Information System (EIS) and submitted by the individual member, guardian or Case Manager. Upon review of information concerning all members within the same priority group who continue to meet financial and medical eligibility criteria and for whom current service plans are in place, DHHS shall determine which members to serve. The determination will be based on a comparison of the members’ known needs, the availability of capable service providers who can adequately meet those needs, and the comparative degree of abuse, neglect or exploitation or risk of abuse, neglect or exploitation that each member will likely experience in the absence of the provision of the benefit.

**21.03-8 Waiting List**

DHHS will maintain a waiting list of eligible MaineCare members who cannot get Home and Community Benefits because a funded opening is not available. Members who are on the waiting list for the benefit services shall be served in accordance with the priorities identified above.

A member has sixty days from the receipt of notification by DHHS of a funded opening to respond with intent to accept waiver services. A member has six months from the receipt of notification to start receipt of services. If the member fails to respond with intent to accept the funded opening within 60 days of this notice or fails to begin services within 6 months, the member shall be removed from the waitlist. A member may reapply at any time for waiver services.

Effective 9/1/14

**21.03-9 Redetermination of Eligibility**

Effective 9/1/14

When determining continued eligibility, the Case Manager will submit a Personal Plan less than six months old and an updated Assessment Form (BMS 99) or current

**21.03 DETERMINATION OF ELIGIBILITY** (Cont.)

Effective

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functional assessment approved by the Department to DHHS twelve (12) months from the date of initial approval, and every twelve (12) months thereafter. If the updated Assessment Form and Personal Plan is not received by the due date, reimbursement for services will be denied until receipt of the assessment form and Personal Plan. Reimbursement for services will resume upon receipt of the Assessment Form and Personal Plan. Whenever significant changes occur that alters level of care, the Case Manager will submit an updated Assessment Form to DHHS.

**21.04 PERSONAL PLAN**

If the member or guardian chooses services under this Section, the request for services must be submitted to DHHS or its Authorized Entity. As part of the planning process, the member’s needs are identified and documented in the Personal Plan. Except for residential services, other services shall be provided to the member within ninety (90) days of the completed execution of a service agreement or amended service agreement. For residential services, if the service agreement or amended service agreement identifies a need, such services shall be provided within eighteen (18) months of the execution of the agreement. The time periods set forth in this section are subject to the funded opening and waiting list provisions in sections 21.01 and 21.03.

**21.04-1 Prior Authorization for Reimbursable Services**

Medically necessary services and units of services must be identified in the Personal Plan. Requests for services must be submitted to DHHS or its Authorized Entity for Prior Authorization in order for the services to be reimbursed. Compliance to the authorization is determined if the average of actual delivered services fall within the range established for that setting or member. If the average falls within the range, then billing at the approved level is authorized. If the average falls below the pre-set level, then billing must reflect the lower level of service provided. All prior authorizations are time-limited, and the length of the authorization may vary by member and service as documented in the Personal Plan. Upon expiration of an authorization, a new authorization must be obtained before reimbursement may be provided for the service.

Effective

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DHHS and its Authorized Entity reserve the right to conduct Utilization Review of any service authorized under this Section, applying the service-specific eligibility standards set forth in this Section. DHHS and its Authorized Entity may terminate or revise a service authorization upon finding that the member no longer satisfies the eligibility standards for the service or level of service authorized.

**21.04-2 Plan Requirements**

The Case Manager will ensure that the Planning Team is convened to initiate development of the Personal Plan prior to services being initiated. The plan must be

**21.04 PERSONAL PLAN** (Cont.)

less than six (6) months old at the time of the member’s eligibility determination or redetermination. The Personal Plan must describe at a minimum:

A. All MaineCare Benefit services determined medically necessary by the team including all other services that may not be covered under this section but the member identifies and may pursue;

B. The frequency of provision of the services;

C. How services contribute to the member’s health and well-being and the member’s ability to reside in a community setting;

D. The member’s goals for strengthening and cultivating personal, community, family, and professional relationships;

E. The role and responsibility of the Direct Support Professional, the Employment Specialist and the member’s other service providers in supporting the member’s goals, including goals for strengthening natural and supportive personal, family, community and professional relationships;

F. Members who chose to receive Home Support-Remote Support must have a safety/risk plan, which shall describe the potential risks to the member’s health and welfare while receiving Home Support-Remote Support and the reasonable steps to alleviate those risks; and

G. In order for the Plan to be authorized the Plan must include signatures of (1) the member, or guardian, if applicable, and (2) the case manager.

The Personal Plan will be used by DHHS to identify the type and units of authorized services the member may receive under this Section. If more than

one provider is reimbursed for the same category of direct support activities, an explanation of the differences in roles and responsibilities of each provider and how services will not be duplicated is required.

All Providers must ensure that notice of the Grievance process outlined in 14-197 CMR Chapter 8 is regularly provided to members served by the Provider. Providing notice includes, at a minimum, ensuring that written notice of the grievance process is provided to the member and/or their guardian at any planning meeting; posting notice of the grievance process in an appropriate common area of all facilities operated by the Provider; and posting notice of the grievance process on any website maintained by the Provider. In addition, the provider must ensure that all staff are trained in the grievance process.

**21.04 PERSONAL PLAN** (Cont.)

**21.04-3 Planning Team Composition**

Each member or guardian will determine the composition of the Planning Team. Planning will occur in a manner that is respectful and reflective of the member’s preference. The planning team may include the following members, if applicable:

A. Case Manager;

B. The member;

C. The member’s parent, guardian or Correspondent;

D. The member’s advocate or friend or any additional individual invited by the member;

E. Operator of the member’s home or a Direct Support Professional providing services to the member;

F. Staff from the member’s Community Support, Work Support, Employment Specialist Services, Assistive Technology or Career Planning Provider; and

G. Any professionals involved or likely to be involved with the member’s Personal Plan.

**21.04-4 Updating the Personal Plan**

The member’s Personal Plan must be reviewed, revised and updated at least annually, and in addition when other significant changes occur relating to the member’s physical, social, or psychological needs, or the member’s significant progress toward his or her goals. When a member’s residential placement changes, the case manager must reconvene the Planning Team to revise and update the Personal Plan, within thirty days of the move. The Case Manager must reconvene the Planning Team to revise and update the Personal Plan.

Effective

9/1/14

Planning meetings must be held both prior to and subsequent to the planned move of a member to a new residence in order to coordinate supports and services and to evaluate the member's satisfaction with the change.

**21.05 COVERED SERVICES**

Members receiving Home and Community Benefits may receive the following services, as specified in the Personal Plan, as long as they are not available under another section of the  *MaineCare Benefits Manual* and the services are medically necessary.

**21.05 COVERED SERVICES** (Cont.)

**21.05-1** **Assistive Technology**- Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of members. Assistive technology service means a service that directly assists a member in the selection, acquisition, or use of an assistive technology device.

Effective

9/1/14

If Authorized, the Department expects that Home Support-Remote Support Hours will be implemented within 90 days of assessment.

Assistive Technology includes;

(A) Assistive Technology-Assessment:

1. The evaluation of the assistive technology needs of a member, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the member in the customary environment of the member;

2. The coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;

3. The training or technical assistance for the member, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the member; and

4. The training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of, members.

Assistive Technology-Assessment is subject to a combined limit per year. See Section 21.07 below.

(B) Assistive Technology-Devices:

1. The purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for members; and

2. The selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.

**21.05 COVERED SERVICES** (Cont.)

Assistive Technology-Devices is subject to a combined limit per year. See Section 21.07 below.

(C) Assistive Technology-Transmission (Utility Services): the transmission of data required for use of the Assistive Technology Device via internet or cable utility. Assistive Technology-Transmission is subject to a combined limit per month. See Section 21.07 below

**21.05-2** **Career Planning** is a person-centered, comprehensive direct support provided to a member that enables a member to obtain, maintain or advance in competitive employment or self-employment. Career Planning assists with identifying a career direction and developing a plan for achieving competitive, integrated, individual employment or self-employment at or above the State’s minimum wage. Services assist in identifying skills, priorities, and capabilities determined through an individualized discovery process. Career Planning may include a referral to benefits planning, referral of assessment for use of assistive technology to increase independence in the workplace, and development of experiential learning opportunities and career options consistent with the member’s skills and interests. Career Planning may be used in preparation to gather information for a referral to Vocational Rehabilitation.

Career Planning is limited to 60 hours annually, to be delivered in a six-month period. No two six-month periods may be provided consecutively. Career Planning services must have the long-term goal of individual, competitive, integrated employment for which the member is compensated at or above the minimum wage. In order to receive Career Planning services, the member’s Personal Plan must identify specific career goals and describe how the Career Planning services will be used to achieve those goals.

Career Planning services can be provided within a variety of community settings such as a Career Center, the community and local business and must be documented in the Person Centered Plan with related goals.

Effective

9/1/14

The cost of Transportation related to the provision of Career Planning is a component of the rate paid for the service.

**21.05-3 Communication Aids** are devices or services necessary to assist individuals with hearing, speech or vision impairments to effectively communicate with service providers, family, friends, and other community members. Communication Aids include:

A. Communicators (including repair and maintenance) such as direct selection, alphanumeric, scanning and encoding communicators;

**21.05 COVERED SERVICES** (Cont.)

B. Speech amplifiers (includes hearing aids), aids and assistive devices (including repair and maintenance) if not otherwise covered for reimbursement under other sections of the  *MaineCare Benefits Manual*;

C. Facilitated communication. Providers must submit a written plan for DHHS’s approval defining the facilitated communication services that will be offered to the member. The provider of this service must have a Certificate of Clinical Competence-Speech Pathology (CCC-SP).

Only communication aids that cannot be obtained as a covered service under other sections of the  *MaineCare Benefits Manual* may be reimbursed under this Section. For communication aids costing more than five hundred dollars ($500), the member

must obtain documentation from a licensed speech-language pathologist, Audiologist or Assistive Technology Professional (ATP) assuring the medical necessity of the devices or services.

**21.05-4 Community Support** is Direct Support provided by a Direct Support Professional in order to increase or maintain a member’s ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on community inclusion, personal development, and support in areas of daily living skills if necessary. Community Support is intended to be flexible, responsive and provided to members consistent with his or her personal plan.

The location of the service and staffing level may vary, allowing for a mix of individualized and group services. The average staff to member ratio for Community Support for each program locationmust not exceed 1:3.

Within the scope of Community Support, there may be activities that require that the service be provided in the member's home; most commonly, this will involve the

origination or termination of a period of the service. This is allowable as long as it does not duplicate Home Support.

Nothing in this rule prohibits one-to-one (1:1) service delivery.

On Behalf of is a component of Community Support and is included in the established authorization and is not a separate billable activity.

A member may not receive Community Support while enrolled in high school. Community Support is not provided in the member’s place of employment.

The cost of transportation related to the provision of Community Support is a component of the rate paid for the service and is not separately billable.

**21.05 COVERED SERVICES** (Cont.)

The maximum annual allowance for Community Support is eleven hundred twenty-five (1,125) hours per year.

**21.05-5 Counseling** is a direct service to assist the member in the resolution of the member’s behavioral, social, mental health, and alcohol or drug abuse issues. Counseling services, as recommended in the Personal Plan, must be approved by DHHS. The provider of this service must be a Licensed Clinical Social Worker (LCSW) or a Licensed Clinical Professional Counselor (LCPC). Counseling is limited to 16.25 hours annually.

**21.05-6 Consultation Services** are services provided to persons responsible for developing or carrying out a member’s Personal Plan. Consultation Services include**:**

1. Reviewing evaluations and assessments of the member's present and potential level of psychological, physical, and social functioning made

through professional assessment techniques; direct interviews with the member and others involved in the Personal Plan; review and analysis of

previous reports and evaluations, and review of current treatment modalities and the particular applications to the individual member;

B. Technical assistance to individuals primarily responsible for carrying out the member's Personal Plan in the member's home, or in other community sites as appropriate;

C. Assisting in the design and integration of individual development objectives as part of the overall Personal Planning process, and training persons providing direct service in carrying out special habilitative strategies identified in the member's Personal Plan;

D. Monitoring progress of a member in accordance with his or her Personal Plan and assisting individuals primarily responsible for carrying out the member’s Personal Plan in the member's home or in other community sites as appropriate, to make necessary adjustments; and

E. Providing information and assistance to the member and other persons responsible for developing the overall Personal Plan.

Consultation is available in the following specialties: Occupational Therapy, Physical Therapy, Speech Therapy, Behavioral and Psychological services. The provider of this service must be an Occupational Therapist, Registered (OTR) for Occupational Therapy Consultation or a Registered Physical Therapist (RPT) for Physical Therapy

**21.05 COVERED SERVICES** (Cont.)

consultation or have a Certificate of Clinical Competence-Speech Pathology (CCC-SP) for Speech Therapy Consultation. For Psychological Consultation, the provider of this service must be a Licensed Psychological Examiner or Licensed Clinical Psychologist. For Behavioral Consultation, the provider of this service must be a Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC) or a Board Certified Behavior Analyst (BCBA). Reimbursement for Consultation Services may only be made to those providers not already reimbursed for consultation as part of another service. Personnel who provide services under Targeted Case Management, Section 13 of the  *MaineCare Benefits Manual* may not be reimbursed for Consultation Services. Consultation is limited to 16.50 hours annually per discipline.

**21.05-7 Crisis Assessment** is a comprehensive clinical assessment of a member who has required intervention by the DHHS Crisis Team on at least three occasions within a two-week period. The assessment includes: a clinical evaluation to identify causes or conditions that may precipitate the crisis, specific crisis prevention activities, and to develop a plan for early intervention and stabilization in the event of a crisis. The required members of a clinical team are a psychiatrist or licensed psychologist and a clinical liaison. Depending upon client need, other team members may include a physician, occupational, physical or speech therapist.

The maximum allowance for this service is limited to one (1) assessment in a three-year (3) period. This cost includes all related follow-up activities.

**21.05-8 Crisis Intervention Services** are direct intensive supports provided to members who are experiencing a psychological, behavioral, or emotional crisis. The scope, intensity, duration, intent and outcome of Crisis Intervention must be documented in the Personal Plan. Crisis Intervention is commonly provided on a short-term intermittent basis.

Emergency Crisis Intervention services may be authorized by a primary designated DHHS representative without Personal Plan documentation for a period of two weeks only. Outside of regular business hours, a secondary designated DHHS representative may authorize Crisis Intervention until the next business day only. Ongoing Crisis Intervention services must be recommended by the Planning Team and documented in the Personal Plan before the Department will authorize any further services for reimbursement.

Progress notes must indicate that Crisis Intervention services were provided, even if the services are provided in conjunction with Home Support and/or Community Support services.

Crisis Intervention services may only be provided by staff employed by an approved agency enrolled in MaineCare.

**21.05 COVERED SERVICES** (Cont.)

**21.05-9 Employment Specialist Services** include services necessary to support a member in maintaining employment. Services include: (1) periodic interventions on the job site to identify a member’s opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion; (2) assistance in transitioning between employers when a member’s goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the member in acclimating to a new job; and (3) Employment Specialist Services for job development, if Vocational Rehabilitation denies services under the *Rehabilitation Act* and the member is unable to benefit from Vocational Rehabilitation. If Employment Specialist Services are used for job development, current documentation of ineligibility from Vocational Rehabilitation is required.

Effective

9/1/14

Employment Specialist Services are provided by an Employment Specialist, who may work either independently or under the auspices of a Supported Employment agency but must have completed the approved Employment Specialist training as outlined by DHHS in order to provide Employment Specialist Services. The need for continued Employment Specialist Services must be documented in a Personal Plan as necessary to maintain employment over time.

Employment Specialist Services are provided at work locations where non-disabled individuals are employed as well as in entrepreneurial situations. Employment Specialist Services may be utilized to assist a member to establish and/or sustain a business venture that is income-producing. MaineCare funds may not be used to defray the expenses associated with the start-up or operating a business.

A member may not receive Employment Specialist Services while enrolled in high school.

The cost of transportation related to the provision of Employment Specialist Services is a component of the rate paid for the service.

On Behalf Of is a component of Employment Specialist Services Support and is included in the established authorization and is not a separate billable activity.

Employment Specialist Services are provided on an intermittent basis with a maximum of 10 (ten) hours each month. Nothing in this rule prohibits a member from working under a Special Minimum Wage Certificate issued by the Department of Labor under the *Fair Labor Standards Act*. Employment Specialist Services cannot be provided at the same time as Work Support-Group or Work Support-Individual.

**21.05 COVERED SERVICES** (Cont.)

**21.05-10 Home Accessibility Adaptations** are those physical adaptations to the private residence of the member or the member’s family required by the member’s Personal plan, that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home. These include adaptations that are not covered under other sections of the  *MaineCare Benefits Manual* and are determined medically necessary as documented by a licensed physician and approved by DHHS.

Adaptations commonly include:

Bathroom modifications;

Widening of doorways;

Light, motion, voice and electronically activated devices;

Fire safety adaptations;

Air filtration devices;

Ramps and grab-bars;

Lifts (can include barrier-free track lifts);

Specialized electric and plumbing systems for medical equipment and supplies;

Lexan windows (non-breakable for health & safety purposes);

Specialized flooring (to improve mobility and sanitation).

Items not included above but which have been recommended in a Personal Plan are subject to approval by the Department for reimbursement.

Effective

9/1/14

DHHS does not cover those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are also excluded from

this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). In-floor radiant heating is not allowable. General household repairs are not included in this benefit.

All services must be provided in accordance with applicable local, State or Federal building codes.

This service applies to member-owned or a member’s family-owned home only; it is not available in Provider agency-owned or -operated homes. Home Accessibility Adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

The limit for adaptations is ten thousand dollars ($10,000) in a five (5) year period, with an additional annual allowance up to three hundred dollars ($300) for repairs and replacement per year. All items in excess of five hundred dollars ($500) require documentation from a physician or other appropriate professionals such as OT, PT or

**21.05 COVERED SERVICES** (Cont.)

Speech therapists that the purchase is appropriate and medically necessary to meet the member’s need. Medically necessary home modifications that cannot be obtained

as a covered service under any other MaineCare benefit may be reimbursed under this section if they meet all requirements of this Section.

**21.05-11 Home Support-Agency Per Diem** is direct support provided in the member’s home (Agency Home), by a Direct Support Professional to improve and maintain a member’s ability to live as independently as possible. Home Support is direct support to a member and includes primarily habilitative training and/or personal assistance with Activities of Daily Living (ADL) and/or Instrumental Activities of Daily Living (IADL)(self-care, self-management), development and personal well-being.

Effective

9/1/14

Home Support may be provided as either a regularly scheduled "round the clock" service or as individual hours, or blocks of hours, of service depending upon the member’s activities.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

Payment is not made directly, or indirectly, to the member's immediate family.

Within the scope of Home Support, there may be activities that require that the service be carried over into the community. Nothing in this rule is intended to prohibit community inclusion as a reimbursable service accompanied by

documentation on the Personal Plan provided that the service has a therapeutic outcome. An example is shopping for food, which may later be prepared in the home.

This is allowable as long as it does not duplicate Community Support. Home Support cannot be provided at a Member’s employment site.

On Behalf Of is a component of Home Support and is included in the established authorization and is not a separate billable activity. The cost of transportation related to the provision of Home Support is a component of the rate paid for the service and is not separately billable.

**21.05-12 Home Support-Family Centered Support**- is direct support (billed per diem) provided in the member’s home, by a Direct Support Professional to improve and maintain a member’s ability to live as independently as possible. Home Support is direct support to a member and includes primarily habilitative training and/or personal assistance with Activities of Daily Living (ADL) and/or Instrumental Activities of Daily Living (IADL), development and personal well-being.

Effective

9/1/14

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

**21.05 COVERED SERVICES** (Cont.)

The cost of transportation related to the provision of Home Support is a component of the rate paid for the service.

Payment is not made directly, or indirectly, to the member's immediate family.

Within the scope of Home Support, there may be activities that require that the service be carried over into the community. Nothing in this rule is intended to prohibit community inclusion as a reimbursable service accompanied by

documentation on the Personal Plan provided that the service has a therapeutic outcome. An example is shopping for food, which may later be prepared in the home. This is allowable as long as it does not duplicate Community Support. Home Support cannot be provided at a Member’s employment site.

On Behalf Of is a component of Home Support and is included in the established authorization and is not a separate billable activity.

There is an increased level of support for members in Family Centered Support based on the documented needs of the member. The member must require an increased

level of staffing as documented in the member’s Personal Plan. Refer to Appendix I for more information.

As provided in 21.10-8, the Department is discontinuing Family Centered Support and no new placements will be approved.

**21.05-13** **Home Support-Quarter Hour** is direct support (billed per unit) provided in the member’s home, by a Direct Support Professional to improve and maintain a member’s ability to live as independently as possible. Home Support is direct support to a member and includes primarily habilitative training and/or personal assistance with Activities of Daily Living (ADL) and/or Instrumental Activities of Daily Living (IADL), development and personal well-being.

Effective

9/1/14

Within the scope of Home Support, there may be activities that require that the service be carried over into the community. Nothing in this rule is intended to prohibit community inclusion as a reimbursable service accompanied by documentation on the Personal Plan provided that the service has a therapeutic outcome. An example is shopping for food, which may later be prepared in the home. This is allowable as long as it does not duplicate Community Support.

Home Support cannot be provided at a Member’s employment site.

On Behalf Of is a component of Home Support and is included in the established authorization and is not a separate billable activity. The cost of transportation related to the provision of Home Support is a component of the rate paid for the service and is not separately billable.

**21.05 COVERED SERVICES** (Cont.)

Effective

9/1/14

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

Payment is not made directly, or indirectly, to members of the member's immediate family.

The cost of transportation related to the provision of Home Support is a component of the rate paid for the service.

**21.05-14** **Home Support-Remote Support**- This service provides real time, remote communication and support through a wide range of technological options including electronic sensors, video conferencing, environmental sensors (movement, doors, temperature, smoke, CO, etc.), video cameras, microphones and speakers, as wells as health monitoring equipment. This assistive technology links each member’s residence to the Remote Support provider.

The Remote Support provider has staff available 24 hours per day 7 days per week to deliver direct 1:1 care when needed. If a member chooses this service, the member’s Personal Plan must include a safety/risk plan that identifies at least two levels of emergency back-up.

The use of this service is based upon the member’s assessed needs and the resulting Personal Plan. The Personal Plan reflects the member’s consent and commitment to

Effective

9/1/14

the plan elements including all assistive communication, environmental control and safety components. A thorough evaluation of all assistive technology must be completed prior to the finalization of the Personal Plan with the assistance of the Case Manager and use of appropriate assistive technology consultants.

All Remote Support Services must be provided in real time.

All electronic systems must have back-up power connections to ensure functionality in case of loss of electric power. Providers must comply with all federal, state and local regulations that apply to its business including but not limited to the “*Electronic Communications Privacy Act of 1986*”. Any services that use networked services must comply with HIPAA requirements.

There is no overlap between Assistive Technology and Home Support Remote Support. As set forth in §21.05-1, Assistive Technology may be used to provide for assessments, equipment, and the cost of the monthly data transmission utility necessary to facilitate Home Support-Remote Support services. Home Support-Remote Support provides the staff who are monitoring the member.

**21.05 COVERED SERVICES** (Cont.)

There are two types of Remote Support: Interactive Support and Monitor Only. Chapter III reflects the billing for each. Interactive Support includes only the time that staff is actively engaging a member in 1 to 1 direct support through the use of the Assistive Technology Device. Monitor Only is when Assistive Technology equipment is being used to monitor the member without interacting.

**21.05-15** **Non-Medical Transportation Service** is offered in order to enable members to gain access to Section 21 services, as specified by the Personal Plan. Transportation services for Section 21 services are provided under the  *MaineCare Benefits Manual*, Section 113 (Non-Emergency Medical Transportation Services).

Effective

9/1/14

A provider may only be reimbursed for providing transportation services when the cost of transportation is not a component of a rate paid for another service.

Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, must be utilized.

**21.05-16 Non-Traditional Communication Assessments** determine the level of communication present via gesture, sign language or unique individual communication style. The assessment examines signed or gestured vocabulary for everyday objects or actions, as well as the ability to combine gestures and the ability to understand similar communication. Assessment recommendations are made to optimize communication to maximize social integration. The provider of this service must be approved by The DHHS Office of Multi-Cultural Affairs.

**21.05-17 Non-Traditional Communication Consultation** isprovided to members and their direct support staff and others to assist them in order to maximize communication ability as determined from assessment. The goal is to allow for greater participation in the service planning process and to enhance communication within the member’s environment. The provider of this service must be a Visual Gestural Communicator approved by DHHS.

**21.05-18 Occupational Therapy (Maintenance)** is a service that has maintenance of current abilities and functioning level as its goal. Evaluative and rehabilitative Occupational Therapy is included under other Sections of the  *MaineCare Benefits Manual* and is not covered as a component of maintenance therapy under this Section. The provider of this service must be an Occupational Therapist, Registered (OTR) for Occupational Therapy Maintenance or a Certified Occupational Therapy Assistant (COTA) under the supervision of an Occupational Therapist, Registered (OTR).

**21.05 COVERED SERVICES** (Cont.)

**21.05-19** **Physical Therapy (Maintenance)** is a service that has maintenance of current abilities and functioning level as its goal. Evaluative and rehabilitative Physical Therapy is included under other Sections of the  *MaineCare Benefits Manual* and is not covered as a component of maintenance therapy under this Section. The provider of this service must be a Registered Physical Therapist (RPT) for Physical Therapy Maintenance.

**21.05-20** **Shared Living (Foster Care, adult)-**is personal care, protective oversight and supervision and supportive services (e.g., homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under State law)) provided in a private home by a principal care provider who lives in the home and is a Direct Support Professional. Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports and social and leisure skill development that assist the member to reside in the most integrated setting appropriate to the member’s needs. Only one member may receive services in any one Shared Living arrangement at the same time, unless a relationship existed prior to the service arrangement and the arrangement has been approved by DHHS. In such case, no more than two members may be served in any one Shared Living arrangement concurrently.

Effective

9/1/14

An increased level of support may be available for members in Shared Living based on the documented needs of the member. The member must require an increased level of staffing as documented in the member’s Personal Plan. See Appendix I for additional requirements.

**21.05-21** **Specialized medical equipment and supplies** include devices, controls, or appliances specified in the plan of care that enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This benefit also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and nondurable medical equipment not available under the  *MaineCare Benefits Manual*. Items reimbursed under this waiver benefit are in addition to any medical equipment and supplies furnished under the  *MaineCare Benefits Manual*. All items must meet applicable standards of manufacture, design and installation. If used in vehicle modification, this benefit applies to member owned or a member’s family owned vehicle only; it is not available in agency owned, leased or operated vehicles. All items shall be considered the property of the member and must remain at the member’s disposal at all times regardless of where the member resides.

**21.05 COVERED SERVICES** (Cont.)

All items in excess of five hundred dollars ($500) require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the member’s need. Medically necessary adaptive aids

that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this section if they meet all the requirements of this Section.

Examples of this benefit may include but are not limited to the following:

A. lifts such as van lifts/adaptations for vehicles used by members who are unable to access transportation services covered in this Section or in Chapter II, Section 113, Transportation Services of the  *MaineCare Benefits Manual*; lift devices, standing boards, frames, and standard wheelchairs, including those with removable arms and leg rests, pediatric "hemi" chairs, tilt-in-space and reclining wheelchairs;

B. control switches/pneumatic switches and devices such as sip and puff controls, and adaptive switches or devices that increase the member’s ability to perform activities of daily living;

C. environmental control units such as locks, electronic control units and safety restraints; and

D. other devices necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-

durable medical equipment that are not otherwise covered for reimbursement in the  *MaineCare Benefits Manual*.

**21.05-22** **Speech Therapy (Maintenance)** is a service that has maintenance of current abilities and functioning level as its goal. Evaluative and rehabilitative Speech Therapy is included under other Sections of the  *MaineCare Benefits Manual* and is not covered as a component of maintenance therapy under this Section. The provider of this service must have a Certificate of Clinical Competence-Speech Pathology (CCC-SP) for Speech Therapy Maintenance.

**21.05-23** **Work Support-Group** is Direct Support provided to improve a member’s ability to independently maintain employment. Work Support-Group is provided at the member’s place of employment. Work Support-Group comprises services and training activities that are provided in regular business, industry and community settings for groups of two to six members. Mobile work crews, and business-based workgroups (enclaves) employing small groups of workers in employment in the community are examples of the models allowed. Work Support-Group must be demonstrably structured and provided in a manner that promotes the integration into the workplace and interaction between members and people without disabilities in those workplaces. The primary focus of the support is job related and also

Effective

9/1/14

**21.05 COVERED SERVICES** (Cont.)

encompasses adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care.

Effective

9/1/14

To receive this service, a member must have received an assessment and services under the *Americans with Disabilities Act*, and Section 504 of the *Rehabilitation Act* and need for on-going support must have been determined and documented in the Personal Plan. The outcome of this service must be sustained paid employment and work experience leading to further career development and individual integrated community based employment for which the member is compensated at or above the minimum wage, and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Work Support-Group does not include vocational services provided in a facility-based work setting in specialized facilities that are not part of the general workforce.

Work Support-Group may be used to support a member in a job that pays less than the minimum wage only if the employer complies with section 14(c) of the *Fair Labor Standards Act* (29 U.S.C. §214(c)) and 26 M.R.S. §666.

Documentation must be maintained in the file of each member receiving this service that the service is not available under a program funded under section 110 of the *Rehabilitation Act of 1973* or the *Individuals with Disabilities Education Act* (20 U.S.C. 1401 *et seq*.).

Work Support-Group does not include volunteer work.

Work Support-Group cannot be used to cover incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program; 2) payments that are passed through to users of supported employment programs; or 3) payments for training that is not directly related to an individual’s supported employment program.

The cost of transportation related to the provision of Work Support-Group is a component of the rate paid for the service.

The combination of Work Support-Group and Work Support-Individual may not exceed the maximum annual allowance of 850 hours. Where the member receives Community Support services in addition to Work-Support-Group and/or Work Support-Individual, the combined cost of Community Support, Work Support-Individual, and Work Support-Group may not exceed $26,455.00 annually.

**21.05 COVERED SERVICES** (Cont.)

Information must be provided to the member at least yearly that career planning and individual employment is available to the member in order to make an informed decision regarding the services the member receives.

Effective

9/1/14

**21.05-24 Work Support-Individual** is Direct Support provided to improve a member’s ability to independently maintain employment. Work Support-Individual is primarily provided in a member’s place of employment, but may be provided in a member’s home in preparation for work if it does not duplicate services already reimbursed as Home Support, Community Support or Employment Specialist Services.

Work Support-Individual must be provided to members in an integrated employment setting in the general workforce and the member must be compensated at or above the minimum wage, and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

This service is provided after a member has received an assessment and services under the *Americans with Disabilities Act* and Section 504 of the *Rehabilitation Act* and need for on-going support has been determined and documented in the Personal Plan. Work Support-Individual may be provided to self-employed members where the member requires support operating his or her own business. Support may be used for customized employment for members with severe disabilities to include long term support to successfully maintain a job due to the ongoing nature of the member’s support needs, changes in life situation, or evolving and changing job responsibilities. The primary focus of the support is job related and also encompasses adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care.

Work Support-Individual does not include volunteer work.

Documentation must be maintained in the file of each member receiving this service that the service is not available under a program funded under section 110 of the *Rehabilitation Act of 1973* or the Individuals with *Disabilities Education Act* (20 U.S.C. 1401 *et seq*.).

Work Support-Individual cannot be used to cover incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program; 2) payments that are passed through to users of supported employment programs; or 3) payments for training that is not directly related to an individual’s supported employment program.

**21.05 COVERED SERVICES** (Cont.)

On Behalf Of is a component of Work Support-Individual and is included in the established authorization, and is not a separate billable activity. The maximum annual allowance for work support is eight hundred fifty (850) hours.

The cost of transportation related to the provision of Work Support is a component of the rate paid for the service.

The combination of Work Support-Group and Work Support-Individual may not exceed the maximum annual allowance of 850 hours. Where the member receives Community Support services in addition to Work-Support-Group and/or Work Support-Individual, the combined cost of Community Support, Work Support-Individual, and Work Support-Group may not exceed $26,455.00 annually.

**21.06 NON-COVERED SERVICES**

Services for which reimbursement is not allowed under this Section include, but are not limited to, the following:

**21.06-1** Services not identified by the Personal Plan;

**21.06-2** Services to any MaineCare member who receives services under any other federally approved MaineCare Home and Community based waiver program;

**21.06-3** Services to any member who is a nursing facility resident, or ICF/IID resident;

**21.06-4** Services that are reimbursable under any other sections of the  *MaineCare Benefits Manual*;

**21.06-5** Any service otherwise reimbursable under the *Rehabilitation Act of 1973* or the *Individuals with Disabilities Education Act*, including but not limited to job development and vocational assessment or evaluations;

**21.06-6** Room and board; The term “room” means shelter type expenses, including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term “board” means three meals a day or any other full nutritional regimen. Board does not include the provision of a meal at an adult day health or similar facility outside the member’s home. Board also does not include the delivery of a single meal to a member at his/her own home through a meals-on-wheels service;

**21.06-7** Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the member’s parent, sibling or other biological family member. This rule will not be avoided by adult adoption. Persons appointed by a probate court as legal guardian prior to and up to December 30, 2007, who are not

**21.06 NON-COVERED SERVICES** (Cont.)

biological family, and who are directly or indirectly reimbursed for services, may continue to receive reimbursement under this Section;

**21.06-8** Work Support-Individual, Work Support-Group or Employment Specialist Services when the member is not engaged in employment. Work Support-Group must be provided at the member’s place of employment; it may be provided in a member’s home in preparation for work if it does not duplicate services already reimbursed as Home Support, Community Support or Employment Specialist Services;

**21.06-9** Specialized Medical Equipment and Supplies, Communication Aids, or Home Accessibility Adaptations unless the service has been determined non-reimbursable under Medical Supplies and Durable Equipment, Section 60 or other sections of the  *MaineCare Benefits Manual*.

**21.07 LIMITS**

**21.07-1** MaineCare members can receive services under only one Home and Community Waiver Benefit at any one time.

**21.07-2** The maximum annual allowance for Community Support is eleven hundred twenty-five (1,125) hours per year. The maximum combined annual allowance for Work Support-Group and Work Support-Individual Services is eight hundred and fifty (850) hours per year. Where the member receives Community Support services in addition to Work Support-Group and/or Work Support-Individual services, the combined cost of Community Support, Work Support-Individual and Work Support-Group may not exceed $26,455.00 annually.

**21.07-3** Home Accessibility Adaptations are limited to a ten thousand dollar ($10,000.00) limit in a five (5) year period with an additional annual allowance up to three hundred dollars ($300.00) for repairs and replacement per year.

**21.07-4** All items in excess of five hundred dollars ($500) require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that

purchase is appropriate to meet the member’s need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this section only if they meet all

requirements of this Section. This benefit applies to personal homes only; it is not available in agency owned or operated homes.

**21.07-5** For Specialized Medical Equipment and Supplies costing more than five hundred dollars ($500), the member must obtain documentation from a physician or other appropriate professional such as an OT, PT or Speech therapist assuring that the purchase is appropriate to meet the member’s need and is medically necessary.

**21.07 LIMITS** (Cont.)

Specialized Medical Equipment and Supplies are limited to only specialized medical equipment and supplies that cannot be obtained, as a covered service under other sections of the  *MaineCare Benefits Manual* will be reimbursed under this Section. These services are to be considered the property of the member.

**21.07-6** For communication aids costing more than five hundred dollars ($500), the member must obtain documentation from a licensed speech-language pathologist, Licensed Audiologist or a Certified Assistive Technology Professional (ATP) assuring that the purchase is appropriate to meet the member’s need and assures the medical necessity of the devices or services. Only communication aids that cannot be obtained as a covered service under other sections of the  *MaineCare Benefits Manual* will be reimbursed under this Section.

**21.07-7** Consultation services are limited to those providers not already reimbursed for consultation as part of another service. Personnel who provide services under targeted case management may not be reimbursed for consultation services.

**21.07-8** Crisis Intervention Services that have not been included on the Personal Plan are limited to a period not to exceed two weeks and must be authorized by the DHHS or its Authorized Entity. Crisis Intervention Services may not extend past two (2) weeks without a recommendation from the member’s Person Centered Team and additional approval from DHHS.

Effective

9/1/14

**21.07-9** Crisis Assessment Services are limited to one (1) assessment in a three-year (3) period and includes all related follow-up activities.

* + 1. A member may not receive Community Support, Employment Specialist Services or Work Support while enrolled in high school.

**21.07-11** A member may not receive Community Support or Home Support at his or her place of employment.

**21.07-12** No Family Centered Support will be approved after 12/20/2007.

**21.07-13** If a current waiver recipient enters a nursing facility or a hospital, payment under the waiver will be temporarily suspended. If the waiver recipient remains in the nursing

facility or hospital for more than thirty (30) consecutive days, enrollment in this waiver will be terminated unless there is a written request to the Department to continue holding the funded opening.

**21.07-14** Work Support-Individual services are limited to one DSP per member at a time.

**21.07 LIMITS** (Cont.)

**21.07-15** As of December 24, 2012,Home Support- Agency Per Diem placements will only be approved at sites where at a minimum two (2) members receiving Home Support- Agency Per Diem reside.

**21.07-16** Home Support Quarter Hour - may not exceed three hundred and thirty six (336) quarter hour units or eighty four (84) hours a week.

**21.07-17** Authorizations for services to be provided out of state will not exceed sixty (60) days of service within a given fiscal year and not exceed sixty (60) days within any six (6) month period except as provided in title 42 C.F.R. §431.52 (b).

**21.07-18** Annual MaineCare expenditures for services under this waiver for an individual member are limited to two hundred percent (200%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department.

**21.07-19** Assistive Technology services are not covered under this rule if they are available under another MaineCare rule. Assistive Technology-Assessment is subject to a combined limit of 32 units (8 hours) per year. Assistive Technology-Devices, including the selecting, fitting, customizing, adapting, applying, maintaining, repairing or replacing of assistive technology devices, is subject to a combined limit of $6,000 per year. Assistive Technology-Transmission (Utility Services) is subject to a combined limit of $50 per month.

Effective

9/1/14

**21.07-20** Career Planning is limited to 60 hours annually to be delivered in a six-month period. No two six month periods may be provided consecutively.

**21.07-21** Counseling is limited to 16.25 hours annually.

**21.07-22** Consultation is limited to 16.50 hours annually per discipline.

**21.07-23** Employment Specialist Services are provided on an intermittent basis with a maximum of ten hours each month.

**21.07-24** Home Support-Remote Support is limited to 48 units (12 hours) per day.

**21.08 DURATION OF CARE**

**21.08-1** **Voluntary Termination-** A member who currently receives the benefit, but no longer wants to receive the benefit, will be terminated, after DHHS receives written notice from the member that he or she no longer wants the benefit.

**21.08 DURATION OF CARE** (Cont.)

**21.08-2** **Involuntary Termination-**DHHS will give written notice of termination to a member at least ten (10) days prior to the effective date of the termination, providing the

reason for the termination, and the member’s right to appeal such decision. A member may be terminated from this benefit for any of the reasons listed below:

A. The member has been determined to be financially or medically ineligible for this benefit or MaineCare;

B. The member has been determined to be a nursing facility resident or ICF/IID resident without an approved Personal Plan to return to his or her home;

C. The member has been determined to be receiving MaineCare services from another Home and Community Based Waiver benefit;

D. The member is no longer a resident of the State of Maine;

E. The health and welfare of the member can no longer be assured because:

1. The member or immediate family, guardian or caregiver refuses to abide by the Personal Plan or other benefit policies;

2. The home or home environment of the member becomes unsafe to the extent that benefit services cannot be provided without risk of harm or injury to the member or to individuals providing covered services to the member; or

3. There is no approved Personal Plan..

F. The member has not received at least one service in a thirty (30) day period; or

G. The annual cost of the member’s services under this waiver exceeds two hundred percent (200%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department.

**21.08-3** **Provider Termination from the MaineCare Program-** The provider must provide the member and DHHS thirty (30) days written notice prior to the effective date of termination.

**21.09 MEMBER RECORDS**

Each provider serving the member must maintain a specific record for each member it serves in accordance with the requirements of Chapter I of the  *MaineCare Benefits Manual*. The member’s record is subject to DHHS’s review.

In addition, the member’s records must contain:

**21.09-1** The member's name, address, birth date, and MaineCare identification number;

**21.09-2** The member's social and medical history, and diagnoses;

**21.09-3** The member’s Personal Plan: and

**21.09-4** Written progress notes that identify any progress toward the achievement of the goals, activities and needs established by the member’s Personal Plan signed by the staff performing the service.

DHHS will conduct a review of provider records that may include, but is not limited to, staff schedules, payroll records and member records to substantiate service delivery and units of authorization.

The provider must document each service provided, the date of each service, the type of service, the activity, need or goal to which the service relates, the length of time of the service, and the signature of the individual performing the service. Services requiring a 2:1 ratio staffing may be documented by 1 (one) staff member, but both staff must sign the progress note. If services are provided by two (2) or more staff working different shifts, then each shift must be documented separately.

Example: a member receives twenty four hour (24) coverage from three (3) staff members working Monday through Friday in eight (8) hour shifts, and one (1) staff member that covers the week end. The provider must have documentation for each eight (8) hour shift per day.

If crisis intervention is required, a separate progress note must be included in the member's chart. The documentation must describe the crisis services provided, the date in which the crisis service was provided, the length of the crisis service, and the signature of the individual performing the crisis service.

Shared Living Providers and Family Centered Support Providers must also document the level of Service provided.

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS**

To provide services under this section a provider must be a qualified vendor as approved by DHHS and enrolled by the MaineCare program. Once a provider has been authorized to provide services, the provider cannot terminate the member’s services without written authorization from DHHS.

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (Cont.)

Effective 9/1/14

**21.10-1** **Direct Support Professional (DSP)** is a person who provides Home Support, Work Support, Community Support, Career Planning or Crisis Intervention and:

A. Has successfully completed the Direct Support Professional curriculum as adopted by DHHS**,** or demonstrated proficiency through DHHS’s approved Assessment of Prior Learning, or has successfully completed the curriculum

from the Maine College of Direct Support within six (6) months of date of hire. The Maine College of Direct Support is accessed on the internet at:

<http://www.maine.gov/dhhs/oads/disability/ds/cds/index.shtml>;

1. Has a background check consistent with Section 21.10-5;
2. Has an adult protective and child protective record check;

D. Be at least 18 years of age;

E. Has graduated from high school or acquired a GED; and

F. Completed the following four modules from the College of Direct Support prior to providing services to a member alone:

1. Introduction to Developmental Disabilities

2. Professionalism

3. Individual Rights and Choice

4. Maltreatment

Documentation of completion must be retained in the personnel record.

G. A DSP who also provides Work Support- Individual or Work Support-Group must have completed the additional employment modules in the Maine College of Direct Support in order to provide services.

H. A DSP who also provides Career Planning must have completed the additional employment modules in the Maine College of Direct Support and an additional 6 hours of Career Planning and Discovery training provided through Maine’s Workforce Development System.

Effective

9/1/14

All new staff or subcontractors shall have six (6) months date of hire to obtain DSP certification. Evidence of date of hire and enrollment in the training must be documented in writing in the employee’s personnel file or a file for the subcontractor.

Services provided during this time are reimbursable as long as the documentation exists in the personnel file.

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (Cont.)

A person who provides Direct Support must be a DSP regardless of his or her status as an employee or subcontractor of an agency.

A DSP can supervise another DSP.

Only a DSP who is certified as a Certified Nursing Assistant-Medications (CNA-M), a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN)may administer medications to a member.

**21.10-2** An **Employment Specialist** is a person who provides Employment Services or Work Support and has:

1. Successfully completed an Employment Specialist Certification program as approved by DHHS. Certification must occur within six months of date of hire;
2. Supervision during the first six months of hire must be from a Certified Employment Specialist in order to provide services;
3. Work Support staff can either be certified as an Employment Specialist or complete the Approved Direct Support Curriculum along with additional modules specific to employment;

D. Graduated from high school or acquired a GED;

E. Has a background check consistent with Section 21.10-5; and

F. Worked for a minimum of one (1) year with a person or persons having an Intellectual Disability or Autism.

G. A Employment Specialist who also provides Career Planning must have completed the additional 6 hours of Career Planning and Discovery provided through Maine’s Workforce Development System.

**21.10-3** A **Crisis Assessment Team** is a team of clinicians convened to provide Crisis Assessment Services. The team may include, but is not limited to, any or all of the following, if licensed or certified to practice within their profession:

A. Neuropsychiatrist or psychiatrist, who has worked with persons with developmental disabilities as a primary part of their practice;

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (Cont.)

B. Psychologist or behaviorist who has worked with persons with developmental disabilities as a primary part of their practice;

C. Clinic liaison person, having a bachelor’s degree or a nursing degree; direct experience with persons with developmental disabilities; and extensive experiences that provide a working knowledge of medical, psychiatric, and behavioral perspectives;

D. General medical practitioner;

E. Occupational therapist;

F. Physical therapist; or

G. Speech therapist.

**21.10-4 Emergency Intervention and Behavioral Treatment**

A provider must follow DHHS’s rule governing emergency intervention and behavioral treatment for persons with Intellectual Disabilities (14-197 CMR Chapter 5), and training on approved behavioral interventions procedures (e.g., Mandt) if applicable and indicated as a need in the member’s Personal Plan.

**21.10-5 Background Check Criteria**

The provider must conduct background checks on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide direct support services under this Section. Background checks on persons professionally licensed by the State of Maine will include a confirmation that the licensee is in good standing with the appropriate licensing board or entity. The provider shall not hire or retain in any capacity any person who may directly provide services to a member under this Section if that person has a record of:

A. any criminal conviction that involves abuse, neglect or exploitation;

B. any criminal conviction in connection to intentional or knowing conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person;

C. any criminal conviction resulting from a sexual act, contact, touching or solicitation in connection to any victim; or

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (Cont.)

D. any other criminal conviction, classified as Class A, B or C or the equivalent of any of these, or any reckless conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person within the preceding two (2) years.

Employment of persons with records of such convictions more than five (5) years ago is a matter within the provider's discretion after consideration of the individual's criminal record in relation to the nature of the position. The provider shall contact child and adult protective services (including the Office of Aging and Disability Services) units within State government to obtain any record of substantiated allegations of abuse, neglect or exploitation against an employment applicant before hiring the same. In the case of a child or adult protective services investigation substantiating abuse, neglect or exploitation by a prospective employee of the provider, it is the provider’s responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with licensing standards. Providers are not required to obtain records from child protective services for employees who do not provide services to children.

**21.10-6 Informed Consent Policy**

Providers must put in place and implement an informed consent policy approved by the Department. For the purposes of this requirement, informed consent means consent obtained in writing from a person or the person's legally authorized representative for a specific treatment, intervention or service, following disclosure of information adequate to assist the person in making the consent. Such information may include the diagnosis, the nature and purpose of the procedure(s) or service(s) for which consent is sought, all material risks and consequences of the procedure(s) or service(s), an assessment of the likelihood that the procedure(s) or service(s) will accomplish the desired objective(s), any reasonably feasible alternatives for treatment, with the same supporting information as is required regarding the proposed procedure(s) or service(s), and the prognosis if no treatment is provided. At a minimum, a provider’s informed consent policy must ensure that members served by the provider (and their guardians, where applicable) are informed of the risks and benefits of services and the right to refuse or change services or providers.

**21.10-7 Reportable Events**

Providers shall comply with all terms and conditions of the Department’s Regulations Governing Reportable Events, Adult Protective Investigations and Substantiation Hearings regarding persons with Intellectual Disabilities or Autism as described in 14-197 CMR, chapter 12 **.** All staff must receive training in mandatory reporting/reportable events either before they begin work with members or, at the latest, within thirty (30) days of being hired.

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (Cont.)

**21.10-8 Phase-Out of Family Centered Support**

The Department is discontinuing the Family Centered Support service. If a bed becomes vacant in a Family Centered Support home, that vacancy may be filled. No new licenses or license transfers for Family Centered Support homes will be approved.

Effective

9/1/14

Providers of Family Centered Support shall not transfer, in whole or in part, ownership, management, or responsibility for day-to-day operations of the Family Centered Support home to another individual or entity. The Department will not authorize Family Centered Support services under a new license.

**21.10-9 Residential Vacancies in Two-Person Homes**

Whenever a bed becomes vacant at a site at which two members receive Agency Home Support-Per Diem, whether due to a member’s death, hospitalization, or transfer to another residence, the provider shall take the following steps:

A. No later than twenty-four hours from the time of vacancy, the provider shall provide notice of the vacancy to the responsible Resource Coordinator in the Office of Aging and Disability Services and the case managers for both the departing and remaining members.

B. No later than three business days from the time of vacancy, the provider shall submit a new proposed staffing pattern for the home that adjusts for the vacancy and is sufficient to maintain the remaining member’s safety.

C. If the vacancy is the result of hospitalization, the provider may hold the vacant bed for the hospitalized member for a period of thirty calendar days. If, after thirty calendar days, there is no imminent plan for the hospitalized member to return to his or her home, the provider shall issue a thirty-day discharge notice to the hospitalized member, his or her guardian, and the Department and proceed with the steps below.

D. If the provider determines that the remaining member cannot be safely served in the current residence with a new housemate, the provider shall issue a thirty-day discharge notice to the remaining member and the Department within five business days of the vacancy (or, where the vacancy results from hospitalization, from the passage of thirty days from the time of hospitalization).

E. If the provider determines that the remaining member can be safely served in the current residence with a new housemate, the provider and Department shall attempt to identify another member to fill the vacancy.

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (Cont.)

Effective

9/1/14

1. **Ninety-Day Letter:** If no suitable candidate to fill the vacancy has been found after ninety calendar days from the date of vacancy (or, where the vacancy results from hospitalization, from the passage of thirty days from the time of hospitalization), the provider shall send a letter to the remaining member and his or her guardian, where applicable, stating that no suitable housemate has been located and that the member should consider looking for other residential options within or outside the agency. The letter shall state clearly that, should the provider be unable to fill the vacancy within thirty days of the letter, the provider will issue a thirty-day discharge notice.
2. **Thirty-Day Discharge Notice:** If no suitable candidate to fill the vacancy has been found after thirty calendar days from the mailing of the ninety-Day Letter, the provider shall issue a thirty-day discharge notice to the member, his or her guardian, where applicable, and the Department. The provider shall cooperate with the resident’s planning team in developing a transition plan for the member to move to other housing, whether permanent or interim, within thirty days.

Should the provider fail to meet the obligations set forth above, the Department may suspend reimbursement to the provider for the remaining member’s home support services until such time as the provider complies.

**21.11 APPEALS**

In accordance with Chapter I of the  *MaineCare Benefits Manual*, members have the right to appeal in writing or orally any decision made by DHHS to reduce, deny or terminate services provided under this benefit. The right to appeal does not extend to changes in law or policy adversely affecting some or all recipients.

The appeal must be (a) requested in writing and mailed to the address below, or (b) requested by telephone by calling Local: 207-287-6598, Toll Free: 1-800-606-0215 or TTY: 711.

Office of Aging and Disability Services

Department of Health and Human Services

11 State House Station

Augusta, ME 04333-0011

**21.12 REIMBURSEMENT**

Reimbursement methodology for covered services shall be the amount listed in Chapter III, Section 21, Allowances for Home and Community Benefits for members with Intellectual Disabilities or Autistic Disorder or the provider’s usual and customary charge, whichever is lower.

**21.12 REIMBURSEMENT** (Cont.)

In accordance with Chapter I, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing MaineCare. Therefore, a service provider under this benefit is expected to seek payment from sources other than MaineCare that may be available to the member.

**21.13 BILLING INSTRUCTIONS**

Providers must bill in accordance with DHHS's Billing Instructions.

**21.14 Appendix I- Shared Living and Family Centered Per Diem Criteria for increased level of support**

The Standard support level is an all-inclusive reimbursement for Services defined in 21.05-. At times, a member may require increased levels of staff support due to more intensive needs. DHHS may authorize an increased level of support for the purposes of additional staff for those members who have current and documented challenging behavioral issues or high medical and safety needs. DHHS will use the following criteria to determine when this increased level of reimbursement to support the additional staff is utilized.

To qualify for the increased level of support a member must have an extraordinary need listed in at least one of the categories below.

1) **Behavioral issues**-Members with behavioral issues and/or behavioral health challenges that significantly raise health and safety concern may have increased levels of support authorized to assist with Behavioral issues. These may include high risk behavior such as a history of sexual offense, aggression to self or others, or criminal behavior. The planning team must identify a behavioral need that requires an increased level of support and is documented in the member’s record. The Personal Plan will outline specific activities and desired outcomes of the service being provided and those activities must be separately documented in the member’s record.

2) **Medical Support**- Members that require support over and beyond routine services such as ventilators, nebulizers, diabetes management-insulin dependent, suctioning, seizure management-uncontrolled, chronic eating disorders, or persons with co-existing conditions that significantly affect physical movement and require near total physical assistance on a daily basis may have an increased level of support authorized to assist with medical issues. The Personal Plan will outline specific activities and desired outcomes of the service being provided and those activities must be separately documented in the member’s record.

For Behavioral issues and Medical Support there must be a written recommendation from a Physician, Psychologist or Psychiatrist which must specify:

1) The specific illness or condition to be addressed that requires increased support;

2) The manner in which increased support will be utilized;

3) The expected duration of the increased support. If the increased support is expected to be needed for an indefinite period of time then this expectation should be specified; and

4) The anticipated frequency of the increased support on a daily, weekly, or monthly basis.

**21.14 Appendix I- Shared Living and Family Centered Per Diem Criteria for increased level of support (Cont.)**

**Process of Application for the increased level of service**:

The Provider must complete the Home Support Frequency tool provided by DHHS that will summarize the support needs of the member and submit the tool along with identified materials to the case manager. The Home Support Frequency tool can found at this website, <http://www.maine.gov/dhhs/oads/disability/ds/MaineCare/protocol/index.shtml> .

The Case Manager will be responsible for reviewing the information provided, verifying that the Personal Plan and all other information is most current.

A central review team designated by the Director of OADS will review the information provided. The central review team may also review additional information such as reportable events, crisis team or case management notes, etc., to determine that the member meets the standard of need for the increased level of support. Increased support that is anticipated to be needed for an extended or indefinite period of time must be reviewed at least annually by the central review team.

The central review team will issue a written decision within twenty (20) working days of receipt of all required documentation. If additional information is required, a written request will be issued. Upon receipt of the additional information, DHHS will approve or deny the request in writing within ten (10) working days.

**21.15 APPENDIX II-Guidelines for Approval of Medical Add On in Maine Rate Setting**

The purpose of this Appendix is to detail guidelines for Office of Aging and Disability Services personnel or Authorized Entity in approving a Medical Add On to the established published rate. All current statutes, regulations, decree provisions, policies, and licensing standards regarding medical services are unaffected by these guidelines. This Appendix develops criteria that warrant an adjustment to the Department’s established published rate for Home Support, Community Support, Employment Specialist Services and Work Support Services-Individual.

Effective

9/1/14

The following standards and practices must be demonstrated in order for the Department of Health and Human Services to approve a Medical Add On:

A. **Physician Order**

1. There must be a written physician’s order for the member. This order must specify:

a. The specific illness or condition to be addressed;

1. The specific procedure(s) that will be utilized;
2. The time span over which the treatment or intervention is expected to be needed. If the treatment or intervention is expected to be needed for an indefinite period of time then this expectation should be specified;

d. The anticipated frequency of treatment or intervention on a daily, weekly, or monthly basis;

e. Where applicable and possible:

1. The approximate length of time required for each episode of the treatment or intervention and

2. The degree of licensure or certification required for those who carry out the treatment, and those who provide training and oversight relative to its application.

B. **Planning Team**

1. The team must meet or otherwise confer for the following purposes:

1. To determine whether the setting where the member is served is appropriate to carry out the physician’s recommended treatment or intervention;

**21.15 APPENDIX II - Guidelines for Approval of Medical Add On in Maine Rate Setting** (Cont.)

b. To determine how the member’s needs shall be met and what the staffing requirements are

2. All of these determinations and recommendations must be noted in the plan, or in an amendment to an existing plan..

C. **Provider Requirements**

1. The provider must be an enrolled MaineCare provider.

2. For any physician order specifying a skilled medical professional who shall train, monitor, or deliver treatment, the provider must have regular access to the professional, either as an employee, or via a contract, or via an established relationship; or alternatively, the provider must be able to gain this access in a time frame commensurate with the treatment requirements.

D. **Approval Process**

1. The DHHS or Authorized Entity will issue a written decision for the Medical Add On, within twenty (20) working days of receipt of all required documentation. If additional information is required, a written request will be issued. Upon receipt of the additional information DHHS or Authorized Entity will approve or deny the request within five (5) working days.

Effective

9/1/14

2. Documents will be reviewed by a designated representative.

3. Approvals will include a specification of the authorized daily or weekly units of service which require the Medical Add On. Approval may be retroactive to the date of application of the Add On based on documentation.

4. Treatments or interventions that are anticipated to be needed for an extended or indefinite period of time must be reviewed at minimum, annually by the team. Verification of this continued need must be provided to the DHHS or Entity within a year of the original approval, in order for the Medical Add On to continue.

**21.16 APPENDIX III-On Behalf of** **Covered Activities**

Support and supervision that is offered whenever the staff and the member are in the same physical environment is considered ***direct support time.*** This would include, for example, staff waiting for a member during a medical appointment or a home visit.

**Hours that may be claimed as being On Behalf**

Examples of acceptable activities include:

Services, activities and time that are directly related to a member: such as scheduling medical appointments, dental appointments and therapy appointments. This includes any time a staff may need to spend discussing with a physician, dentist, or therapist any intervention regarding the member.

Services, activities and time that are directly related to a member that are associated with that member’s Personal Plan, medical plan or behavioral plan including in-service training specific to a member’s plan of support, consultations with supervisors, therapist, clinicians, member’s employer and or medical staff; activities relating to a member’s parent, guardian or Maine Developmental Services Oversight and Advisory Board (MDOAB) representative; documentation, reports and presentations to review committees.

Services, activities and time that are directly related to a member that are associated with home visits, family events and or family reunification including transporting someone to their parents, guardian, or friends home for visits, returning a member to their home, and any time spent during such a visit such as attending a family function with the member.

Services, activities and time that are directly related to a member’s safety such as “shadowing” a member as he or she learns to take a bus.

### On Behalf of Non Covered Activities

Services, activities and time that are related to group activities and/or services, activities or time that cannot be directly linked to member’s Personal Plan. For example, grocery shopping for a home.

Services, activities and time that are related to home cleaning, home maintenance, facility cleaning or facility maintenance.

Services, activities and time that are related to staff training, unless the training is specific and exclusive to the member.

Services, activities and time that are related to landscaping, snow removal, spring clean-up or similar activities.

Services, activities and time that are related to securing or maintaining a license or certificate such as a group home license, or CARF accreditation.

**21.16 APPENDIX III-On Behalf of** **Covered Activities** (Cont.)

Services, activities and time that are related to staff recruitment, even if the staff is being recruited for the member.

Services, activities and time provided by a salaried staff member unless there is evidence that the salaried staff was working as a Direct Support Professional for the time being claimed.

**21.17 APPENDIX IV Performance Measures**

The primary goal of Performance Measurement is to use data to determine the level of success a service is achieving in improving the health and well-being of members. Performance Goals and Performance Measures assist to monitor quality, inform and guide reimbursement decisions and conditions of provider participation across MaineCare services. This focus on Performance Measurement is anticipated to enhance the overall quality of services provided and raise the level of public accountability for both the Department and MaineCare providers.

**21.17-1 Performance Goals**

Members receiving this service will experience improved or preserved functional abilities while being able to live in a safe and stable setting within the community.

**21.17-2 Performance Measures**

a. 65% of members receiving Work Support-Individual services will have worked a total number of hours of paid employment during the quarter that is greater than the total number of Work Support-Individual support hours they received during the quarter.

b. 100% of members receiving Work Support-Group employment making less than minimum wage, will have a Personal Plan in place that identifies how Work Support is being utilized to increase the member’s productivity and ensure good job match in order to move toward an hourly wage that meets or exceeds the State of Maine minimum wage standard.

**21.17-3 Performance Measure Data Source**

Providers must electronically enter individual level data into a DHHS defined web-based data collection system by the 15th of the month following the quarter end.

**21.17-4 Performance Measurement Compliance**

DHHS may exercise the following steps to ensure compliance:

**Step 1**: DHHS will notify the Provider in writing of any compliance and performance issues identified by DHHS staff. The notice will include the performance provision that is in noncompliance and a date by which the provider will correct or remedy the identified non-compliance/performance issue.

**21.17 APPENDIX IV Performance Measures (Cont.)**

**Step 2**: If the compliance/performance issues described by DHHS in Step 1 have not been addressed by the specified dates, the Provider and a representative of DHHS will meet, discuss, and document the compliance/performance issues. DHHS and the Provider will develop a corrective action plan which must include:

1. A statement of the corrective actions required for compliance with the Performance Measures;

2. The date by which the Provider will comply with the terms of the Performance Measures;

3. The consequences for non-compliance which may include the sanctions described in Chapter I of this manual or other consequences as determined by the Department; and

4. Signatures of the Provider and DHHS representative.

**Step 3**: In accordance with Chapter I, if the Provider fails to undertake the corrective actions in the corrective action plan, DHHS may impose sanctions, up to and including termination of the Provider Agreement in accordance with the procedures described in Chapter I, *General Administrative Policies and Procedures*, Section 1.03-4, Termination of Participation by Provider or DHHS and Section 1.19, Sanctions/Recoupments.