

10-144 CH. 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 2

ADULT FAMILY CARE SERVICES

5/6/96
Last Updated 7/1/08

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2.01 **DEFINITIONS**

- 2.01-1 **Activities of Daily Living (ADLs)** include bed mobility, transfer, locomotion, dressing, eating, toilet use, bathing, personal hygiene, and walking.
- 2.01-2 **Adult Family Care Home (AFCH)** means a residential style home for eight or fewer residents, which is licensed by the Department pursuant to the Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level III Residential Care Facilities or Assisted Housing Programs: Level IV Residential Care Facilities and is primarily engaged in providing services to the elderly.
- 2.01-3 **Adult Family Care (AFC) Services** include personal care services such as: assistance with activities of daily living and instrumental activities of daily living, personal supervision, protection from environmental hazards, diversional and motivational activities, dietary services and care management, as further defined in the Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level III Residential Care Facilities or Assisted Housing Programs: Level IV Residential Care Facilities.
- 2.01-4 **Cueing** means any spoken instruction or physical guidance that serves as a signal to do a specified activity. Cueing is typically used when caring for individuals who are cognitively impaired.
- 2.01-5 **Department** means the Maine Department of Health and Human Services (DHHS).
- 2.01-6 **Individual Service Plan (ISP)** means a written service plan developed with a resident based upon an assessment of the resident's needs and abilities, and including (as appropriate) habilitative or rehabilitative goals and objectives, program goals and objectives, and the resources and methods necessary to implement the plan.
- 2.01-7 **Instrumental Activities of Daily Living (IADL)** include main meal preparation; routine housework; grocery shopping and storage of purchased groceries; and laundry either within the residence or at an outside laundry facility.
- 2.01-8 **MaineCare Weight** is the resource group weight applied to each resource group to calculate the resource-adjusted price for each member residing in the adult family care home.
- 2.01-9 **Member** is an individual who is deemed eligible for MaineCare services.

2.01 DEFINITIONS (cont.)

- 2.01-10 **Minimum Data Set- Assisted Living Services (MDS-ALS)** is the assessment tool approved by the Department to provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. The Department utilizes this tool to divide members into resource groupings that determine the resource-adjusted price for each member.
- 2.01-11 **Physician** means an individual currently licensed by the Board of Licensure in Medicine to practice medicine or by the Board of Osteopathic Licensure to practice osteopathy in the State of Maine, or the State or Province in which services are provided.
- 2.01-12 **Provider** means the entity licensed by the Department, pursuant to the *Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level III Residential Care Facilities*. Provider, owner, licensee and operator are all synonymous terms.
- 2.01-13 **Registered Nurse or “Registered Professional Nurse”** means an individual who is currently licensed by the Maine State Board of Nursing to practice professional nursing.
- 2.01-14 **Resource Adjusted Price** is the per diem rate the Department determines and pays to adult family care providers for the provision of services to a member. The Department determines this rate by considering the resources required to serve the needs of members based on assessment by the MDS-ALS assessment.
- 2.01-15 **Unadjusted Price** is the price calculated for payment prior to resource group adjustment. This represents the average reimbursement for the service.

2.02 ELIGIBILITY FOR CARE

2.02-1 General Financial Eligibility Requirements

Individuals must meet financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

2.02-2 Specific Eligibility Requirements

Members who are financially eligible must also meet specific eligibility requirements to determine medical necessity of AFC services, as determined by the MDS-ALS assessment tool. The MDS-ALS assessment must show the member's need for assistance or cueing with a minimum of two ADLs.

2.02 ELIGIBILITY FOR CARE (cont.)

2.02-3 Determination of Eligibility

- A. MaineCare will cover services only when an individual is determined by the Department or its authorized agent to be both medically and financially eligible for MaineCare. For each individual seeking MaineCare coverage of AFC services, the provider shall:
1. Verify the Department's determination of the individual's financial eligibility for MaineCare, and check for dates of eligibility. If financial eligibility has not been determined, the provider shall refer the applicant, or his/her authorized representative, to the local regional DHHS office if he/she is not a MaineCare member. Providers should also see MaineCare Benefits Manual, Chapter I for information regarding retroactive eligibility. The provider shall inform the local DHHS office when a person will be moving into the facility and will need financial assistance to pay for his or her care. The provider shall do this whether or not the individual already receives MaineCare and/or SSI benefits.
 2. Complete an MDS-ALS within thirty (30) days of admission and maintain the completed assessment tool in the member's record.
 3. Notify the local regional DHHS office when the member has been admitted. The local DHHS office must also be notified at the time of discharge.
 4. Submit a valid MDS-ALS assessment for the member in order for the Department to compute the member's classification group resource weight necessary for payment.

2.03 DURATION OF CARE

An eligible Title XIX or XXI member is entitled to receive as many days of AFC services as necessary, as long as the member meet the eligibility for care requirements set forth under Section 2.02. The Department, or its authorized agent may, at any time, review a member's need for AFC services.

2.04 COVERED SERVICES

2.04-1 A. Personal Care Services

Services: Services covered under adult family care services include the following Personal Care Services:

1. Assistance with activities of daily living such as bathing, dressing, eating, toileting, ambulation, transfers, changing positions in bed, personal hygiene, and grooming (shaving, oral care, shampooing, and nail care), bladder and bowel requirements, routine catheter care and routine colostomy care;
2. The performance of instrumental activities of daily living and incidental household tasks essential to the activities of daily living or to the maintenance of the member's health and safety within the facility, such as meal preparation, and bedmaking, dusting and vacuuming of the member's room;
3. Supervision of, or assistance with, administration of prescribed medication;
4. Personal supervision or awareness of the member's general safety and whereabouts; observation or monitoring of the member to ensure and promote his/her health and safety; reminding the member to carry out activities of daily living or of important appointments; and assisting the member in adjusting to residence in the facility;
5. Arranging transportation and making phone calls for appointments as recommended by medical providers, as well as reporting deviations or changes from the member's normal appearance, behavior or state of health to the guardian, physician, or designated health services provider; and
6. Arranging or providing motivational and diversionary activities (individual or group) that focus on social interaction to reduce isolation or withdrawal and to enhance communication and social skills.

B. Professional RN Services

1. A professional nurse (RN) must monitor the status and needs of each member when medically necessary in the RN's professional judgment and at least every 90 days. The RN shall review the MDS-ALS, progress notes, and medications, discuss the status of the member with the provider, see the member face-to-face if medically necessary, and initial and date the member's individual service plan at least every 90 days. This information must be maintained in the

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2.04 COVERED SERVICES (cont.)

member's record (See Section 2.07-2), together with recommendations of the RN concerning the health care of the member.

2. Professional Private Duty Nursing Services, as set forth in Section 96 of this Manual, may be provided to a member directly by an AFC services provider who is an RN and who is enrolled as a MaineCare provider. The member's nursing services must be authorized and signed by the member's physician every 60 days and maintained in the member's medical record in the facility. Services shall be delivered and billed in accordance with the requirements of Chapter II, Section 96.

2.04-2 Service setting

In order to qualify for reimbursement under this Section, AFC services must be delivered in either a Level III Residential Care Facility or Assisted Housing Program: Level IV Residential Care Facility.

2.05 LIMITATIONS

2.05-1 Duplication of services is not allowed. It is the responsibility of the AFC services provider to coordinate services with other "in-home" services to address the full range of a member's needs. Other MaineCare-covered services must not duplicate AFC covered services. For example, if a member receives Section 96, Private Duty Nursing and Personal Care Services; or Section 40, Home Health Services; or Section 19, Home and Community-Based Benefits for the Elderly and Adults with Disabilities, or Section 43, Hospice Services, all personal care services shall be delivered by the AFC services provider and not by a Certified Nursing Assistant (CNA), Home Health Aide (HHA), Personal Care Attendant (PCA) or Personal Support Specialist (PSS) as otherwise allowed in these Sections.

2.05-2 Private Duty Nursing Services and Personal Care Services are subject to financial "caps" as described in Section 96, Private Duty Nursing and Personal Care Services.) For members who receive Private Duty Nursing services, the cost of AFC services and Private Duty Nursing services combined must not exceed the member's approved Private Duty Nursing and Personal Care Services "cap." It is the responsibility of the Private Duty Nursing provider to monitor the cost of services and stay within the "cap."

2.05 LIMITATIONS (cont.)

2.05-3 MaineCare Waiver Services- A member receiving AFC services may receive services under a MaineCare Waiver program such as (Section 19, Waiver Services for the Elderly and for Adults with Disabilities; Section 22, Waiver Services for the Physically Disabled).

However, the cost of the MaineCare-covered AFC services shall be included within the established waiver financial “cap.” The Department’s designated agency responsible for administering the member’s waiver services must include the cost of MaineCare-covered AFC services within the member’s “cap.”

2.06 NON-COVERED SERVICES

- A. Room and board, including the cost of meals and transportation for services that are not otherwise covered by MaineCare.
- B. Household or chore services unless furnished as an integral but subordinate part of the personal services, as described in Section 2.04-1(A)(2), that is furnished directly to the member.
- C. Other non-covered services as described in Chapter I of the MaineCare Benefits Manual (MBM), including services that are primarily academic, social, vocational or custodial in nature.

2.07 POLICIES AND PROCEDURES

2.07-1 Assessments for Service Planning

- A. Assessment: Providers shall conduct an assessment, with the Department’s assessment tool to determine each member’s level of functioning and general health status, regardless of eligibility or source of payment. The results of the assessment shall be the basis for the development of the individual service plan described in Section 2.07-2. Providers must submit a copy of the completed assessment to the Department’s authorized representative within 14 days of the assessment. A copy must be maintained in the member’s record.
 - 1. A person trained in the use of the MDS-ALS must conduct the initial assessment within 30 days of admission. Providers must use the Department-approved tool (MDS-ALS) according to the instructions in the training manual for the MDS-ALS tool.
 - 2. The member, or his or her legally responsible representative, will provide input into and be an integral part of the assessment process. The member’s family or significant other also may be involved, unless such involvement is not feasible or contrary to the wishes of the member or legally responsible representative.

2.07 POLICIES AND PROCEDURES (cont.)

3. Re-assessments. After the initial assessment, the member shall receive an assessment using MDS-ALS at least once every six months, or sooner in the event of a significant change, either an improvement or decline, in his or her functional status. The provider must revise the service plan based upon the needs identified at the re-assessment. Providers shall submit a copy of the completed assessment to the Department's agent within 14 days of the assessment. The assessments will be sequenced from the date in Section S.2.B. of the MDS-ALS, assessment completion date. Providers must complete subsequent assessments within 180 days from the date in S.2.B. Providers must complete significant change assessments within 14 days after determination is made of a significant change in resident status as defined in the training manual for the MDS-ALS tool. Providers must complete a resident tracking form within 7 days of the discharge, transfer or death. The provider must maintain all completed assessments within the previous 12 months in the member's active record.

4. Accuracy of Assessments

The accuracy of the MDS-ALS will affect coverage of services outlined in individual service plans as well as payment to the provider. The Department will aggregate results of the assessment to give the provider feedback on critical quality indicators. Therefore, the following requirements must be met:

- a. Only staff trained in completion of the MDS-ALS by the Department may conduct or coordinate assessments.
- b. Each individual who completes a portion of the assessment must sign and date the form to certify the accuracy of that portion of the assessment.
- c. The Department requires documentation to support the time periods and information coded on the MDS-ALS.
- d. The Department may sanction a provider whenever the provider willfully and/or knowingly certifies (or causes another individual to certify) a material and false statement in an assessment. This may be in addition to any other penalties provided by statute, including but not limited to, 22 M.R.S.A. §15.

2.07 POLICIES AND PROCEDURES (cont.)

- e. The Department has the right to review all forms, documentation and evidence used for completion of the MDS-ALS at any time. The Department will undertake quality review periodically to ensure that assessments are completed accurately, correctly, and on a timely basis.
- f. Facilities shall submit completed assessments to include admissions, semi-annuals, annuals, significant change, and other required assessments and MDS-ALS tracking forms within 30 days of completion to the Department of its designated agent.

5. Quality Review of the MDS-ALS process: Definitions

The Department conducts MDS-ALS assessment reviews. The process includes a review of assessments, documentation and evidence used in completion of the assessments, in accordance with this Section to ensure that assessments accurately reflect the member's characteristics and condition.

Assessment review error rate is the percentage of unverified resource-adjusted price group records in the drawn sample. The Department will draw samples from resource-adjusted group records completed for MaineCare members.

A *verified resource-adjusted group record* is an MDS-ALS assessment form completed by the provider that has been determined to accurately represent the member's characteristics during the MDS-ALS assessment review process. Verification activities include reviewing assessment forms and supporting documentation, conducting interviews and observing members.

An *unverified resource-adjusted group record* is one that cannot be verified for payment purposes, since the Department has determined it may not accurately represent the member's characteristics and condition and, therefore, may result in an inaccurate classification of the member into a resource-adjusted grouping that increases the MaineCare weight assigned to the member.

An *unverified MDS-ALS record* is one that does not accurately reflect the member's condition.

2.07 POLICIES AND PROCEDURES (cont.)

6. Criteria for Quality Review

The Department will select providers for an MDS-ALS quality review based upon but not limited to any of the following:

- a. The findings of a licensing survey conducted by the Department indicating that the provider is not accurately assessing persons receiving assisted living services;
- b. An analysis of a provider's resident resource group profile indicating changes in the frequency distribution of members in the major categories or a change in the average resource adjusted groupings; or
- c. Performance of the provider, including but not limited to, on-going problems with assessment completion and timeliness, untimely submissions and high assessment error rates.

7. Quality Review Process

- a. Department staff or designated agent(s) shall conduct reviews.
- b. Providers selected for review must coordinate access to members, and provide access to professional and direct care staff, the provider assessors, member records, and completed assessment tools, as well as documentation regarding the member's service needs and services delivered.
- c. The Department shall draw samples from MDS-ALS assessments completed for MaineCare members.
- d. At the conclusion of the on-site portion of the review process, the reviewers shall hold an exit conference with provider representatives. Reviewers will share written findings for reviewed records. The reviewer may also request reassessment of members where assessments are in error.

8. Sanctions

The Department will sanction providers who fail to accurately complete assessments in a timely manner. Effective July 1, 2004, when a sanctionable event occurs, the Department shall base the sanctions on the total MaineCare payment to the provider from the 4th through the 6th months preceding the month in which the sanctionable event occurred. (For example, if the sanctionable event occurred in July, the sanction would be calculated by

2.07 POLICIES AND PROCEDURES (cont.)

multiplying the sanction rate times the total MaineCare payments to the provider during the preceding January, February and March.) The amount of the sanction will be based on an application of the percentages below multiplied by the MaineCare payments to the provider during the 4th through 6th months preceding the event. In no event will the payment to the provider be less than the price that would have been paid with an average resource-adjusted price equal to 0.551. The Department will calculate sanctions as follows:

- a. 2% of MaineCare payments when the assessment review results in an error rate of 34% or greater, but is less than 37%;
- b. 5% of MaineCare payments when the assessment review results in an error rate of 37% or greater, but is less than 41%;
- c. 7% of MaineCare payments when the assessment review results in an error rate of 41% or greater, but is less than 45%;
- d. 10% of MaineCare payments when the assessment review results in an error rate of 45% or greater; or
- e. 10% of MaineCare payments if the provider fails to complete reassessments within 7 days of a written notice/request by the Department.

2.07-2 Individual Service Plan

- A. Providers must develop and implement an individual service plan for each member. This plan must be based upon the results of the assessment described in Section. 2.07-1. The plan must contain long- and short-range goals (as appropriate), and identify the resources and strategies necessary to meet the goals. The plan must describe the specific personal care services and other services required and specify who will perform each service and how frequently. The provider must also include other items, as appropriate, such as orders for medications and treatments, safety measures to protect against injury, nutritional requirements and therapeutic diets, and discharge plans, etc. The plan must include the use of the member's natural support system. Additionally, for cognitively impaired residents, providers must include activities, safeguards for wandering, and behavior management approaches in the individual service plan.

2.07 POLICIES AND PROCEDURES (cont.)

The individual service plan must summarize any other “in home” services the member is receiving (including: Section 96, Private Duty Nursing and Personal Care Services; Section 40, Home Health Services; Section 19, Home and Community-based Benefits for the Elderly and Adults with Disabilities; Section 43, Hospice Services; or Section 22, Waiver Services for the Physically Disabled) and how these services will be coordinated with Adult Family Care Services. The plan must describe the services and frequency delivered by each provider (see also Section 2.05-1).

- B. The member, or legally responsible representative, and others chosen by the member, shall have an integral role in the development of the service plan, in reviewing its effectiveness, and in revising the plan.
- C. The provider shall coordinate AFC services with any other services the member may utilize. The provider shall assist the member to access other services that are needed.
- D. The individual service plan shall be reviewed and modified as necessary, based upon the needs identified during reassessments or significant changes in functioning.
- E. The individual service plan must be reviewed and initialed by a professional R.N. every 90 days, and copies must be maintained in the member’s record.

2.07-3 Records

The AFC provider must maintain an individual record for each member including the following:

- A. Name, birthdate, and MaineCare identification number;
- B. Pertinent personal information such as names and addresses of nearest relatives, guardian, power of attorney, and physician or primary care provider;
- C. Contract;
- D. Resident assessments (MDS-ALS);
- E. Monthly summaries of services delivered, frequency of delivery, and identity of the person(s) who delivered the service;
- F. Progress notes written regularly and at least monthly which state the progress the member has made;

2.07 POLICIES AND PROCEDURES (cont.)

- G. Medication Administration Record (MAR), if any;
- H. Copies of all orders for medications and treatments;
- I. Record of physician or primary care provider visits, if any;
- J. Record of rehabilitation or therapy visits, if any;
- K. Documentation of any incidents or accidents; and
- L. Other information, as necessary.

2.07-4 Professional And Other Qualified Staff

- A. Professional Staff may include the following:
 - 1. A registered nurse (RN) who is currently licensed to practice nursing in the State or Province in which services are provided.
- B. Other Qualified Staff include the following:
 - 1. A provider who meets the qualifications set forth under the Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level III - Residential Care Facilities, as evidenced by a valid license issued by the Department; and
 - 2. Other caregivers who meet the qualifications set forth under the Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level III Residential Care Facilities.

2.07-5 Surveillance And Utilization Review

Requirements for Surveillance and Utilization Review are included in Chapter I of the MaineCare Benefits Manual (MBM).

2.07-6 Confidentiality

Disclosure of Information- The disclosure of information regarding individuals participating in the MaineCare program is strictly limited to purposes directly connected with the administration of the MaineCare program.

2.08 REIMBURSEMENT (cont.)

A. The Department will reimburse a resource-adjusted (case-mix) price for covered services. The unadjusted price is listed in Chapter III, Section 2, "Allowances for Adult Family Care Services." The Department will multiply this unadjusted price by the member-specific MaineCare weight. That weight will calculate reimbursement by taking into consideration by resource grouping that some members are more costly to serve than others. Thus, the system requires:

1. Accurate assessment using the MDS-ALS form of all residents;
2. Classification of members into groups which are similar in resource utilization, as reflected in the AFC services classification groups defined in section; and
3. A weighting system that quantifies the relative cost of services for different subsets of members according to a time study that translates into a resource-adjusted price.

There are eight (8) resource-adjusted (case mix) groups, including one classification group used when members cannot be classified into one of the other seven (7) classification groups. Each group has a specific resource adjusted weight, as follows:

Resident Group	Resource Classification Group	Short description	MaineCare Weight
ALS 7-9	1	ADL=7-28	1.657
	2	ADL=0-6	1.210
ALS 5-6	3	ADL=3-28	1.360
	4	ADL=0-1	1.027
ALS 2-4	5	IADLB=12-18	.924
	6	IADLB=10-11	.804
ALS 0-1 or ALS 2-4 and IADL 0-9	7	ALS 0-1 or ALS 2-4 and IADL 0-9	.551
ALS 0-1	8	Unclassified	.551

4. The Department will calculate resource-adjusted prices on assessments as of January 1st and July 1st of each year, beginning on July 1, 2004. The Department will calculate the price for each member based on the MaineCare weight for the period as follows:
 - a. The most recent MDS-ALS for each member in the facility as of the 15th of March for the July rate and the 15th of September for the January rate.

2.08 REIMBURSEMENT (cont.)

- b. The resource-adjusted price will be calculated by multiplying the resource group by the MaineCare weight.
- c. A roster of all members receiving AFC services and sources of payment as of March 15th and July 15th will be sent to facilities for verification prior to rate setting.
- d. The Department will utilize the roster sent to the provider in identifying the MaineCare members and their most recent assessment. It is the provider's responsibility to check the roster, make corrections and submit corrections to the Department or its designee within one week of receiving the roster.

For new facilities without a resource grouping already calculated, the Department will apply a MaineCare weight of .924 to the unadjusted price for the first rate setting period. The actual resource-adjusted price will be applied to the first rate setting period after either a March 15 or September 15 roster is available, as applicable. Sanctions pursuant to Section 2.07-1 will not be applied to new facilities until an actual resource-adjusted price is used in rate setting.

B. Inflation Adjustment

The Commissioner will determine by July 1st of each year whether the price will be adjusted for inflation, using standard industry economic trend factors.

- C. In accordance with Chapter I, of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other sources that are available for the rendered covered service prior to billing the MaineCare Program.

- D. AFC providers may not accept or receive payment for MaineCare covered services in addition to the MaineCare payment.

2.09 BILLING INSTRUCTIONS

Billing must be in accordance with the Department's "*Billing Instructions for Adult Family Care Services.*"