HOME AND COMMUNITY BENEFITS FOR THE ELDERLY AND

SECTION 19 **FOR ADULTS WITH DISABILITIES** **ESTABLISHED 2/20/86**
LAST UPDATED 06/21/10

**** THIS RULE WILL BECOME EFFECTIVE WITH IMPLEMENTATION OF MIHMS (September 1, 2010)****

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Home and Community Benefits for the Elderly and Adults with Disabilities (HCB) are in-home care and other services, designed as a package, to assist eligible members to remain in their homes, or other residential community settings, and thereby avoid or delay institutional nursing facility care. Medical eligibility for these HCB services is established by a medical eligibility determination (MED) assessment, which is conducted by the Department, or its Authorized Agent, the Assessing Services Agency (ASA). All services covered under this Section require prior approval by the Department, or the ASA, and shall be delivered according to the member's authorized plan of care. Services include: care coordination, adult day health, homemaker services, home health services, financial management services, personal support services, personal emergency response systems, respite care, transportation services, and environmental modifications. These services are provided in accordance with Title XIX, §1915(c) of the Social Security Act (42 U.S.C. §1396n(c)). Some of the changes adopted in this rule-making will require amendment of the waiver document filed with the Federal Centers for Medicare and Medicaid Services (CMS), and these amendments will require CMS approval before they are effective.

19.01 **DEFINITIONS**

19.01-1 **Activities of Daily Living** (ADLs) include only the following activities: bed mobility, transfer, locomotion, eating, toilet use, bathing, and dressing.

19.01-2 **Acute/Emergency Episode** is the unforeseen occurrence of an acute health episode that requires a change in the member's physician-ordered treatment plan and authorized plan of care, or the unforeseen circumstance where the availability of the member's caregiver, or informal support system is compromised.

19.01-3 **Adult Day Health Services** are health and social services provided to promote the optimal functioning of the member. Services are delivered according to an individual plan of care at an adult day health site which has in effect a current license pursuant to the Department's "Regulations Governing the Licensing and Functioning of Adult Day Services Programs."

19.01-4 **Adult Family Care Home** (AFCH) is a residential style home which has in effect a current license from the Department pursuant to the "Regulations Governing the Licensing of Adult Family Care Homes." Adult family care services are personal care services.

19.01-5 **Assessing Services Agency (ASA)** is an Authorized Agent of the Department for medical eligibility determinations, care plan development and authorization of covered services under this Section. The ASA conducts face-to-face assessments, using the Department's Medical Eligibility Determination form. A member's medical eligibility is based upon a member's assessment outcome. If medical eligibility is determined for this Section, the ASA develops the plan of care and specifies all

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19.01 **DEFINITIONS** (cont.)

services to be provided under this Section, including type of services and number of hours for all provider types.

19.01-6 **Authorized Agent** is an organization authorized by the Department to perform specified functions under a valid contract or other approved signed agreement. The ASA and the waiver services providers are Authorized Agents under this Section.

19.01-7 **Authorized Plan of Care** is a plan of care which is authorized by the Assessing Services Agency, or the Department, and which specifies all services to be delivered to a member under this Section, including the number of hours for each covered service, and the provider type to deliver each service. The authorized plan of care shall be based upon the member's assessment outcome scores recorded in the Department's MED form, utilizing the time frames contained therein, and the professional clinical judgment of the assessor. The authorized plan of care shall reflect the needs identified by the assessment, taking into account the member's living arrangement, informal supports, and services provided by other public and private funding sources. MaineCare shall not cover any service under this benefit that duplicates another service, regardless of payor or provider, including services such as Medicare and MaineCare hospice services, Private Non-Medical Institution (PNMI) services (see 42 CFR §434.2), and assisted housing services (see 22 MRSA §7852). All authorized, covered services provided under this Section must be listed in the care plan summary on the MED form.

19.01-8 If CMS approves, **Care Coordination Services (Supports Brokerage Services for those Members who have chosen the FPSO)** are those covered services provided by a care coordinator who is employed, or contracted, by the Service Coordination Agency to help the member access the services in the plan of care as authorized by the Department or its Authorized Agent. The purpose of care coordination services is to assist members in receiving appropriate, effective and efficient services, which allow them to retain or achieve the maximum amount of independence possible and desired. Care Coordination Services are designed to assist the member with identifying immediate and long-term needs, and ensure that the member is offered choices in service delivery based on his/her needs, preferences, and goals. These services assist with locating service providers, overseeing the appropriateness of the plan of care by regularly obtaining member feedback, and monitoring the member's health status.

19.01-9 **Care Plan Summary** is a section of the MED form that describes all medical and other services, regardless of funding source, to be provided to the member, the frequency, and the type of provider who delivers each service. The care plan summary shall include, but is not limited to, the HCB authorized by the Department or the ASA.

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19.01 **DEFINITIONS** (cont.)

19.01-10 **Choice Letter** is a document signed by the member or representative indicating the member's decision to select either home and community benefits or institutional services.

19.01-11 **Cognitive capacity** for purposes of this Section, is the member's ability to make decisions, make self understood, ability to understand and the ability to manage finances. Cognitive capacity is measured on the Medical Eligibility Determination form and is determined by the Authorized Agent as part of the eligibility determination. An applicant who chooses to manage the applicant's own services under the family provider service option must meet the following minimum scores to qualify:

(a) Decision making skills: a score of 0 or 1;
(b) Making self understood: a score of 0, 1, or 2;
(c) Ability to understand others: a score of 0, 1, or 2;
(d) Self performance in managing finances: a score of 0, 1, or 2; and
(e) Support in managing finances, a score of 0, 1, 2, or 3.

19.01-12 **Cost of Care** is the monthly dollar amount a member is responsible for paying to the State each month toward the cost of the member's HCB services, as determined by the Office of Integrated Access and Support, Department of Health and Human Services.

19.01-13 **Cueing** is any spoken instruction or physical guidance that serves as a signal to do something. Cueing is typically used when caring for members who are cognitively impaired.

19.01-14 **Environmental Modifications** are physical modifications to the member's place of residence, authorized in the member's plan of care, which are necessary to ensure the health and welfare of the member, or which enable the member to function with greater independence in the home, and are not covered or available under any other funding source. Modifications include, but are not limited to: ramps, lifts, modifications to bathrooms and kitchens, and specialized modifications such as door widening. This does not include major re-modeling or construction. The Department does not cover modification of motor vehicles.

19.01-15 **Extensive Assistance** means although the individual performed part of the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:

- Weight-bearing support three (3) or more times, or

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19.01 **DEFINITIONS** (cont.)

- Full staff performance of activity (three (3) or more times) during part (but not all) of the last seven (7) days.

19.01-16 **Family Member**, for purposes of this Section only, includes individuals related by blood or marriage or adoption as well as two (2) unmarried adults who are domiciled together under a long-term arrangement that evidences a commitment to remain responsible indefinitely for each other's welfare.

19.01-17 **Family Provider Service Option (FPSO)** is a self-directed option that allows a member, twenty-one (21) years or older, to register as a personal support services agency solely for the purpose of managing his/her own services or allows for an adult, twenty-one (21) years or older, to register as a personal support services agency solely for managing the services of no more than two (2) of the adult's family members.

19.01-18 If CMS approves, **Financial Management Services (FMS)** provide administrative and payroll services on behalf of a family provider service option agency for the services of personal care assistance under the family provider service option. FMS services include, but are not limited to, preparing payroll and withholding taxes, making payments to suppliers of goods and services, and assisting with compliance with State and Federal tax and labor regulations and the requirements under this Section. The FMS acts as an agent of the employer in accordance with Federal Internal Revenue Service Codes and Procedures.

19.01-19 **Health Maintenance Activities** are activities to assist the member with activities of daily living and instrumental activities of daily living, and additional activities specified in this definition. These activities are performed by a designated caregiver for an individual who would otherwise perform the activities if he or she were physically or cognitively able to do so, and enable the member to live in his or her home and community. These additional activities include, but are not limited to catheterization, ostomy care, preparation of food and tube feedings, bowel treatments, administration of medications, care of skin with damaged integrity, and occupational and physical therapy activities such as assistance with prescribed exercise regimes.

19.01-20 **Home Health Services** are nursing services, physical therapy, occupational therapy, speech therapy, home health aide (HHA) services, and medical social services, delivered at the member's place of residence, under physician orders and authorized by the ASA.

19.01-21 **Homemaker Services** are services that maintain or supplement housekeeping, homemaking, and chores when the individual regularly responsible for these

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19.01 **DEFINITIONS** (cont.)

activities is absent or unable to manage the home and care for his/her self. This service includes heavy chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access inside the home for the member, and shoveling snow to provide access and egress.

19.01-22 **Instrumental Activities of Daily Living** (IADL) include only the following activities: preparing and serving meals, washing dishes, dusting, making bed, pick-up living space, sweeping, vacuuming and washing floors, cleaning toilet, tub and sink, appliance care, changing linens, refuse removal, shopping for groceries and prepared foods, storage of purchased groceries, laundry, either within the residence or at an outside laundry facility.

19.01-23 **Limited Assistance** is a term used to describe an individual's self-care performance in activities of daily living, as defined by the Minimum Data Set (MDS) assessment process. It means that although the individual was highly involved in the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:

- physical help in guided maneuvering of limbs or other non-weight-bearing assistance three (3) or more times, or

- limited assistance three (3) or more times, plus more help with weight-bearing support provided only one (1) or two (2) times.

19.01-25 **MeCare** is a computerized long-term care medical eligibility system facilitating the entire medical assessment process, from intake through information dissemination.

19.01-26 **Medical Eligibility Determination Form** is the Department's approved form for determining a member's medical eligibility for services under this Section. The MED form's definitions, scoring mechanisms and time frames provide the basis for including services in the authorized plan of care. The Department, or the ASA, shall conduct the MED assessment on a face-to-face basis. Based upon the member's outcome scores, an authorized plan of care is then developed, which specifies the services, numbers of hours, and provider types. The care plan summary section of the MED form documents the authorized plan of care, and identifies any other non-HCB services the member may be receiving, regardless of payor.

19.01-27 **Member** is an individual who meets the eligibility requirements of this Section and is authorized to receive services. For purposes of making health care decisions, a

19.01 **DEFINITIONS** (cont.)

member may be represented by his or her "guardian," "agent" or "surrogate," as these terms are defined in 18-A MRSA Sec. 5-801.

19.01-28 **Nursing Facility Services** are described in Chapter II, Section 67, Nursing Facility Services, of this Manual. They primarily include professional nursing care or rehabilitative services for the injured, disabled, or sick persons which are needed on a daily basis and, as a practical matter, can only be provided in a nursing facility, ordered by and provided under the direction of a physician, and less intensive than hospital inpatient services.

19.01-29 **One-person Physical Assist** requires one (1) person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting. This does not include cueing.

19.01-30 **Personal Emergency Response System** (PERS) is an electronic device that enables certain high-risk members to secure help in the event of an emergency. The member may also wear a portable "help" button to allow for mobility. The system is connected to a member's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

19.01-31 **Personal Support Services,** also known as personal care services, are those covered ADLs, IADLs and health maintenance activities provided in a member's residence by a home health aide, certified nursing assistant (CNA) or personal support specialist, as appropriate, in accordance with an authorized plan of care.

19.01-32 **Personal Support Specialist (PSS),** also known as personal care assistant, is a person who provides personal support services and has completed a Department approved training course of at least fifty (50) hours, unless otherwise exempt under this Section, which includes, but is not limited to, instruction in basic personal support procedures, first aid, handling of emergencies, and review of the mandatory reporting requirement under the Adult Protective Services Act. PSSs are unlicensed assistive personnel as defined in Title 22 MRSA §1717(1)(D).

19.01-33 **Respite Care** is provided to a member who is unable to care for him or herself, and who requires care on a short-term basis due to the temporary absence of, or to provide relief for, the caregiver who normally provides the care.

19.01-34 If CMS approves, **Service Coordination Agency** is an organization that has the capacity to provide Care Coordination, Supports Brokerage and Skills Training to eligible members

19.01 **DEFINITIONS** (cont.)

under this Section, and has met the MaineCare provider enrollment requirements of the Department. In addition to Care Coordination, Supports Brokerage and Skills Training, the Service Coordination Agency is responsible for administrative functions, including but not limited to, maintaining member records, submitting claims, conducting internal utilization and quality assurance activities, and meeting the reporting requirements of the Department. The Service Coordination Agency shall refer to the Department's contracted Waiver Service Provider when a member is determined eligible for any of the following services: homemaker, PERS, environmental modifications and respite care delivered in an institution. In order to prevent a conflict of interest, the Service Coordination Agency providing care coordination services to a member may not be a provider of direct care services.

19.01-35 **Signature** of the Registered Nurse (RN) assessor from the Assessing Services Agency and the care coordinator from the Service Coordination Agency equates with the "login" onto the MeCare eligibility determination computer system.

19.01-36 **Significant Change** is defined as a major change in the member's status that is not self-limiting, impacts on more than one (1) area of his or her health status, and requires multidisciplinary review or revision of the authorized plan of care. A significant change assessment is appropriate if there is a consistent pattern of changes, with two (2) or more areas of improvement or decline that impacts member eligibility.

19.01-37 If CMS approves, **Skills Training** is a service that provides members with the information and skills necessary to carry out their responsibilities when choosing to participate in the self-directed option. This is a required service for those members choosing the FPSO.

19.01-38 If CMS approves, **Supports Brokerage Services** are the same as care coordination services (as outlined under 19.01-4) that are provided to members who have chosen to self-direct their PSS services.

19.01-39 **Total Dependence** means full staff performance of the activity during the entire last seven (7) day period, i.e., complete non-participation by the member in all aspects of the ADLs.

19.01-40 **Transportation** are those services needed to provide the member access to adult day health services and any other service covered under this Section required to carry out the member's individual plan of care. Transportation to other MaineCare covered

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19.01 **DEFINITIONS** (cont.)

services is covered under Chapter II, Section 113 of the MaineCare Benefits Manual (MBM).

19.01-41 **Unstable Medical Condition** exists when the member's condition is fluctuating in an irregular way and/or is deteriorating and affects the member's ability to function independently. The fluctuations are to such a degree that medical treatment and professional nursing observation, assessment and management at least once every eight (8) hours is required. An unstable medical condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record. Not included in this definition is the loss of function resulting from a temporary disability from which full recovery is expected.

19.01-42 If CMS approves, **Waiver Services Provider** is an Authorized Agent of the Department under this Section and holds a valid contract with the Office of Elder Services. This provider is responsible for coordinating the following services: homemaker, PERS, environmental modifications and respite care delivered in an institution. This provider enters into agreements with subcontractors and ensures that these services are delivered according to the authorized plan of care; oversees and assures compliance with policy requirements, and conducts required internal and external utilization review activities with regard to these services. This provider is responsible to bill the Department and reimburse the subcontractors for delivering these services.

19.02 **ELIGIBILITY FOR CARE**

19.02-1 **General and specific requirements**
To be eligible for services under this section, a member must be eighteen (18) years or older and meet the general MaineCare eligibility requirements found in Chapter 332, MaineCare Eligibility Manual, medical requirements, and other specific requirements for Home and Community Benefits for the Elderly and Adults with Disabilities. Even if a member meets all criteria for eligibility for services under this section, the provision of these services is subject to available funding. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the Service Coordination Agency to verify a member's eligibility for MaineCare, as described in Chapter I, prior to coordinating the provision of services authorized by the ASA.

19.02-2 **Medical requirements**
A person meets the medical eligibility requirements for HCB if he or she meets the medical eligibility requirements specified in Chapter II, Section 67.02, Nursing Facility

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19.02 **ELIGIBILITY FOR CARE** (cont.)

Services, of this Manual. The Department, or its Assessing Services Agency, using the medical eligibility determination form must complete a face-to-face assessment. The clinical judgment of the ASA shall be determinative of the scores given on the MED assessment.

19.02-3 **Other specific requirements**

A member meets the requirements of this Section when all of the additional following conditions are met:

A. The projected cost of services under this Section needed by the member on a monthly basis is estimated to be less than one hundred percent (100%) of the average monthly MaineCare cost of care in a nursing facility; and

B A member or applicant who meets the eligibility criteria for nursing facility level of care has been informed of, and offered the choice of available, appropriate and cost effective, home and community benefits; and

C. The member selected home and community benefits as documented by a signed choice letter; and

D. The health and welfare of the applicant/member would not be endangered if the member remained at home or in the community; and

E. The particular services needed by the member are available in the geographic area and a willing provider is available; and

F. Members will be accepted into the program on a combined priority and first-come, first-served basis, based upon the availability of funding. First priority will be given to members who meet the medical eligibility criteria set forth in Chapter II, Section 67.02-3(A), of this Manual. Within this category, applicants will be served on a first-come, first-served basis.

Second priority will be given to members who meet the medical eligibility criteria set forth in Chapter II, Section 67.02-3(B) or (C), of this manual. Within this category applicants will be served on a first-come, first-served basis.

The Office of Elder Services will maintain the waiting list.

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19.02 **ELIGIBILITY FOR CARE** (cont.)

G. To be eligible to manage the member's own services under the family provider service option, a member must meet the definition of cognitive capacity as defined in Section 19.01-11 above.

19.03 **DURATION OF CARE**

Each member receiving services under this Section is eligible for as many covered services as are authorized in the member's plan of care by the Department or the ASA. Services are authorized to meet the needs identified in the member's most recent assessment, based on the outcome scores, time frames and definitions of the MED form, and subject to the limits specified elsewhere in this Section.

MaineCare coverage of services under this Section requires prior approval from the Department, or its Assessing Services Agency. Beginning and end dates of a member's medical eligibility period correspond to the beginning and end dates for MaineCare coverage of the services in the authorized plan of care. The Department reserves the right to request additional information to evaluate medical necessity. Coverage will be denied if the services provided are not included in the authorized plan of care, except as allowed for an acute/emergency episode as described in Section 19.04-2(A)(4).

19.03-1 HCB shall be reduced, denied, suspended or terminated by the Assessing Services Agency, Service Coordination Agency or the Department, as appropriate, if any of the following situations occur:

A. The annual cost of HCB for the member exceeds one hundred percent (100%) of the average annual MaineCare cost of nursing facility services. The member shall be offered placement in a nursing facility under Chapter II, Section 67 of this Manual. The Service Coordination Agency must exercise reasonable care and ensure that in such cases that home and community benefits are continued until the transition is completed, unless a willing provider is not available.

B. The member declines personal support services, nursing services or other home and community benefits;

C. A significant change occurs in the member's medical or functional status such that a plan of care to maintain or delay significant deterioration in the health and welfare of the member at home, or in the community, can no longer be developed and implemented;

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19.02 **DURATION OF CARE** (cont.)

D. The member receives services under Chapter II, Section 96, Private Duty Nursing and Personal Support Services, Chapter II, Section 12, Personal Care Attendant Services, Chapter II, Section 22, Home and Community Benefits for Adults with Physical Disabilities, or Section 40, Home Health Services. Only care management services may be provided under this Section to a member who receives services under Chapter II, Section 96, Private Duty Nursing and Personal Support Services, or Section 40, Home Health Services, until home and community benefits are in place for the member and a transition can be made;

E. The member does not meet the medical eligibility criteria for nursing facility level services as set forth in Chapter II, Section 67.02 of this Manual, as determined by the Assessing Services Agency;

F. The member is not financially eligible to receive MaineCare benefits;

G. The member does not comply with the authorized plan of care for services;

H. The member fails to pay the cost of care for two (2) consecutive months and there is no willing provider available to continue services;

I. When the member's most recent MED assessment, and the clinical judgment of the ASA, determines that the authorized plan of care must be changed or reduced to match the member's needs as identified in the reassessment and subject to the limitations of the cap. Even though the member's medical eligibility for home and community benefits may not be affected, the plan of care may be modified by the ASA to reflect the change in needs or any change in policy that affects all members;

J. The member becomes an inpatient of a hospital, a resident of a nursing facility (NF), or resident of an Intermediate Care Facility for the Mentally Retarded (ICF-MR);

K The member becomes a resident in an assisted living setting or in an adult family care home (as defined in the MBM, Chapter II, Section 2) or other residential care setting including a private non-medical institution (as defined in the MBM, Chapter II, Section 97), sometimes referred to as a residential care facility or supported living, regardless of payment source, (i.e. private or MaineCare).

L. The cost of services is likely to exceed the monthly average cap;

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19.03 **DURATION OF CARE** (cont.)

M. The member has provided fraudulent information in connection with obtaining services;

N. The federally-approved Waiver under which these rules were promulgated expires; or

O. The Department, the SCA or the ASA documents that the member, or other person living or visiting the member's residence, harasses, threatens or endangers the safety of individuals delivering services;

P. Services may be suspended for up to sixty (60) days. If such circumstances extend beyond 60 days, the member's service coverage under this Section will be terminated and the member will need to be reassessed to determine medical eligibility for these services.**Transfer to a Different Home and Community-Based Benefit**

19.03-2 **Transfer to a Different Home and Community Benefit.** A member receiving services under any NF level of care benefit, may transfer to any other NF level of home care benefit as may be necessary due to service needs and/or age requirements. The Service Coordination Agency shall submit the Department's approved transmittal form to the Department indicating the effective date of transfer. A medical eligibility assessment is not required as a part of the transfer process, unless the most recent assessment is over ninety (90) days old.

19.04 **COVERED SERVICES**

Covered services are available for members meeting the eligibility requirements set forth in Section°19.02. Covered services must be required in order to maintain the member's current health status, or prevent or delay deterioration of a member and/or avoid long-term institutional care. Services under this Section require prior approval by the Department, or its Assessing Services Agency, and are included in the calculation of the member's financial cap. Services shall not be reimbursed until both medical and financial eligibility have been approved. Members who meet the eligibility requirements for services under this Section are eligible for the following services, as included by the ASA in the authorized plan of care:

19.04-1 **Adult Day Health** services are delivered four (4) or more hours per day, on a regularly scheduled basis, up to seven (7) days a week. The hours spent in adult day health services shall count as personal care services. If a member's plan of care specifies that a particular covered personal care service is needed, such as a bath, it must be provided. Based upon member needs the adult day health services may include:

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19.04 **COVERED SERVICES** (cont.)

- monitoring of health care
- supervision, assistance with activities of daily living
- nursing
- personal support services
- rehabilitation
- health promotion activities
- exercise groups
- counseling

Noon meals and snacks are provided as a part of adult day health services reimbursement. There must be a regular, ongoing schedule of group and individual activities planned with the participants and based on the assessment of a member participant's needs and interests.

19.04-2 If CMS approves, **Care Coordination** is provided to all members who receive Home and Community-Based Benefits, and activities are guided by the member's authorized plan of care. Care Coordination (Supports Brokerage for FPSO members) is provided through in-person contact in the member's residence, or through telephone and other methods with the member, his/her family and other responsible parties, providers of service, and others as appropriate for providing access to Home and Community-Based Benefits for members who choose to self-direct their services under the FPSO option, supports brokerage includes assisting the member in arranging for, directing and managing his/her self-directed services as allowed, and coordinating access to Skills Training as defined in this section.

A. Responsibilities

1. Making initial contact with the member or the responsible party, by telephone or other appropriate method, within two (2) business days of notification of authorization of care coordination services to discuss choice of provider(s), service delivery options, clarify issues, and answer questions;

2. Ensuring implementation of the authorized plan of care and coordinating service providers who are responsible for delivering services, by making referrals and providing service authorizations to qualified service provider(s) the member chooses; or if the member chooses to self-direct, providing access to Skills Training;

3. Visiting the member at his/her residence within 30 days of receipt of notification of authorization of care coordination services to review

19.04 **COVERED SERVICES** (cont.)

needs and goals, and complete the Health and Welfare tool approved by the Office of Elder Services, address unmet needs;

4. Visiting the member annually to monitor the member's overall health status by completing the Health and Welfare tool and following up on identified needs and issues;

5. Making contacts with family members, designated representatives, guardians, providers of services or supports, the assessing services agency, and the Department to ensure continuity of care and coordination of services;

6. Monitoring the member's receipt of services and reviewing the plan of care by contacting the member at least once per month. Monitoring calls may be reduced to a lesser frequency but not less than quarterly if the member requests less frequent calls and there is documentation in the record to support this choice. Monitoring may be done by telephone unless an in-person visit is needed to be effective;

7. Responding timely to assist the member with resolving problems and other concerns;

8. Advocating on behalf of the member for appropriate community resources and services by providing information, making referrals and otherwise facilitating access to these supports;

9. Modifying the authorized plan of care, within the following parameters:

   a. In the event a member experiences a change in the need for services, the care coordinator has the authority to adjust the frequency of services under the authorized plan of care, in order to address the needs. However, the total number of hours authorized for the eligibility period shall not be exceeded.

   b. In the event a member experiences an emergency or acute episode as defined in this section, the care coordinator may adjust the authorized plan of care up to fifteen (15) percent of the monthly authorized amount, not to exceed the monthly program cap. Services added or changed due to the emergency or acute episode may not continue beyond fourteen (14) days.

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19.03 **COVERED SERVICES** (cont.)

10. Making referrals for reassessments prior to the end of the eligibility period, and based upon a significant change in the member's health status or change in service needs;

11. Issuing notices of intent to suspend, reduce or terminate, as appropriate, when the member is ineligible for such services or the level of services are reduced. The care coordinator may not issue a notice to reduce or terminate services based on medical eligibility;

12. Other activities include, but are not limited to:

    a. Complying with the Department's internal authorization protocols,

    b. Maintaining member records,

    c. Providing information as required by the Department,

    d. Following requirements regarding mandated reporting.

19.04-3 **Environmental Modifications** include the following medically necessary modifications to the member's residence:

A. Ramps;

B. Lifts, such as porch or stair lifts and hydraulic, manual or other electronic lifts;

C. Modifications to bathroom facilities such as: roll-in showers, sink, bathtub, toilet and plumbing modifications, water faucet controls, floor urinal and bidet adaptations and turn-around space adaptations;

E. Modifications to kitchen facilities such as: sink modifications, sink cut-outs, and water faucet controls, turn-around space adaptations, surface adjustments/additions and cabinetry adjustments/additions; and

F. Specialized accessibility/safety adaptations such as: door-widening, electrical wiring, grab bars and handrails, automatic door openers/doorbells, voice activated, light activated, motion activated and electronic devices, fire safety adaptations, medically necessary air filtering devices, low-pile carpeting, and smooth or non-skid flooring needed to assure safe ambulation or wheelchair mobility.

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19.04 **COVERED SERVICES** (cont.)

All requests for, and repairs to, environmental modifications must be authorized in advance by the Department, or the ASA. The Department, or the ASA, shall make the determination of medical necessity for environmental modifications. Reimbursement shall not be provided for general house repairs or re-modeling. Modification of motor vehicles is not covered under this Section.

All environmental modifications must be provided in accordance with applicable Federal, State or local building codes and, if applicable, performed by or supervised by State licensed/certified professionals. The waiver services provider shall maintain documentation in support of services billed to the Department. Reimbursement for environmental modifications under this Section shall be provided only when payment for these services may not be made under any other Section of this Manual. There is an annual limit on expenditures for environmental modifications under this Section, which shall include any expenditure for environmental modifications provided under any other Section of this manual, of $3,000 per member, per waiver year. This amount does not count toward the monthly cost cap.

19.04-4 If CMS approves, **Financial Management Services (FMS)** will be covered only for those members who are electing the FPSO option. FMS related duties and tasks include:

A. Assist members in verifying support worker citizenship status;

B. Collect and process timesheets of PSS workers and disburse PSS payments;

C. Process payroll, withholdings, filings and payment of applicable Federal, state and local employment-related taxes and insurances.

D. Establish and maintain member files in accordance with this section.

19.04-5 **Homemaker Services** will be covered only in cases where neither the member, nor anyone else in the household, is capable of performing them and where no other relative, caretaker, landlord, community volunteer/agency or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease, may be examined prior to the authorization of services, upon request of the Department, the ASA, SCA, or the waiver services provider, as appropriate. Activities performed may include:

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19.04 **COVERED SERVICES** (cont.)

A. Routine household care, including sweeping, washing and vacuuming of floors, dusting, cleaning of plumbing fixtures (toilet, tub, sink), appliance care, changing of linens, refuse removal;

B. Doing laundry within the residence or outside the home, including washing and drying of clothing and household linens such as sheets, towels, blankets, etc.;

C. Meal planning/preparation, including purchasing meals;

D. Shopping for groceries and prepared foods, errands, and storage of purchased groceries;

E. Chore services including, but not limited to: occasional heavy-duty cleaning, raising and lowering of combination screen/storm windows, repairs and similar minor tasks to eliminate safety hazards in the environment, lawn mowing or snow shoveling;

F. Assistance with incidental personal hygiene, such as: combing hair, brushing teeth, shaving, applying makeup, and washing/drying back and feet;

G. Incidental help with dressing that includes assisting a person to put on, fasten, and take off all items of clothing, including stockings and socks; and

H. Transportation services necessary to access MaineCare covered services described in a member's plan of care, such as medical appointments. Reimbursement shall only be made for mileage in excess of ten (10) miles per single trip on a one-way trip.

19.04-6 **Home Health Services** are provided in fifteen (15) minute increments or on a "visit" basis. However, only home health agencies that are Medicare certified and licensed in the State of Maine may bill on a "visit" basis. The type and frequency of each covered home health service must be authorized by the ASA in the plan of care. The direct care provider shall develop a nursing plan of care, which shall include the personal support and nursing services authorized by the ASA or the Department, and the medical treatment plan which shall be reviewed and signed by the member's physician. This plan shall be provided to the SCA at no additional cost.

If a member is receiving Home Health Services under this Section, the member is ineligible for services under Chapter II, Section 40, Home Health Services and Section 96, Private Duty Nursing and Personal Care Services of this Manual. Home Health Services under these HCB include the following, which may be provided by an independent contractor with the exception of LPN, MSW and home health aide/ CNA services:

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19.04 **COVERED SERVICES** (cont.)

Registered nurse supervisory visits made for the sole purpose of supervising other home health staff are not billable as a visit and are, therefore, not reimbursable as a HCB service. If nursing services are delivered as part of the visit, those nursing services may be covered.

A. **Registered Nurse** services, include:

1. Initiating a plan of nursing treatment and revising it as necessary. Copies of the nursing treatment plan, regardless of the reimbursement source shall be made available to the SCA;

2. Skilled nursing services not reimbursable by Medicare or another third party;

3. Informing the physician, the care coordinator and other parties, as appropriate, of changes in the member's condition and needs;

4. Teaching the member and family about meeting nursing and related needs;

5. Performing all other duties and responsibilities within the scope of the nursing license.

B. **Licensed Practical Nurse** services include all duties and responsibilities within the scope of the nursing license.

C. **Physical Therapy** services are those restorative services provided in accordance with physician orders, by a physical therapist, or by a physical therapist assistant working under the direct supervision of a licensed physical therapist, licensed in Maine in which services are provided, and acting within the scope of that license.

In order for pool therapy to be covered under this Section, physician orders are required and pool therapy must be specified in the authorized plan of care. Physical therapy services delivered in a pool setting must be provided by a licensed physical therapist. No additional reimbursement will be provided for pool fees.

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19.04 **COVERED SERVICES** (cont.)

D. **Occupational Therapy** services are those restorative services provided in accordance with physician orders, by an Occupational Therapist, Registered (OTR), or by a Certified Occupational Therapist Assistant (COTA) under the direct supervision of an OTR, licensed in Maine, and acting within the scope of that license. These services include:

1. Task-oriented activities such as treatment to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the member;

2. Evaluation of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance and assessment of living areas for the disability; and

3. Specific occupational therapy techniques such as assistance with activities of daily living skills, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual andcreative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance, and treatment techniques to improve physical capabilities for activities.

The occupational therapist assists the physician in evaluating level of function, helps develop and revise a plan of treatment, and prepares clinical and progress notes.

E. **Speech-Language Therapy** services are those services which are provided by an individual licensed in Maine, and acting within the scope of that license as a Speech-Language Pathologist, which include speech, voice and language evaluation, diagnosis and plan of care, speech, voice and language therapy and/or aural rehabilitation, speech pathology, collateral services, speech and language periodic re-evaluation, speech pathology diagnostic services, hearing screening, and speech, voice and/or language screening. The speech language pathologist assists the physician in evaluating level of function, helps develop the plan of treatment and prepares clinical and progress notes.

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19.04 **COVERED SERVICES** (cont.)

F. **Home Health Aide/Certified Nursing Assistant Services** are delegated and overseen by a registered nurse. Written instructions for member's care are prepared by a registered nurse or therapist as appropriate. Duties include:

1. the performance of simple procedures as an extension of therapy services;

2. assistance with ADLs and IADLs (as defined in Section 19.01), also known as personal support services;

3. assistance with medications that are allowed under the scope of practice;

4. reporting changes in the member's condition and needs to the nurse;

5. completing appropriate records; and

6. transportation services may be provided when necessary to access covered services described in the plan of care. Reimbursement shall only be made for mileage in excess of ten (10) miles per single (one-way) trip. Prior to providing such service, the criteria listed in Section 19.04-8 must be met.

F. **Medical Social Services** are provided by an individual with a Masters of Social Work (MSW) who is licensed in Maine, and acts within the scope of that license. The social worker:

1. assists the physician and other team members in understanding the significant social and emotional factors related to the health problems;

2. participates in the development of the social worker plan of treatment;

3. educates the family regarding the member's health status and plan of care;

4. Performs all other duties and responsibilities within the scope of social work licensure.

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19.04 **COVERED SERVICES** (cont.)

19.04-7 **Personal Support Services (PSS),** include services related to a member's physical requirements for assistance with ADLs, including assistance with health maintenance activities. Health maintenance activities must be activities that would otherwise be performed by the member, if the member were physically or cognitively able to do so. PSS will not be authorized for the sole purposes of providing assistance with IADLs. Household tasks and the allotted hours must be specified in the authorized plan of care. The tasks are defined in Section 19.01-23.

Qualified PSSs may provide escort and/or transport services necessary to provide covered HCB as described in the authorized plan of care. Reimbursement shall only be made for mileage in excess of ten (10) miles per one-way trip. (Also see Section 19.04-8, Transportation Services.)

19.04-8 **Personal Emergency Response Systems (PERS)** are covered only for those members who live alone, or who are alone for significant parts of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision. PERS can serve as a contingency plan to assure access to emergency assistance. Reimbursement is limited to the installation fee and the monthly phone charge for the emergency response system and the home unit communicator.

19.04-9 **Transportation Services** provided by individuals or private carriers (taxi) are covered only when it is documented that other personal, family, or community resources and public regional transportation agencies, are unavailable and/or have been exhausted. Documentation of the transportation agency's or personal/family inability to provide services as requested must be included in the member's record indicating when the request was denied and by whom.

When personal, family, and community resources are unavailable, transportation services necessary to carry out a member's plan of care may be provided by homemakers, personal support specialists, home health aides, and certified nursing assistants when the cost effectiveness of such services is documented in the member's plan of care. Any individual providing transportation must hold a valid State of Maine driver's license for the type of vehicle being operated. All providers of transportation services shall maintain adequate liability insurance coverage for the type of vehicle being operated.

19.04-10 **Respite Services** shall be provided by a qualified staff person, in the member's home, or it shall be provided in a licensed nursing facility or a licensed residential care setting. Federal financial participation shall not be claimed for room and board except when provided as part of respite care in a licensed nursing facility. Expenditures for respite care shall not exceed the allowed maximum, which is equal to the State average cost of thirty (30) days of nursing facility services, per State fiscal year, per member. A facility

19.05 **COVERED SERVICES** (cont.)

must bill the waiver services provider for reimbursement of respite services provided in an institution. For respite services delivered in the member's home, the appropriate staff for meeting the member's needs (i.e., RN, HHA/CNA or PSS) can be utilized and reimbursement shall be at that worker's regular rate. All respite services must be billed using the appropriate respite procedure code and rate (home: number of hours per RN or HHA/CNA or PSS; or nursing facility, or residential care facility service component only).

19.04-11 If CMS approves, **Skills Training** services instruct the member in the management of personal support specialists. Instruction in management of personal support services includes instruction in recruiting, interviewing, selecting, training, scheduling, discharging, and directing a competent PSS in the activities in the authorized plan of care and requirements under this Section.

Skills training must occur prior to the start of services. Initial skills training must occur within thirty (30) calendar days of the determination of medical eligibility before services can start. A competency–based assessment may be performed in lieu of skills training for members who have previously completed such training.

19.05 **NON-COVERED SERVICES**

The following services are non-covered services:

A. Services that are not in the authorized plan of care according to Section 19.04, except as allowed under an acute/emergency episode (see Section 19.04-2(A)(4));

B. Services that are described as non-covered services in Chapter I of this Manual;

C. Household tasks, except included as IADL or homemaker services in the authorized plan of care, according to Section 19.04;

D. Personal support services provided by a spouse of the member, or by the parents or stepparents of a minor child who is a member;

E. Services provided by anyone prohibited from employment under the following:

1. a personal support specialist or homemaker who is prohibited from employment under Title 22 MRSA §1717(3), §2149-A, §7851 or §8606; or

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2. a certified nursing assistant who is prohibited from employment under Title 22 MRSA §1812(G).

F. Custodial care or supervision;

G. Personal support specialist services delivered in a licensed or unlicensed assisted housing setting, including a residential care facility, or a supported living arrangement certified by Department of Health and Human Services, Integrated Services for behavioral and developmental services.

H. Room and board and food (except when allowed for respite services delivered in the NF setting);

I. Travel time and mileage except as allowed under Section 19.04-8, when it is authorized in the plan of care to carry out an authorized service;

J. Services provided not in the presence of the member unless in the provision of covered IADLs, such as grocery shopping or laundry while the member remains at home;

K. Services provided when the member is in the hospital, nursing facility, PNMI, or ICF- MR;

M. Supervisory visits for HHAs, CNAs, and PSSs;

N. Other services described as non-covered in Chapter I of the MaineCare Benefits Manual including recreational, custodial and leisure activities; and

O. Services in excess of forty (40) hours per week provided by an individual worker to any individual member receiving services under the FPSO option.

19.06 **LIMITS (If CMS Approves)**

A. Skills Training Services shall not exceed 14.25 hours annually including the hours needed for initial instruction.

B. Care Coordination Services or Supports Brokerage Services shall not exceed 18 hours annually.

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19.07 GENERAL ELIGIBILITY PROCEDURES

The procedure for determining eligibility, in accordance with the criteria outlined in §19.02 above, for HCB is as follows:

A. **Medical eligibility**: A complete, standardized referral, or verbal/written request by the member, or designated representative, for a medical eligibility assessment shall be submitted to the Department or the ASA. The ASA shall conduct a medical eligibility assessment within five (5) calendar days of receipt of a request, except when the member is receiving acute level of care services. In such cases, the assessment is delayed until twenty-four (24) hours after discharge, or when continued acute level services are denied.

The Department or its authorized agent shall conduct a face-to-face medical eligibility assessment at the member's residence using the MED assessment form. The individual conducting the assessment shall be a registered nurse and will be trained in conducting assessments and developing an authorized plan of care using the Department's approved tool. The RN assessor's findings and scores recorded in the MED form shall be determinative in establishing eligibility for services and the authorized plan of care. Applicants (guardian, agent, or surrogate), who meet the eligibility criteria set forth in Section 19.02, and as documented on the Department's MED assessment form, shall:

1. Receive an authorized plan of care based upon the scores, time frames and findings recorded in the MED assessment and level of care for which they are eligible. The covered services to be provided in accordance with the authorized plan of care shall: 1) not exceed the established financial caps; 2) be subject to prior approval by the Department or the ASA; and 3) the nursing or therapy treatment plan shall be under the direction of the member's physician, when applicable.

2. Inform the applicant (guardian, agent, or surrogate) of the options stated in the choice letter. The applicant (guardian, agent, or surrogate) will need to indicate his or her choice of either nursing facility services or home and community benefits on the choice letter and state his or her wish to initiate services by signing the choice letter. The choice letter must be signed annually.

3. If the applicant or member chooses nursing facility care, the individual shall be placed in accordance with existing placement procedures as set forth in this Manual, Chapter II, Section 67. In the event a nursing facility bed is not available, the member may choose home and community benefits within thirty (30) days of the assessment date. A new choice letter must be signed.

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19.06 **GENERAL ELIGIBILITY PROCEDURES** (cont.)

4. If the financial eligibility process has not been initiated, the ASA assessor will provide an application for financial eligibility determination and refer the applicant to the Office of Integrated Access and Support (OIAS).

5. The ASA assessor shall approve an initial eligibility period for up to ninety (90) days, based upon the scores and needs identified in the MED assessment and the assessor's clinical judgment.

6. The ASA shall forward the completed assessment packet to the Department's Service Coordination Agency within two business days of the medical eligibility determination and development of the authorized plan of care.

B. **Financial Eligibility**: Financial eligibility is determined by the local office of the Office of Integrated Access and Support (OIAS) as outlined in the MaineCare Eligibility Manual. The ASA's pre-screen intake process may instruct the applicant and/or designated representative to initiate the financial eligibility process at the local OIAS office. For SSI members, no financial determination process is necessary. The RN assessor will verify SSI status. Financial eligibility procedures are as follows:

1. OIAS will notify the Applicant or member as to whether the member is medically and financially eligible.

2. If the Department, or the ASA, determines that the applicant or member is medically ineligible for nursing facility level of care, the Department will inform OIAS of the applicant's medical ineligibility. OIAS will notify the applicant in the notification letter of the applicant's medical ineligibility and whether his/her financial eligibility for MaineCare is affected.

3. If the Applicant or member is found to be ineligible under financial or medical eligibility criteria, OIAS will specify in the notice which eligibility criteria the Applicant or member has failed to meet. The Applicant or member shall be informed of his/her right to request an administrative hearing before the Department of Health and Human Services in accordance with Chapter I of this Manual under the Section describing "Member Appeals."

When HCB funds are not available, the ASA will discuss other funding service options during the assessment process. The ASA will initiate any necessary referrals on the member's behalf to access home care options. The member will be informed that his or her name has been referred to the HCB wait list, when applicable.

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19.07 **GENERAL ELIGIBILITY PROCEDURES** (cont.)

C. **Implementation of the authorized plan:** On receipt of the eligibility packet the Service Coordination Agency shall:

1. contact the member within two (2) business days;

2. assist the member with locating providers and obtaining authorized services;

3. implement and coordinate services with the provider agency or independent contractor using service authorizations;

4. monitor service utilization and assure compliance with this policy; and

5. send a copy of the authorized plan of care to the attending physician, with a cover letter inviting the physician to participate and comment on the plan of care.

In addition to the above, the SCA shall be responsible for entering service authorizations according to Department procedures. When the services are terminated the SCA will be responsible for entering service end-dates by the next business day.

C. Redetermination of Eligibility

1. For all members receiving services under this Section, in order for the reimbursement of services to continue uninterrupted beyond the approved eligibility period, a reassessment and prior approval of services is required and must be conducted no earlier than twenty-one (21) days prior to and no later than the eligibility end-date.

2. The Service Coordination Agency will provide relevant information to the ASA, prior to the reassessment due date. The information shall be shared with the ASA as part of the referral for re-determination of medical eligibility and development of the authorized plan of care.

19.08 **POLICIES AND PROCEDURES**

19.08-1 **Member Complaint Logs**

The ASA, SCA and waiver services provider shall each be responsible for maintaining a log of member complaints regarding home and community benefits. This shall include all verbal and written complaints. There shall be documentation regarding the member, date and nature of the complaint and how each complaint was

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addressed or resolved. The member complaint log shall be made available to the Department upon request.

19.08-2 **Professional and Other Qualified Staff**

If registered professional nurses, physical therapists, occupational therapists and speech-language pathologists are acting as independent contractors, they must be enrolled as a MaineCare provider in order to provide services under this Section. Services shall be provided by the following staff:

A. **Professional Staff**

The following professional staff must be fully licensed, which license must be documented by written evidence from the appropriate governing body. All professional staff must provide services only to the extent permitted by licensure and approval to practice conditions. If the professional is not acting as an independent contractor he/she must be employed directly by or through a contractual relationship with a MaineCare provider.

1. Registered Professional Nurse: A registered professional nurse may provide nursing services within the scope of his or her licensure.

2. Practical Nurse: A licensed practical nurse may provide nursing services within the scope of his or her licensure provided they are supervised by a registered professional nurse.

3. Master's Social Worker: A social worker must hold a Master's Degree from a school of social work accredited by the Council on Social Work Education.

4. Physical Therapist: A physical therapist who meets the requirements as defined in Section 85.02-3 and the qualifications set forth in Section 85.09 may provide physical therapy services.

5 Occupational Therapist: A registered occupational therapist who meets the requirements as defined under Section 68.02-3 and the qualifications under Section 68.09-1 may provide occupational therapy services.

6. Speech-Language Pathologist: A speech-language pathologist meeting the requirements and qualifications as defined under Section 109.09-3 may provide speech and language therapy services.

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B. **Other Qualified Staff**

Other qualified staff members, other than professional staff defined above, must have appropriate education, training, certification, and experience, as verified by the employing agency that is enrolled as a MaineCare provider.

1. **Care Coordinator**
In order to provide care coordination services under this section, the care coordinator must be a licensed social service or health professional, or possess four years of education in the health or social services field and one year of community experience.

2. **Home Health Aide**

A home health aide must be listed on the Maine Registry of Certified Nursing Assistants and must not be prohibited from employment under Title 22 MRSA §1812(G). Home health aides employed by a home health agency must be in compliance with the Regulations Governing the Licensing and Functioning of Home Health Care Services. A home health aide shall work under the direct supervision of a registered nurse. A HHA who has completed and passed the BEAS medication course may assist members with medications, within the scope of that certification.

3. **Certified Nursing Assistant**

A CNA must be listed on the Maine Registry of Certified Nursing Assistants and must not be prohibited from employment under Title 22 MRSA §1812(G). A CNA shall work under the direct supervision of an RN. A CNA who has completed and passed the Office of Elder Services medication course may assist members with medications, within the scope of that certification.

4. **Certified Nursing Assistant/Medications**

A CNA/medications must meet the CNA requirements above and also satisfactorily complete a Department-approved medication course for certified nursing assistants, consistent with the Rules and Regulations of the Maine State Board of Nursing and be listed on the CNA registry.

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19.08 **POLICIES AND PROCEDURES** (cont.)

5. **Personal Support Specialist**

A PSS must be employed by, or acting under a contractual relationship with, a licensed home health agency or by a registered personal care agency, or be registered as a personal care agency under the family provider service option (FPSO).

a. All individuals employed as a PSS must:

i. Undergo criminal background check and CNA registry check. PSSs may not be employed by the provider agency if they are prohibited from employment under Title 22 MRSA §1717.

ii. Meet one (1) of the training and examination requirements below. An individual without the required training may be hired and reimbursed for delivering personal support services as long as the individual enrolls in a certified training program within sixty (60) days of hire and completes training and examination requirements within nine (9) months of employment and meets all other requirements. PSSs under the FPSO are exempt from this training requirement. If the individual fails to pass the examination within nine (9) months, reimbursement for his or her services must stop until such time as the training and examination requirements are met. A PSS must meet one (1) of the following:

aa. Hold a valid certificate of training for nursing assistants and be listed on the Maine Registry of Certified Nursing Assistants; or

bb. Hold a valid certificate of training, issued within the past three (3) years, for nurse's aide or home health aide training that meets the standards of the Maine State Board of Nursing nursing assistant training program; or

cc. If a CNA's status on the Maine Registry of Certified Nursing Assistants has lapsed, or an individual holds a valid certificate of training meeting the standards of the Maine

19.08 **POLICIES AND PROCEDURES** (cont.)

State Board of Nursing nursing assistant program issued more than three (3) years ago, the individual must pass the competency-based examination of didactic and demonstrated skills from the Department's approved personal support specialist curriculum. A certificate of training as a personal care assistant/personal support specialist will be awarded upon passing this examination; or

dd. Hold a valid certificate of training as a personal support specialist issued as a result of completing the Department approved personal support specialist training curriculum and passing the competency-based examination of didactic and demonstrated skills. The training course must include at least fifty (50) hours of formal classroom instruction, demonstration, return demonstration, and examination. Tasks covered under this Section must be covered in the training; or

ee. Be a personal support specialist who successfully completed a Department-approved curriculum prior to September 1, 2003. Such individuals will be grandfathered as a qualified PSS.

b. New employee orientation must be provided as follows:

i. A PSS, newly hired to an agency, who meets the Department's PSS training requirements, must receive an agency orientation. The training and certification documents must be on file in the PSS's personnel file.

ii. With the exception of family provider service option PSS, a newly hired PSS who does not yet meet the Department's training and examination requirements must undergo an eight (8) hour orientation that reviews the role, responsibilities and tasks of the PSS. To meet the required eight hours for orientation an agency may choose to use job shadowing for a maximum of two (2) hours of the 8 hour time requirement. The orientation must be completed by the PSS prior to the start of delivering services. The PSS must demonstrate competency to the employing agency in

19.08 **POLICIES AND PROCEDURES** (cont.)

all required tasks prior to being assigned to a member's home, with the exception of health maintenance activities, whereby a PSS can demonstrate competency via on the job training once being assigned to a member's home.

c. Provider agency responsibilities include, but are not limited to the following:

i. Assuring that a PSS meets the training, competency, and other requirements of this Section, and maintaining documentation of how each requirement is met in the PSS's personnel file, including: evidence of orientation, CNA registry check, criminal background check, and the verification of credentials including the certificate of training and/or verification of competency.

ii. Supervisory visits

aa. Initial visit. A provider agency supervisor or representative must make an initial visit to a member's home prior to the start of PSS services to develop and review with the member the plan of care as authorized by the ASA on the care plan summary and as ordered by the care coordinator.

bb. Scheduled supervisory visits. Except when reimbursement is provided under the family provider service option, a PSS employed by a provider agency must receive on-site supervision of the implementation of the member's authorized plan of care by the agency employer at least quarterly to verify competency and member satisfaction with the PSS performance of the care plan tasks. More frequent or additional on-site supervision visits of the PSS occur at the discretion of the provider agency as governed by its personnel policies and procedures.

cc. Supervisory visits for the family provider service option. A PSS reimbursed under the family provider service option must have on-site home

19.08 **POLICIES AND PROCEDURES** (cont.)

supervisory visits by the SCA to evaluate the condition of the member, implementation of the care plan and the member's satisfaction with the services. Failure to allow the SCA on-site visits is grounds for terminating reimbursement to the family provider service option agency.

iii. A provider agency must develop and implement written policies and procedures that insure a smoke-free environment. PSSs are not allowed to smoke, consume alcohol, or use controlled substances in the member's home or vehicle during work hours.

iv. A provider agency must develop and implement written policies and procedures that prohibit abuse, neglect or misappropriation of a member's property.

d. A family member who meets the requirements of this Section may be a PSS and receive reimbursement for delivering personal support services, with the exception of the MaineCare member's spouse, or the parent (including stepparent) of a minor child who is a MaineCare member. Refer to Federal regulation 42 CFR 440.167, and the State Medicaid Manual, Section 4480, Personal Care Services (prohibiting the coverage of personal care services delivered by these legally responsible family members.)

e. The Department has the authority to recover funds for services provided if the provider agency does not provide required documentation to support qualifications of the agency or staff or services billed.

f. The Office of MaineCare Services has the responsibility of ensuring the quality of services and the authority to determine whether a PSS agency has the capacity to comply with all service requirements. Failure to meet standards must result in non-approval or termination of the contract for PSS services.

g. The following requirements apply to an individual employed under the family provider service option:

i. The member or family member must register as a personal care agency (the "family provider service option") with the

19.08 **POLICIES AND PROCEDURES** (cont.)

Department of Health and Human Services pursuant to Title 22 MRSA §1717.

ii. The family provider service option agency must conduct a criminal history background check if required by Title 22 MRSA §1717 and check the CNA registry for any individual hired as a PSS. The family provider service option agency may not employ an individual who is prohibited from employment under Title 22 MRSA §1717(3). The adult who is registered as the agency may not be paid to provide care to the member. A consumer who does not have cognitive capacity may not register as a personal care agency. A member's guardian may not be paid to provide care to the member.

iii. The family provider service option agency must provide adequate orientation for the PSS to meet the needs of the member(s). The provision of orientation, including specific dates and the content matter of the orientation must be documented in the employee's personnel file. The PSS must demonstrate competency to the family provider service option agency in all required tasks.

iv. A provider agency will not be reimbursed for more than forty hours of service per week provided by an individual PSS.

v. The family provider service option agency must use a qualified financial management service as the payroll agent.

h. The Service Coordination Agency shall check the CNA Registry and conduct a criminal background check on the individual who registers as a personal care agency; establish a monthly cost limit based on the authorized plan of care; manage professional and/or covered services (RN, PERS for example), other than personal support services.

6. **Other Workers**

The waiver services provider may contract with other workers qualified by training and/or experience, to perform specific chore, household and related tasks. Qualified and experienced contractors are required to build environmental modifications.

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19.08 **POLICIES AND PROCEDURES** (cont.)

19.08-3 **Member's Record**

A. **SCA and provider agency responsibilities.** The SCA and direct care provider agencies are responsible for maintaining a specific record for each member, which shall include, but is not limited to the member's name, address, birth date, MaineCare ID, pertinent medical history, and diagnosis.

All member records shall be kept current in accordance with the rules outlined under Chapter I, Section 1, General Administrative Policies and Procedures and available to the Department as documentation of services included on invoices. Records shall be retained for a period of not less than five (5) years from the date of service delivery, with the exception that, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and a cost settlement has been finalized.

B. **SCA responsibilities**. In addition to the requirements in Section 19.07-3(A), the SCA shall maintain all notes, progress notes and documentation related to the responsibilities and requirements set forth under Section 19.04-2, Care Coordination Services.

C. **Provider agency responsibilities.** In addition to the requirements in Section 19.07-3(A), direct care provider agencies must maintain the nursing assessment and nursing care plan developed by their agency when applicable, documentation of the dates, type, amount and duration of services provided, progress notes, discharge summary, release of information authorization, and service approval issued by the SCA.
Written progress notes shall contain:

1. Identification of the service provided, date, and by whom;

2. Documentation of the total hours spent in the home for each visit, by provider: nurse, HH aide, CNA, or PSS. Exclude travel time unless provided as a service as described in Sections 19.01 and 19.04;

3. Progress toward the achievement of long and short-range goals. Include explanation when goals are not achieved as expected;

4. Signature of the service provider; and

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19.08 **POLICIES AND PROCEDURES** (cont.)

5. Full account of any unusual condition or unexpected event, dated and documented.

All entries shall be signed by the individual who performed the service.

19.08-4 **Member Appeals**

A member or applicant has the right to appeal in writing or verbally any decision made by the Department or its Authorized Agent to suspend, reduce, deny or terminate services provided under this benefit. In order for a member's services to continue during an appeal process, a request must be received by the Department within ten (10) days of the notice to reduce or terminate services. Otherwise, a member or applicant has sixty (60) days in which to appeal a decision. Members shall be informed of their right to request an Administrative Hearing in accordance with this section and Chapter I of this Manual.

An appeal for members must be requested in writing or verbally to:

Director
Office of Elder Services
c/o Hearings
11 State House Station
Augusta, ME 04333-0011

19.08-5 **Program Integrity**

All providers are subject to the Department's Program Integrity activities. Refer to Chapter I, General Administrative Policies and Procedures for rules governing these functions.

Ongoing monitoring shall be conducted by the Department of Health and Human Services, Office of Elder Services, which will include on-site visits to the ASA, and the SCA and visits to a sample of members. The Department will monitor the ASA's and SCA's compliance with the Waiver document, regulations and contract performance.

19.09 **CONFIDENTIALITY**

The disclosure of information regarding MaineCare members is strictly limited to purposes directly connected with the administration of the MaineCare program. Providers shall maintain

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the confidentiality of information regarding MaineCare members in accordance with 42 CFR 431 Subpart F of the federal regulations.

19.10 **REIMBURSEMENT**

Reimbursement for covered services shall be the lowest of:

A. The amount listed in Chapter III, Section 19, Allowances for Home and Community Benefits for the Elderly and Adults with Disabilities for members authorized for these services;

B. The servicing provider's usual and customary charge; or

C. The fee negotiated between the Waiver Services Provider and providers contracted for environmental modifications.

In accordance with Chapter I, it is the responsibility of the provider to seek payment from any other resources (private or group insurance benefits, Workers' Compensation, Medicare, etc.) that are available for payment of a rendered service prior to billing MaineCare. Therefore, a service provider under these HCB is expected to seek payment from sources other than MaineCare that may be available to the member.

Providers should document all efforts to collect from a third party.

19.11 **BILLING INSTRUCTIONS**

Billing must be accomplished in accordance with the CMS 1500 Billing Instructions and Chapter III procedure codes.

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Appendix #1
TASK TIME ALLOWANCES

ADL = Activities of Daily Living			
Activity	**Definitions**	**Time Estimates**	**Considerations**
Bed Mobility	How person moves to and from lying position, turns side to side and positions body while in bed	5 – 10 minutes	Positioning supports, cognition, pain, disability level
Transfer	How person moves between surfaces to/from: bed, chair, wheelchair, standing position (exclude to/from bath/toilet)	5 – 10 minutes up to 15 minutes	Use of slide board, gait belt, swivel aid, supervision needed, positioning after transfer, cognition Mechanical lift transfer
Locomotion	How person moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair	5 - 15 minutes (Document time and number of times done in POC)	Disability level, type of aids used, cognition, pain
Dressing & Undressing	How person puts on, fastens and takes off all items of street clothing, including donning/removing prosthesis	20 - 45 minutes	Supervision, disability, cognition, pain, type of clothing, type of prosthesis
Eating	How person eats and drinks (regardless of skill)	5 minutes 30 minutes 30 minutes	Set up, cut food and place utensils Individual is fed Supervision of activity due to swallowing, chewing, cognition issues
Toilet Use	How person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter and adjusts clothes	5 -15 minutes/use	Bowel, bladder program, ostomy regimen, catheter regimen, cognition
Personal Hygiene	How person maintains personal hygiene (exclude baths and showers)	20 min/day Washing face, hands, perineum, combing hair, shaving and brushing teeth 20 min/week Shampoo (only if done separately) 15 min up to 3 times/week Nail Care 20 min/week	Disability level, pain, cognition, adaptive equipment

Walking	a. How person walks for exercise only b. How person walks around own room c. How person walks within home d. How person walks outside	Document time and number of times in POC, and level of assistance needed	Disability, cognition, pain, mode of ambulation (cane), prosthesis needed for walking
Bathing	How person takes full-body bath/shower, sponge bath (exclude washing of back, hair), and transfers in/out of tub/shower	15 - 30 minutes	If shower used and shampoo done then consider as part of activity**,** cognition

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IADL = Instrumental Activities of Daily Living			
Activity	**Definitions**	**Time Estimates**	**Considerations**
Light Meal, Lunch & Snacks	Preparation and clean up	5 – 20 minutes	Member participation; type of food preparation; number of meals in POC and preparation for more than one meal
Main Meal Preparation	Preparation and clean up of main meal	20 - 40 minutes	Is Meals on Wheels being used? Preparation time for more than one meal and member participation
Light Housework/ Routine Housework	Dusting, picking up living space Kitchen housework- put the groceries away, general cleaning Making/changing beds Total floor care all rooms and bathrooms Garbage/trash disposal Non-routine tasks, outside chores, seasonal	30 min – 1.5 hr/week	Size of environment, member needs and participation, others in household
Grocery Shopping	Preparation of list and purchasing of goods	45 min - 2 hours/week	Other errands included: bills, banking and pharmacy. Distance from home
Laundry	Sort laundry, wash, dry, fold and put away	**In-home** 30 minutes/load 2 loads/week	Other activities which can be done if laundry is done in the house or apartment
		Out of home 2 hours/week	

Task time allowances are used for the authorization of covered services under this Section. Refer to Section 19.04.

These allowances reflect the time normally allowed to accomplish the listed tasks. The Authorized Agent will use these allowances when authorizing a member's care plan for covered services. If these times are not sufficient when considered in light of a member's extraordinary unique circumstances as identified by the Authorized Agent, the Authorized Agent may make an appropriate adjustment as long as the authorized hours do not increase.