

# Application for a 1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

---

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in  1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for a Renewal to a 1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

---

Describe any significant changes to the approved waiver that are being made in this renewal application:

As part of the waiver renewal process, the State solicited and received extensive feedback from stakeholders and the general public over the past four years regarding the service and supports needs of individuals with intellectual

## Application for a 1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

---

**A.** The **State of Maine** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of  1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

Home and Community Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

**C. Type of Request: renewal**

**Requested Approval Period:** (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years  5 years

**Original Base Waiver Number: ME.0159**

**Waiver Number: ME.0159.R06.00**

**Draft ID: ME.006.06.00**

**D. Type of Waiver** (*select only one*):

Regular Waiver

**E. Proposed Effective Date:** (*mm/dd/yy*)

07/01/15

### 1. Request Information (2 of 3)

---

**F. Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to

individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

**Hospital**

Select applicable level of care

**Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

**Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

**Nursing Facility**

Select applicable level of care

**Nursing Facility as defined in 42 CFR §§440.40 and 42 CFR §§440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

## 1. Request Information (3 of 3)

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

**Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

**§1915(b)(1) (mandated enrollment to managed care)**

**§1915(b)(2) (central broker)**

**§1915(b)(3) (employ cost savings to furnish additional services)**

**§1915(b)(4) (selective contracting/limit number of providers)**

**A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

**A program authorized under §1915(i) of the Act.**

**A program authorized under §1915(j) of the Act.**

- A program authorized under §1115 of the Act.**

Specify the program:

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

---

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

This waiver was initially approved in 1983. Since that time it has served many purposes in support of Maine citizens with disabilities. It has been a major tool for the State of Maine to build a comprehensive system of care and support as

## 3. Components of the Waiver Request

---

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes. This waiver provides participant direction opportunities.** Appendix E is required.
- No. This waiver does not provide participant direction opportunities.** Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

---

- A. Comparability.** The State requests a waiver of the requirements contained in  1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of  1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in  1902(a)(1) of the Act (*select one*):
- No
- Yes

If yes, specify the waiver of statewide that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewide is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- Limited Implementation of Participant-Direction.** A waiver of statewide is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

---

In accordance with 42 CFR  441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to  1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least

annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

---

*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
- Staff members from the The Office of Aging and Disability Services routinely meet with people with disabilities, family members and various representatives from provider and advocacy groups. Due to its broad scope and high
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

---

- A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

Roberts-Scott

**First Name:**

Ginger

**Title:**

Children's and Waiver Services Program Manager

**Agency:**

DHHS MaineCare Services

**Address:**

11 State House Station

**Address 2:**

242 State Street

**City:**

Augusta

**State:**

Maine

**Zip:**

04333

**Phone:**

(207) 624-4048

**Ext:**



TTY

**Fax:**

(207) 287-1864

**E-mail:**

ginger.roberts-scott@maine.gov

- B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

Bagley

**First Name:**

Bridget

**Title:**

**Agency:**

**Address:**

**Address 2:**

  
**City:**

**State:****Maine****Zip:**

**Phone:**

**Ext.:**

 **TTY**
**Fax:**

**E-mail:**


## 8. Authorizing Signature

---

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

**Signature:**


State Medicaid Director or Designee

**Submission Date:**

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

---

**Last Name:**

Nadeau

**First Name:**

Stefanie

**Title:**

Director, MaineCare Services

**Agency:**

Maine Department of Health and Human Services

**Address:**

SHS #11

**Address 2:**

242 State Street

**City:**

Augusta

**State:**

Maine

**Zip:**

04333

**Phone:**

(207) 287-2093 Ext:   TTY

**Fax:**

(207) 287-1864

**E-mail:**

stefanie.nadeau@maine.gov

## Attachments

---

### Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.
- Combining waivers.
- Splitting one waiver into two waivers.
- Eliminating a service.

- Adding or decreasing an individual cost limit pertaining to eligibility.
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- Reducing the unduplicated count of participants (Factor C).
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

This waiver serves adults age 18 and older who meet clinical criteria for Intellectual Disability or Autism Spectrum Disorders and are medically eligible for services provided in an intermediate care facility for individuals with

### Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

Beginning with a thorough review of waiver policies, all written policy and rules are being compared to those rules to the new requirements. A primary focus is to ensure Maine has the ability to check, or verify, over time that the new

### Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Additional information for Section G 2 a i.

### Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

## Appendix A: Waiver Administration and Operation

---

### 2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

---

- 3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

The Department of Health and Human Services contracts with Transportation Brokers to organize and provide Transportation Services.

- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

---

- 4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

---

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Office of MaineCare Services has a dedicated position to manage the contract with the Transportation Brokers for the Me.19 NEMT Transportation waiver.

## Appendix A: Waiver Administration and Operation

---

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

For Transportation Services Performance Measures included in the 1915b waiver (ME.19) outline the specific methods and functions.

## Appendix A: Waiver Administration and Operation

---

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

**a. Methods for Discovery: Administrative Authority**

*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*

**i. Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

*Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are*

*identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and Percent of the rules/policies associated with the waiver that are promulgated by the Medicaid agency.**

**Data Source** (Select one):

**Presentation of policies or procedures**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>

**Other**  
Specify:

**Performance Measure:**

**Number and Percent of provider agreements/contracts that adhered to the State's uniform agreement/contract requirements (specific to service provider type).**

**Numerator: Number of conforming agreements/contracts. Denominator: Total number agreements/contracts.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b>	<input type="checkbox"/> <b>Annually</b>

Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and Percent of newly enrolled participants whose waiver costs did not exceed approved limits. Numerator: Number of newly enrolled participant costs within limits. Denominator: Total number of newly enrolled participants.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>

<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

- ii. **Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism	18	<input type="text"/>	<input checked="" type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	18	<input type="text"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

- b. Additional Criteria.** The State further specifies its target group(s) as follows:

- c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- Not applicable. There is no maximum age limit
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:
- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
  - Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. *Complete Items B-2-b and B-2-c.*

The cost limit specified by the State is (*select one*):

- The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

- Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent:

- Other:**

Specify:

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Prior to formal determination of eligibility for the waiver, each person and their planning team identify the required mix of services to meet their needs and to assure their health and welfare. Based on the plan each new

- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Participants may be authorized to receive additional services that exceed the cost limit identified in Section B-2-a. If the participant is receiving additional services under the State plan, any limits on those services

- Other safeguard(s)**

Specify:

A combination of other MaineCare state plan services (including consideration of ICF-IID), state funds, and informal supports may be utilized to meet additional needs. If the participant is receiving additional

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for

the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

Waiver Year	Unduplicated Number of Participants
Year 1	2990
Year 2	2990
Year 3	2990
Year 4	2990
Year 5	2990

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- The State does not limit the number of participants that it serves at any point in time during a waiver year.
- The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

**Table: B-3-b**

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	2840
Year 2	2840
Year 3	2840
Year 4	2840
Year 5	2840

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (2 of 4)**

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- Not applicable. The state does not reserve capacity.
- The State reserves capacity for the following purpose(s).

Purpose(s) the State reserves capacity for:

Purposes	
1. To respond to adult protective services situations.	
3. Children in transition	
2. To move from institution to community	

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (2 of 4)**

**Purpose** *(provide a title or short description to use for lookup)*:

1. To respond to adult protective services situations.

**Purpose** (*describe*):

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

**Describe how the amount of reserved capacity was determined:**

The number reserved associated with #1 is an average based on the State's data for those in need of adult protective services in recent years.

**The capacity that the State reserves in each waiver year is specified in the following table:**

Waiver Year	Capacity Reserved
Year 1	111
Year 2	56
Year 3	56
Year 4	56
Year 5	56

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** (*provide a title or short description to use for lookup*):

3. Children in transition

**Purpose** (*describe*):

This capacity is reserved for children that are in out of home residential placements.

**Describe how the amount of reserved capacity was determined:**

The reserved capacity was based on current out of state placement of 5 individuals.

**The capacity that the State reserves in each waiver year is specified in the following table:**

Waiver Year	Capacity Reserved
Year 1	4
Year 2	4
Year 3	4
Year 4	4

Year 5	4
--------	---

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (2 of 4)**

**Purpose** (provide a title or short description to use for lookup):

2. To move from institution to community

**Purpose** (describe):

2. This capacity is reserved for those people who currently reside in an institutional setting but would rather receive their services and support in the community.

**Describe how the amount of reserved capacity was determined:**

2. Recent history indicates that there are approximately six (6) individuals per year who may choose to move from an institutional setting (usually ICF's/IID or Nursing Facilities) to a

**The capacity that the State reserves in each waiver year is specified in the following table:**

Waiver Year	Capacity Reserved
Year 1	4
Year 2	4
Year 3	4
Year 4	4
Year 5	4

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (3 of 4)**

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (select one):
  - The waiver is not subject to a phase-in or a phase-out schedule.**
  - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**
- e. **Allocation of Waiver Capacity.**

Select one:

- Waiver capacity is allocated/managed on a statewide basis.**
- Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among

local/regional non-state entities:

- f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

MaineCare Benefits Manual Section 21 which defines the Waiting List protocol for Adult ID Services. There are defined priority levels within this protocol. First priority is given to an individual who is in need of

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

**Answers provided in Appendix B-3-d indicate that you do not need to complete this section.**

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- §1634 State  
 SSI Criteria State  
 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No  
 Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

**Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)**

- Low income families with children as provided in §1931 of the Act  
 SSI recipients  
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121  
 Optional State supplement recipients  
 Optional categorically needy aged and/or disabled individuals who have income at:

*Select one:*

- 100% of the Federal poverty level (FPL)  
 % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)  
 Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

- Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

---

*Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

---

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

- 100% of FPL

- % of FPL, which is lower than 100%.

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR 441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR 435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR 435.217:

*Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.**

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).*

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

- Use spousal post-eligibility rules under §1924 of the Act.**  
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

- b. Regular Post-Eligibility Treatment of Income: SSI State.**

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

**i. Allowance for the needs of the waiver participant (select one):**

- The following standard included under the State plan**

Select one:

- SSI standard  
 Optional State supplement standard  
 Medically needy income standard  
 **The special income level for institutionalized persons**

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)**  
 **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

Specify dollar amount:  If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:**

Specify:

- Other**

Specify:

**ii. Allowance for the spouse only (select one):**

- Not Applicable
- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

When a participant has a spouse this allowance is allowed.

Specify the amount of the allowance (select one):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The following dollar amount:

Specify dollar amount:  If this amount changes, this item will be revised.

- The amount is determined using the following formula:

Specify:

**iii. Allowance for the family (select one):**

- Not Applicable (see instructions)
- AFDC need standard
- Medically needy income standard
- The following dollar amount:

Specify dollar amount:  The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:

Specify:

- Other

Specify:

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**i. Allowance for the personal needs of the waiver participant**

(select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**
- A percentage of the Federal poverty level**

Specify percentage:

- The following dollar amount:**

Specify dollar amount:  If this amount changes, this item will be revised

- The following formula is used to determine the needs allowance:**

*Specify formula:*

- Other**

*Specify:*

- ii. **If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- Allowance is the same**  
 **Allowance is different.**

*Explanation of difference:*

- iii. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges  
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*  
 **The State does not establish reasonable limits.**  
 **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (5 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

- e. **Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

**Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

**f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

**g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

**ii. Frequency of services.** The State requires (select one):

- The provision of waiver services at least monthly  
 Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are

performed (*select one*):

- Directly by the Medicaid agency**
- By the operating agency specified in Appendix A**
- By an entity under contract with the Medicaid agency.**

*Specify the entity:*

- Other**  
*Specify:*

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The person conducting the assessment must meet the standard of Qualified Intellectual Disability Professional as outlined in 42 CFR 483.430(a). Specifically the person has at least one year of experience working directly with

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

ICF-IID level of care criteria as identified on the medical eligibility instrument utilized in this program. (form BMS-99) In 1999, this assessment form was submitted to CMS for comparative analysis of this form and the

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
  - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The waiver instrument was updated in 1999 at that time the exact criteria or examples of ICF-IID level of care were transposed to the waiver instrument from the ICF-IID evaluation tool.

- f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Initial Evaluation: The Case manager submits the person centered plan,  Choice Letter,  and the assessment form to OADS/DHHS. The QIDP reviews the information for level of care determination.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):
- Every three months**
  - Every six months**
  - Every twelve months**
  - Other schedule**  
*Specify the other schedule:*

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):
- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
  - The qualifications are different.**  
*Specify the qualifications:*

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

Maine's Enterprise Information System will generate a "tickler" notification to the case manager and supervisor as well as an overall report of upcoming reevaluations. This will occur with a 60-day advance notice.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The Medicaid Agency and the case manager will maintain these records for a minimum period of three years.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

*The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.*

**i. Sub-Assurances:**

- a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and Percent of new applicants who had an LOC indicating need for institutional level of care (ICF/IID) prior to receipt of services. Numerator: Total**

number of LOC determinations. Denominator: Total number of referrals for the waiver.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

**Other**  
Specify:

**Performance Measure:**  
Number and Percent of initial level of care determinations made by using the instrument in the approved waiver.

**Data Source** (Select one):  
**Record reviews, off-site**  
If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

- c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and Percent of initial level of care assessments completed by a qualified evaluator. Numerator: Total number of initial LOCs completed and applied appropriately by a qualified evaluator. Denominator: Total number of LOC assessments.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>

<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and Percent of initial level of care determinations made by using the instrument in the approved waiver.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

--	--	--

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

n/a

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

When the level of care is not completed in a timely manner, appropriate actions are taken through State personnel or community agency staff. For example, if the level of care has not been determined in a

- ii. **Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="Every 6 months"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix B: Participant Access and Eligibility**

**B-7: Freedom of Choice**

**Freedom of Choice.** As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the

feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Prior to participation in this program all individuals are involved in a planning process. As part of the process this waiver is discussed as a potential source of needed or recommended services. If the waiver appears to be an

- b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Freedom of Choice forms will be electronically stored in the Enterprise Information System (EIS) the written version will be housed in the Medicaid Agency and with the case manager.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The DHHS Office of Multicultural Services is available to assist anyone in need of communication assistance. These services can be viewed at <http://www.maine.gov/dhhs/oma/interpreters.html>. Some services that can be accessed

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service	✘	✘
Statutory Service	Community Support		
Statutory Service	Home Support (1/4 hour)		
Statutory Service	Per Diem Home Support		
Statutory Service	Respite		
Statutory Service	Work Support-Group		
Other Service	Adult Foster Care/ Shared Living		
Other Service	Assistive Technology		
Other Service	Career Planning		
Other Service	Communication Aids		
Other Service	Consultation		
Other Service	Counseling		
Other Service	Crisis Assessment		
Other Service	Crisis Intervention		
Other Service	Employment Specialist Services		
Other Service	Home Accessibility Adaptations		
Other Service	Home Support-Remote Support		
Other Service	Home Support-Residential Habilitation-Family Centered Support		

Other Service	Non Traditional Communication Consultation
Other Service	Non-Medical Transportation
Other Service	Non-traditional Communication Assessment
Other Service	Occupational Therapy (Maintenance)
Other Service	Physical Therapy (Maintenance)
Other Service	Qualified Extra Support Service
Other Service	Semi-Independent Supported Living (SISL) (Residential Habilitation)
Other Service	Skilled Nursing Service for Persons with Intellectual Disabilities and Autism Spectrum Disorder
Other Service	Specialized Medical Equipment and Supplies
Other Service	Speech Therapy (maintenance)
Other Service	Work Support-Individual

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

**Service:**

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Community Support is Direct Support provided in order to increase or maintain a member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	OADS Approved Provider Agency

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**  
**Service Name: Community Support**

**Provider Category:**

**Provider Type:**

**Provider Qualifications**

**License (specify):**

	-
	-

**Certificate** (*specify*):

A staff person must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by DHHS, or	-
	-

**Other Standard** (*specify*):

Provider Agency must have:	-
* Completed the enrollment process for the "Maine Integrated Health Management Solution"	-

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by	-
	-

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.	-
	-

## Appendix C: Participant Services

---

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service	▼
-------------------	---

**Service:**

Personal Care	▼
---------------	---

**Alternate Service Title (if any):**

Home Support (1/4 hour)	-
	-

**HCBS Taxonomy:****Category 1:**

	▼
--	---

**Sub-Category 1:**

▼
---

**Category 2:**

	▼
--	---

**Sub-Category 2:**

▼
---

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Home Support is direct support provided to improve and maintain a member's ability to live as independently as possible in his or her home. Home Support (1/4 hour) may be provided in a family home,

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	OADS Approved Provider Agency

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**  
**Service Name: Home Support (1/4 hour)**

**Provider Category:**

**Provider Type:**

**Provider Qualifications****License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications****Entity Responsible for Verification:**

**Frequency of Verification:**

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

**Service:**

**Alternate Service Title (if any):**

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Home Support is direct support provided to improve and maintain a member's ability to live as independently as possible in his or her home. Home Support may be provided in a Licensed or unlicensed

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	OADS Approved Provider Agency

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**  
**Service Name: Per Diem Home Support**

**Provider Category:**

**Provider Type:**

OADS Approved Provider Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

A staff person must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by DHHS, or

**Other Standard** (*specify*):

Provider Agency must have:  
\* Completed the enrollment process for the "Maine Integrated Health Management Solution"

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon Enrollment and every three (3) years thereafter

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09011 respite, out-of-home

**Category 2:**

**Sub-Category 2:**

**Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Respite Services are provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the member.
---

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

• Maximum approval of 350 hours per year of respite service is available to participants living with unpaid caregivers.
---

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	OADS Approved Provider Agency

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

---

**Service Type: Statutory Service**  
**Service Name: Respite**

---

**Provider Category:**

Agency	▼
<b>Provider Type:</b>	
OADS Approved Provider Agency	
<b>Provider Qualifications</b>	
<b>License (specify):</b>	
<b>Certificate (specify):</b>	
A staff person providing respite must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by	
<b>Other Standard (specify):</b>	
Provider Agency must have: * Completed the enrollment process for the "Maine Integrated Health Management Solution"	
<b>Verification of Provider Qualifications</b>	
<b>Entity Responsible for Verification:</b>	
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by	
<b>Frequency of Verification:</b>	
Upon enrollment and every three (3) years thereafter.	

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service ▼

**Service:**

Supported Employment ▼

**Alternate Service Title (if any):**

Work Support-Group

**HCBS Taxonomy:**

**Category 1:**

▼

**Sub-Category 1:**

▼

**Category 2:**

▼

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Work Support is Direct Support provided to improve a participant’s ability to independently maintain employment. Work Support is provided at the participant’s place of employment; it may be provided in a

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	OADS Supported Employment Agency

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**

**Service Name: Work Support-Group****Provider Category:**

Agency

**Provider Type:**

OADS Supported Employment Agency

**Provider Qualifications****License (specify):****Certificate (specify):**

A staff person must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by DHHS, or

**Other Standard (specify):**

Provider Agency must have:

\* Completed the enrollment process for the "Maine Integrated Health Management Solution"

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three years after.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Adult Foster Care/ Shared Living

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Personal care and supportive services (e.g., homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under State law) provided in a private home by a principal care provider

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method** (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by** (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	OADS Provider Agency

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

---

**Service Type: Other Service**  
**Service Name: Adult Foster Care/ Shared Living**

---

**Provider Category:**

Agency

**Provider Type:**

OADS Provider Agency

**Provider Qualifications****License (specify):****Certificate (specify):**

A staff person must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by DHHS, or

**Other Standard (specify):**Provider Agency must have:  
\* Completed the enrollment process for the "Maine Integrated Health Management Solution"**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

---

## Appendix C: Participant Services

### C-1/C-3: Service Specification

---

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Assistive Technology

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Assistive Technology-Assessment is subject to a combined limit of 32 units (8 hours) per year. Assistive Technology-Devices, including the selecting, fitting, customizing, adapting, applying, maintaining, repairing

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	OADS Provider Agency

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

---

**Service Type: Other Service**  
**Service Name: Assistive Technology**

---

**Provider Category:**

Agency ▾

**Provider Type:**

OADS Provider Agency ▾

**Provider Qualifications****License** (*specify*):Occupational Therapist  
Speech Pathologist ▾**Certificate** (*specify*):Direct Support Staff must be a certified Direct Support Professional (DSP) and  
Certification as Rehabilitation Engineering Technologist (RET) or an Assistive Technology ▾**Other Standard** (*specify*):Minimum requirements may include compliance with:  
Equipment must adhere to ▾**Verification of Provider Qualifications****Entity Responsible for Verification:**Enrollment in the MIHMS is shared responsibility and application and other information and  
materials are shared and reviewed by a number of entities within DHHS. Final verification is by ▾**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter. ▾

---

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service ▾

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Career Planning ▾

**HCBS Taxonomy:****Category 1:**

▾

**Sub-Category 1:**

▾

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Career Planning is a person centered, comprehensive direct support provided to a participant that enables a participant to obtain, maintain or advance in competitive employment or self-employment.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The maximum annual allowance is 60 hours to be delivered within a six month period. No two six month periods may be provided consecutively. Career Planning may not be provided at the same time as

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	OADS Provider Agency

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

---

**Service Type: Other Service**  
**Service Name: Career Planning**

---

**Provider Category:**Agency **Provider Type:**OADS Provider Agency **Provider Qualifications****License (specify):****Certificate (specify):**A staff person must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by DHHS, or **Other Standard (specify):**Provider Agency must have:  
\* Completed the enrollment process for the "Maine Integrated Health Management Solution" **Verification of Provider Qualifications****Entity Responsible for Verification:**Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by **Frequency of Verification:**Upon enrollment and every three (3) years thereafter. 


---

## Appendix C: Participant Services

### C-1/C-3: Service Specification

---

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**Communication Aids **HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Communication Aids are devices or services necessary to assist individuals with hearing, speech or vision impairments to effectively communicate with service providers, family, friends, and other community

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Only communication aids that cannot be obtained as a covered service under other sections of the MaineCare Benefits Manual will be reimbursed under this Section. For communication aids costing more

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Speech and Hearing Agencies and Home Health Care Agencies
Individual	Independent Practitioners

**Appendix C: Participant Services**

---

## C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**  
**Service Name: Communication Aids**

**Provider Category:**

Agency

**Provider Type:**

Speech and Hearing Agencies and Home Health Care Agencies

**Provider Qualifications****License (specify):**

Licensed if applicable  
 A Licensed Audiologist

**Certificate (specify):**

CCC-SP for agency employees  
 Assistive Technology Professional(ATP)from the Rehabilitation Engineering and Assistive

**Other Standard (specify):**

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS).

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Communication Aids**

**Provider Category:**

Individual

**Provider Type:**

Independent Practitioners

**Provider Qualifications****License (specify):**

Licensed if applicable  
 A Licensed Audiologist

**Certificate (specify):**

CCC-SP (Certificate of Clinical Competence-Speech Pathology)  
 Assistive Technology Professional(ATP)from the Rehabilitation Engineering and Assistive

**Other Standard (specify):**

Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS). Received addition approval from OADS for provision of waiver services as required

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Consultation

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**



Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Consultation Services are services provided to persons responsible for developing or carrying out a member's Individual Plan. Consultation services allows a therapist or clinician to provide services to the

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Participants are allowed up to 66 units or 16.5 hours per discipline per year.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual Practitioner
Agency	Home Health Agency

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Consultation**

**Provider Category:**

Individual

**Provider Type:**

Individual Practitioner

**Provider Qualifications**

**License (specify):**

Licensed Psychological Examiner or Licensed Clinical Psychologist or Licensed Clinical Social Worker or Licensed Clinical Professional Counselor.

**Certificate (specify):**

Certificate of Clinical Competence-Speech Pathology (CCC-SP), or Registered Physical Therapist (RPT), or Occupational Therapist, Registered (OTR) or Board Certified Behavior

**Other Standard (specify):**

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS). Enrollment includes MaineCare Provider Agreement, Program Integrity

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Consultation**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications****License (specify):**

Licensed as a Home Health Agency in Maine

**Certificate (specify):**

May be Medicare certified, but not required under this waiver.

**Other Standard (specify):**

Provider must complete the enrollment process in the Maine Integrated Health Management Solution. Enrollment includes MaineCare Provider Agreement, Program Integrity Unit review,

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Counseling

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**


Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Counseling is a direct service to assist the participant in the resolution of the participants behavioral, social, mental health, and alcohol or drug abuse issues. Counseling services are recommended in the Individual	·
---	---

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

16.25 hour per year.	·
----------------------	---

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual Practitioner
Agency	Mental Health Agency and Home Health Agency

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Counseling****Provider Category:**

Individual ▾

**Provider Type:**

Individual Practitioner ▾

**Provider Qualifications****License (specify):**

Licensed Clinical Social Worker, Licensed Clinical Professional Counselor ▾

**Certificate (specify):**

▾

**Other Standard (specify):**

Provider must complete the enrollment process in the Maine Integrated Health Management Solution. Enrollment includes MaineCare Provider Agreement, Program Integrity Unit review, ▾

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by ▾

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter. ▾

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Counseling****Provider Category:**

Agency ▾

**Provider Type:**

Mental Health Agency and Home Health Agency ▾

**Provider Qualifications****License (specify):**Licensed as a Mental Health Agency or Home Health Agency in Maine.  
Licensed Clinical Social Worker, Licensed Clinical Professional Counselor ▾

**Certificate** *(specify):*

**Other Standard** *(specify):*

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS). Enrollment includes MaineCare Provider Agreement, Program Integrity

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR § 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Crisis Assessment

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Crisis Assessment is a comprehensive clinical assessment of a person who has required intervention by the state Crisis Team on at least three occasions within a two-week period. The assessment includes: a clinical

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The maximum allowance for this service is \$2,250. This cost includes all related follow-up activities.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Mental Health or OADS Approved Provider Agency

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Crisis Assessment**

**Provider Category:**

**Provider Type:**

Community Mental Health or OADS Approved Provider Agency

**Provider Qualifications**

**License (specify):**

Agency MH License as per DHHS, individual practitioners (employees or contractors) must also be licensed as per state requirements.

**Certificate** (*specify*):

**Other Standard** (*specify*):

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS). Enrollment includes MaineCare Provider Agreement, Program Integrity

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR § 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Crisis Intervention

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Crisis Intervention is direct intensive support provided to individuals who are experiencing a psychological, behavioral, or emotional crisis. Crisis intervention is commonly provided on a short-term intermittent basis.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Crisis intervention Services may be authorized in an emergency situation for a period not to exceed two weeks by OADS personnel.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	OADS Approved Provider Agency or Mental Health Agency

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Crisis Intervention**

**Provider Category:**

**Provider Type:**

OADS Approved Provider Agency or Mental Health Agency

**Provider Qualifications****License** (*specify*):

DHHS License as required.

**Certificate** (*specify*):

A staff person must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by DHHS, or

**Other Standard** (*specify*):

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIHMS). Enrollment includes MaineCare Provider Agreement, Program Integrity

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Employment Specialist Services

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Employment Specialist Services include services necessary to support an individual in maintaining Employment. Services include: (1) periodic interventions on the job site to identify an individual's

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Employment Specialist Services are provided on an intermittent basis with a maximum of 10 hours each month.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	OADS Supported Employment Agency

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Employment Specialist Services**

**Provider Category:**

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

A staff person must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by DHHS, or

**Other Standard** (*specify*):

Provider Agency must have:  
\* Completed the enrollment process for the "Maine Integrated Health Management Solution"

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Home Accessibility Adaptations are those physical adaptations to the home, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

\$10,000 limit in 5-year period with an additional annual allowance up to \$300 for repairs and replacement per year. All items in excess of \$500 require documentation from physician or other appropriate

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Independent Service Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type:** Other Service  
**Service Name:** Home Accessibility Adaptations

**Provider Category:**

**Provider Type:**

**Provider Qualifications**

**License (specify):**

State Licensure, if applicable.

**Certificate (specify):**

Professional Certification, if applicable. Any other requirements set forth by the Department or participant IF applicable.

**Other Standard (specify):**

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS). Enrollment includes MaineCare Provider Agreement, Program Integrity

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Prior to provision of service.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Home Support-Remote Support

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

This service is designed to provide habilitation support and to assist the participant achieving the most integrated setting possible and increase the participant's independence through assistive technology. This

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Remote Support is not available at the same time as any other type of Home Support or Personal Care. Home Support-Remote Support is limited to 48 units per day.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	OADS approved provider agency

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Home Support-Remote Support**

**Provider Category:**

**Provider Type:**

**Provider Qualifications****License** (*specify*):
**Certificate** (*specify*):

A staff person must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by DHHS, or

**Other Standard** (*specify*):

Provider Agency must have:  
\* Completed the enrollment process for the "Maine Integrated Health Management Solution"

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Provider enrollment verifies provider qualifications at time of enrollment and every three years thereafter.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**


As provided in 42 CFR § 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Home Support is direct support provided to improve and maintain a member's ability to live as independently as possible in his or her home. Home Support may be provided in a Licensed or unlicensed

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	OADS approved Individual

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Home Support-Residential Habilitation-Family Centered Support**

**Provider Category:**

**Provider Type:**

**Provider Qualifications****License** (*specify*):
**Certificate** (*specify*):

A staff person must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by DHHS, or

**Other Standard** (*specify*):

\* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**


As provided in 42 CFR § 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Non-Traditional Communication (NTC) Consultation is provided to participants and their direct support staff and others to assist them in to maximize communication ability as determined from assessment. The

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The limit is up to 60 hours per year.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual Practitioner

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Non Traditional Communication Consultation**

**Provider Category:**

**Provider Type:**

**Provider Qualifications****License** (*specify*):
**Certificate** (*specify*):

Approval by Office of Aging and Disability Services (based on successful completion of a program for teaching Visual Gestural Communication (Houston or other).

**Other Standard** (*specify*):

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS). Enrollment includes MaineCare Provider Agreement, Program Integrity

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon initial application and at least every 3 years.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**


As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Transportation service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This is offered in addition to

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Services must be coordinated through a broker.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Broker

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Non-Medical Transportation**

**Provider Category:**

**Provider Type:**

**Provider Qualifications**

**License** *(specify):*

The driver must have a Driver's license, registration and insurance.

**Certificate** *(specify):*

**Other Standard** *(specify):*

The states transportation services are managed through a 1915 b (Me.19) waiver run concurrently with this waiver. The transportation is managed through a broker. The broker's

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Provider Enrollment verifies that the broker is qualified. The broker verifies that the individual driver is qualified.

**Frequency of Verification:**

Provider enrollment verifies these qualifications upon enrollment and every 3 years thereafter.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR § 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Non-traditional Communication Assessment

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Non-Traditional Communication Assessments determine the level of communication present via gesture, sign language or unique individual communication style. The assessment examines signed or gestured

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

40 units annually.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual Practitioner

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Non-traditional Communication Assessment**

**Provider Category:**

**Provider Type:**

**Provider Qualifications****License** (*specify*):
**Certificate** (*specify*):

Approval by Office of Aging and Disability Services (OADS)(based on successful completion of a program for teaching Visual Gestural Communication (Houston or other).

**Other Standard** (*specify*):

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS). Enrollment includes MaineCare Provider Agreement, Program Integrity

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**


As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Occupational Therapy (Maintenance) Service that has maintenance of current abilities and functioning level as its goal. Maintenance therapy allows for the implementation of services that include direct therapy and

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Evaluative and rehabilitative Occupational Therapy is included in the state plan and is not covered as a component of maintenance therapy.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Individual Practitioner

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Occupational Therapy (Maintenance)**

**Provider Category:**

**Provider Type:**

Home Health Agency	⋮
--------------------	---

**Provider Qualifications****License** (*specify*):

State license	⋮
---------------	---

**Certificate** (*specify*):

Employee/therapist Occupational Therapist, Registered (OTR)	⋮
Certified Occupational Therapy Assistant (COTA) under the supervision of a Occupational	⋮

**Other Standard** (*specify*):

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS). Enrollment includes MaineCare Provider Agreement, Program Integrity	⋮
---	---

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by	⋮
--	---

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.	⋮
---	---

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Occupational Therapy (Maintenance)****Provider Category:**

Individual ▾

**Provider Type:**

Individual Practitioner	⋮
-------------------------	---

**Provider Qualifications****License** (*specify*):

	⋮
--	---

**Certificate** (*specify*):

Occupational Therapist, Registered (OTR)	⋮
Certified Occupational Therapy Assistant (COTA) under the supervision of a Occupational	⋮

**Other Standard** (*specify*):

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS). Enrollment includes MaineCare Provider Agreement, Program Integrity	⋮
---	---

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by	⋮
--	---

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.	⋮
---	---

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**


As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**


Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Physical Therapy (Maintenance) Service that has maintenance of current abilities and functioning level as its goal. Maintenance therapy allows for the implementation of services that include direct therapy and

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Evaluative and rehabilitative Physical Therapy is included in the state plan and is not covered as a component of maintenance therapy.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E  
 Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual Practitioner
Agency	Home Health Agency

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Physical Therapy (Maintenance)**

**Provider Category:**

Individual ▾

**Provider Type:**

Individual Practitioner

**Provider Qualifications****License (specify):****Certificate (specify):**

Registered Physical Therapist (RPT)

**Other Standard (specify):**

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS). Enrollment includes MaineCare Provider Agreement, Program Integrity

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

**Appendix C: Participant Services**

## C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**  
**Service Name: Physical Therapy (Maintenance)**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications****License (specify):**

State License

**Certificate (specify):**

Employee/therapist Registered Physical Therapist (RPT)

**Other Standard (specify):**

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIHMS). Enrollment includes MaineCare Provider Agreement, Program Integrity

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Qualified Extra Support Service

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Qualified Extra Support Service is an additional support service designed to cover unique medical and behavioral support needs not captured within the Supports Intensity Scale (SIS) Assessment. This service

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Up to two thousand eighty hours per year, 40 hours per week maximum support approved. Level of support is at the discretion of the Extraordinary Support Committee (ERC) upon approval.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	OADS Approved Provider Agency

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**  
**Service Name: Qualified Extra Support Service**

**Provider Category:**

Agency

**Provider Type:**

OADS Approved Provider Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

A staff person must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by DHHS, or

**Other Standard (specify):**

To provide this service a DSP must also have the following training/expertise:  
 -A minimum of three (3) years working as a DSP means in the Home or Community or

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon Enrollment and every three (3) years thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR § 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Semi-Independent Supported Living (SISL) (Residential Habilitation)

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Semi-Independent Supported Living (SISL) is a living model for which a participant will have their own apartment or unit that is separate from other participants and has availability of 24/7 direct support staffing.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

No other type of Residential Habilitation is available at the same time.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
-------------------	---------------------

Agency OADS Approved Provider Agency

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type:** Other Service

**Service Name:** Semi-Independent Supported Living (SISL) (Residential Habilitation)

**Provider Category:**

Agency

**Provider Type:**

OADS Approved Provider Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

A staff person must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by DHHS, or

**Other Standard (specify):**

Provider Agency must have:  
\* Completed the enrollment process for the "Maine Integrated Health Management Solution"

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon Enrollment and every three (3) years thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Skilled Nursing Service for Persons with Intellectual Disabilities and Autism Spectrum Disorder

**HCBS Taxonomy:**

**Category 1:**

05 Nursing

**Sub-Category 1:**

05020 skilled nursing

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Skilled Nursing Service for Persons with Intellectual Disabilities and Autism Spectrum Disorder is an additional support service designed to cover unique medical and healthcare needs that may exceed the

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

This service is limited to a weekly maximum benefit of \$265.00 per week- participants are able to receive service from either an RN or LPN per week but can not exceed the budget amount. The total yearly amount

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
-------------------	---------------------

Agency OADS Approved Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Skilled Nursing Service for Persons with Intellectual Disabilities and Autism Spectrum Disorder**

**Provider Category:**

Agency

**Provider Type:**

OADS Approved Provider

**Provider Qualifications**

**License (specify):**

Registered Nurse:

- Certification by the Developmental Disabilities Nursing Association (DDNA)

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OADS verifies at time of enrollment with State Medicaid Agency and every three years thereafter.

**Frequency of Verification:**

Provider enrollment verifies provider qualifications at time of enrollment and every three years thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Specialized Medical Equipment and Supplies

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive,

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

All items in excess of \$500 require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the individual's need. Medically necessary

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Businesses specializing in Durable Medical Equipment (DME)

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Equipment and Supplies****Provider Category:**

Agency

**Provider Type:**

Businesses specializing in Durable Medical Equipment (DME)

**Provider Qualifications****License (specify):**

State licensure, if applicable.

**Certificate (specify):****Other Standard (specify):**

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS). Enrollment includes MaineCare Provider Agreement, Program Integrity

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Prior to provision of service.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR 440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Speech Therapy (maintenance)

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Speech Therapy (Maintenance) Service that has maintenance of current abilities and functioning level as its goal. Maintenance therapy allows for the implementation of services that include direct therapy and

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Evaluative and rehabilitative Speech Therapy is included in the state plan and is not covered as a component of maintenance therapy.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual Practitioner
Agency	Speech and Hearing Agency

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Speech Therapy (maintenance)**

**Provider Category:**

Individual ▾

**Provider Type:**

Individual Practitioner

**Provider Qualifications****License (specify):****Certificate (specify):**

Certificate of Clinical Competence- Speech Pathology (CCC-SP)

**Other Standard (specify):**

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIMHS). Enrollment includes MaineCare Provider Agreement, Program Integrity

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Speech Therapy (maintenance)**

**Provider Category:**

Agency ▾

**Provider Type:**

Speech and Hearing Agency

**Provider Qualifications****License (specify):****Certificate (specify):**Employee/therapist Certificate of Clinical Competence  Speech Pathology (CCC-SP)**Other Standard (specify):**

Provider must complete the enrollment process in the Maine Integrated Health Management Solution (MIHMS). Enrollment includes MaineCare Provider Agreement, Program Integrity

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Work Support-Individual

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Work Support is Direct Support provided to improve a participant’s ability to independently maintain employment. Work support-individual is provided at the participant’s place of employment; it may be

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	OADS Approved Supported Employment Agency

**Appendix C: Participant Services**

**C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Work Support-Individual**

**Provider Category:**

**Provider Type:**

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Provider Agency must have: * Completed the enrollment process for the "Maine Integrated Health Management Solution"	-
--	---

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by	-
--	---

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.	-
---	---

**Appendix C: Participant Services****C-1: Summary of Services Covered (2 of 2)**

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.  
 **Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

- As a waiver service defined in Appendix C-3.** Do not complete item C-1-c.  
 **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.  
 **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.  
 **As an administrative activity.** Complete item C-1-c.
- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

State employees or approved and certified private agencies deliver case management to waiver participants.	-
--	---

**Appendix C: Participant Services****C-2: General Service Specifications (1 of 3)**

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- No. Criminal history and/or background investigations are not required.**  
 **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a) Any position that provides direct service e.g., direct support professionals, employment specialist. As per MaineCare policy, it is the responsibility of the employing provider to conduct background checks.	-
---	---

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

c. **Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:***

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**
  - i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	<input checked="" type="checkbox"/>
Assisted Housing Level I	
Assisted Housing Level II	
Assisted Housing Level III	

- ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The state believes that with six or fewer beds and often four or fewer the integrity of a home living environment can be maintained. Currently there are only three or four sites in Maine with a five or

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Assisted Housing Level I

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Home Support-Remote Support	<input checked="" type="checkbox"/>
Skilled Nursing Service for Persons with Intellectual Disabilities and Autism Spectrum	

Disorder	<input checked="" type="checkbox"/>
Home Support (1/4 hour)	<input type="checkbox"/>
Non-traditional Communication Assessment	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Adult Foster Care/ Shared Living	<input type="checkbox"/>
Occupational Therapy (Maintenance)	<input type="checkbox"/>
Counseling	<input type="checkbox"/>
Consultation	<input type="checkbox"/>
Employment Specialist Services	<input type="checkbox"/>
Crisis Intervention	<input checked="" type="checkbox"/>
Per Diem Home Support	<input checked="" type="checkbox"/>
Home Support-Residential Habilitation-Family Centered Support	<input type="checkbox"/>
Career Planning	<input type="checkbox"/>
Non Traditional Communication Consultation	<input type="checkbox"/>
Qualified Extra Support Service	<input type="checkbox"/>
Community Support	<input type="checkbox"/>
Work Support-Individual	<input type="checkbox"/>
Semi-Independent Supported Living (SISL) (Residential Habilitation)	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Physical Therapy (Maintenance)	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Crisis Assessment	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Work Support-Group	<input type="checkbox"/>
Communication Aids	<input type="checkbox"/>
Speech Therapy (maintenance)	<input type="checkbox"/>

**Facility Capacity Limit:**

1-2

**Scope of Facility Sandards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed

Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Assisted Housing Level II

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Home Support-Remote Support	<input checked="" type="checkbox"/>
Skilled Nursing Service for Persons with Intellectual Disabilities and Autism Spectrum Disorder	<input checked="" type="checkbox"/>
Home Support (1/4 hour)	<input type="checkbox"/>
Non-traditional Communication Assessment	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Adult Foster Care/ Shared Living	<input type="checkbox"/>
Occupational Therapy (Maintenance)	<input type="checkbox"/>
Counseling	<input type="checkbox"/>
Consultation	<input type="checkbox"/>
Employment Specialist Services	<input type="checkbox"/>
Crisis Intervention	<input checked="" type="checkbox"/>

Per Diem Home Support	<input checked="" type="checkbox"/>
Home Support-Residential Habilitation-Family Centered Support	<input type="checkbox"/>
Career Planning	<input type="checkbox"/>
Non Traditional Communication Consultation	<input type="checkbox"/>
Qualified Extra Support Service	<input type="checkbox"/>
Community Support	<input type="checkbox"/>
Work Support-Individual	<input type="checkbox"/>
Semi-Independent Supported Living (SISL) (Residential Habilitation)	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Physical Therapy (Maintenance)	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Crisis Assessment	<input type="checkbox"/>
Assistive Technology	<input checked="" type="checkbox"/>
Work Support-Group	<input type="checkbox"/>
Communication Aids	<input type="checkbox"/>
Speech Therapy (maintenance)	<input type="checkbox"/>

**Facility Capacity Limit:**

3-6

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

## Appendix C: Participant Services

### C-2: Facility Specifications

#### Facility Type:

#### Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Home Support-Remote Support	<input checked="" type="checkbox"/>
Skilled Nursing Service for Persons with Intellectual Disabilities and Autism Spectrum Disorder	<input checked="" type="checkbox"/>
Home Support (1/4 hour)	<input type="checkbox"/>
Non-traditional Communication Assessment	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Adult Foster Care/ Shared Living	<input type="checkbox"/>
Occupational Therapy (Maintenance)	<input type="checkbox"/>
Counseling	<input type="checkbox"/>
Consultation	<input type="checkbox"/>
Employment Specialist Services	<input type="checkbox"/>
Crisis Intervention	<input checked="" type="checkbox"/>
Per Diem Home Support	<input checked="" type="checkbox"/>
Home Support-Residential Habilitation-Family Centered Support	<input type="checkbox"/>
Career Planning	<input type="checkbox"/>
Non Traditional Communication Consultation	<input type="checkbox"/>
Qualified Extra Support Service	<input type="checkbox"/>
Community Support	<input type="checkbox"/>
Work Support-Individual	<input type="checkbox"/>
Semi-Independent Supported Living (SISL) (Residential Habilitation)	<input type="checkbox"/>
Home Accessibility Adaptations	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Physical Therapy (Maintenance)	<input type="checkbox"/>

Non-Medical Transportation	<input type="checkbox"/>
Crisis Assessment	<input type="checkbox"/>
Assistive Technology	<input checked="" type="checkbox"/>
Work Support-Group	<input type="checkbox"/>
Communication Aids	<input type="checkbox"/>
Speech Therapy (maintenance)	<input type="checkbox"/>

**Facility Capacity Limit:**

3-6

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

---

### C-2: General Service Specifications (3 of 3)

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a

waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

	-
--	---

- e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

	-
--	---

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Only those waiver services identified in the Personal Plan for which the relatives/legal guardian has been determined to be eligible to provide. Relatives/legal guardians who provide waiver services must meet the	-
--	---

- Other policy.**

Specify:

	-
--	---

- f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any person or entity showing interest in various MaineCare programs may enroll as a provider so long as all necessary qualifications are met. The State has on-going open enrollment and State staff available to assist with	-
---	---

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

**a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

**i. Sub-Assurances:**

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and Percent of provider applications (by type) for which providers obtained appropriate licensure/certification in accordance with State law and waiver requirements prior to service provision. Numerator: Total number of provider applications (by type) for which providers obtained appropriate licensure/certification. Denominator: Total number of provider applications (by type).**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and</b>	<input type="checkbox"/> <b>Other</b>

	<b>Ongoing</b>	Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of providers, by provider type, continuing to meet applicable licensure/certification following initial enrollment.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- b. **Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and Percent of provider applications (by type) for which non-licensed providers met waiver requirements prior to service provision. Numerator: Total number of provider applications (by type) for which non-licensed providers met**

**waiver requirements prior to service provision. Denominator: Total number of non-licensed provider applications (by type).**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>

**Other**  
Specify:

**Performance Measure:**  
**Number and Percent of provider applications (by type) for which non-licensed providers who continue to meet waiver requirements following initial enrollment.**  
**Numerator: Total number of provider applications (by type) for which non-licensed providers met waiver requirements following initial enrollment.**  
**Denominator: Total number of non-licensed provider applications (by type).**

**Data Source (Select one):**  
**Record reviews, off-site**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and Percent of providers, by type, that meet training requirements in accordance with state law and waiver requirements. Numerator: Total number of providers, by type, that meet training requirements. Denominator: Total number of providers, by type.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

**Provider enrollment portal**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

		<input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

DSPs must successfully complete a minimum set of training modules established through the Maine College of Direct Support. During the first 6 months of employment, supervisors will review all

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Absence of appropriate licensure/certification and attestation to Medicaid policy will disqualify the agency from enrollment into the Medicaid program. An agency that has not re-enrolled or verified

- ii. **Remediation Data Aggregation**  
**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>

<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: <input type="text" value="Licensure, certification, or training is verified upon enrollment and when"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

---

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

---

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

**Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable -** The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

- Other Type of Limit.** The State employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

1. The State of Maine is transitioning participants and providers over to the new HCBS rules using the timelines noted in the submitted Transition Plan. The settings that are in compliance are privately owned participants homes or apartments.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

#### State Participant-Centered Service Plan Title:

Person Centered Plan (PCP)

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):
- Registered nurse, licensed to practice in the State**
  - Licensed practical or vocational nurse, acting within the scope of practice under State law**
  - Licensed physician (M.D. or D.O)**
  - Case Manager** (qualifications specified in Appendix C-1/C-3)

- Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

DESCRIPTION: Performs professional social work for eligible adults with developmental disabilities, physical disabilities, co-occurring diagnoses such as mental health issues and brain injury.

- Social Worker**

*Specify qualifications:*

State Employee  
MINIMUM REQUIREMENTS

- Other**

*Specify the individuals and their qualifications:*

Community Case management workers-BA/BS in social work/social welfare.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

- b. **Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

	-
	-

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

- c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Plan development and service planning includes the case manager, participant, guardian, and other individuals in planning team. Information reviewed includes the planning tools, review of reportable events	-
	-

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

- d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws,

regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a)The case manager is responsible for the service plan but it is developed in conjunction with the participant, and guardian (if applicable). Service plans are required to be developed at least annually.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The Personal Planning process identifies potential risks by those invited to the planning meeting and a review of reportable events over the last 12 months. The planning team addresses potential risks as part of the plan. A

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Choice of providers for waiver participants is assured by two complimentary processes. The Office of Aging and Disability Services (OADS) maintains a provider directory on its website. Listings are voluntary and must

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

- g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Office of Aging and Disability Services (OADS), which administers this waiver, is part of the single state Medicaid agency. OADS reviews all personal plans and has ultimate authority of personal plan approval.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

- h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

*Specify the other schedule:*

- i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a

minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

A. Case managers are responsible for the monitoring and assurance of the implementation of the personal plan. This includes monitoring of the health, welfare and safety of the individual. The district quality manager also

- b. **Monitoring Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

- i. **Sub-Assurances:**

- a. **Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

#### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State*

*to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and Percent of all participant service plans that adequately address all assessed needs as reflected in the assessment process. Numerator: Total number of participant service plans that adequately address all assessed needs. Denominator: Total number of participant service plans.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and Percent of participant service plans that adequately address health and safety risks. Numerator: Total number of participant services plans that adequately address health and safety risks. Denominator: Total number of participant service plans.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

--	--

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**Number and Percent of all participant service plans that adequately address all personal goals as defined in the planning process with the participant. Numerator:** Total number of participant service plans that have unmet needs. **Denominator:** Total number of participant service plans.

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100px; height: 20px;" type="text"/>
---

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100px; height: 20px;" type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100px; height: 20px;" type="text"/>

- b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and Percent of all participant service plans that are completed using the process outlined in the waiver policy. Numerator: Total number of all participant service plans that are completed using the process outlined in the waiver policy. Denominator: Total number of participant service plans.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and Percent of all participant service plans that were reviewed, and revised as required, on or before the participants annual review date. Numerator:** Total number of all participant service plans that were reviewed, and revised as needed/required, on or before the participants annual review date. **Denominator:** Total number of participant service plans.

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/>	<input type="checkbox"/>

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Performance Measure:**  
**Number and Percent of all participant service plans that were reviewed, and revised as required, due to changing needs of the participant. Numerator: Total number of all participant service plans that were reviewed, and revised as required, due to changing needs of the participant. Denominator: Total number of participant service plans.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>		<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify:		

--	--	--

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and Percent of all participants who received services in the type, scope, amount, frequency and duration specified in the service plan. Numerator: Total number of all participants who received services in the type, scope, amount, frequency and duration specified in the service plan. Denominator: Total number of participant service plans**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- e. *Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and Percent of all participants who signed a freedom of choice form that specified choices offered between institutional care and waiver services.**

**Numerator: Total number of all who signed a freedom of choice form that specified choices offered between institutional care and waiver services.**

**Denominator: Total number of participants.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**  
**Number and Percent of all waiver participant records reviewed with appropriately documented freedom of choice among waiver services and providers. Numerator:** Total number participant records with appropriately documented freedom of choice among waiver services and providers. **Denominator:** Total number of participant records reviewed.

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

OADS relies on its Enterprise Information System to hold data and produce reports that are essential to Quality Management activities. New reports are being developed on a regular basis and they are

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

It is the responsibility of the case manager to assure that the personal plan meets the identified needs of the participant. In addition, the case manager is responsible to monitor implementation of the personal

- ii. **Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party(check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

	Every six (6) months
--	----------------------

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- No**  
 **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

--

## Appendix E: Participant Direction of Services

---

**Applicability** (from Application Section 3, Components of the Waiver Request):

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.  
 **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**  
 **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

---

### E-1: Overview (1 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

## Appendix E: Participant Direction of Services

---

### E-1: Overview (2 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

## Appendix E: Participant Direction of Services

---

### E-1: Overview (3 of 13)

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

## Appendix E: Participant Direction of Services

---

### E-1: Overview (4 of 13)

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (5 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (6 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (7 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (8 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (9 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (10 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (11 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (12 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services**

---

**E-1: Overview (13 of 13)**

---

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

---

**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant Direction (1 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (2 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (3 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (4 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (5 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services****E-2: Opportunities for Participant-Direction (6 of 6)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix F: Participant Rights****Appendix F-1: Opportunity to Request a Fair Hearing**

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The following is copied from: Chapter 1, MaineCare Benefits Manual, General Administrative Policies and Procedures. Notices requesting fair hearings are kept in the Medicaid Agency's Health Care Management Unit.

**Appendix F: Participant-Rights****Appendix F-2: Additional Dispute Resolution Process**

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates an additional dispute resolution process**

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

	-
--	---

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

- a. **Operation of Grievance/Complaint System.** *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

- b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

Developmental Services, within the Office of Aging and Disabilities Services, has a grievance process that is specific to those individuals for whom it has statutory obligations to serve.	-
---	---

- c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) A grievance is a complaint. A grievance can be about an action or inaction of DHHS. It can be about a person or agency providing services or supports to you. A grievance can be about a violation of your rights. Or	-
---	---

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- Yes. The State operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)**
- No. This Appendix does not apply (do not complete Items b through e)**  
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

	-
--	---

- b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an

appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The following is copied from DHHS State Rule #14- 197 CMR Ch 12:

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information about critical incident reporting is available through brochures or on the Department's website.

One can also report an event or obtain more information through their case manager, Office of Advocacy, Adult

- d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

AGENCY POLICIES AND PROCEDURES; APPROVED INVESTIGATORS

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Department of Health & Human Services is responsible for overseeing the reporting a response to critical incidents or events that affect waiver participants.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

- The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

- The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Under the Departments Reportable Events Regulations all emergency restraints are reportable. If it is found that organizations are not reporting, either through family, mandated reporters, case managers,

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DHHS has the responsibility. For additional detail please see above for the review process.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- The use of restrictive interventions is permitted during the course of the delivery of waiver services**

Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Pursuant to 34-B M.R.S.A. § 5605(13), the planning team must evaluate factors that may be contributing to the occurrence of the behavior. Restrictive interventions must be developed by a

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DHHS has the responsibility of monitoring the use of restrictive interventions. This is done as follows:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Under the Departments Reportable Events Regulations all emergency restraints are reportable. If it is found that organizations are not reporting, either through family, mandated reporters, case managers,

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DHHS has the responsibility. For additional detail please see above for the review process.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

- a. **Applicability.** Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)  
 **Yes. This Appendix applies** (complete the remaining items)

- b. **Medication Management and Follow-Up**

- i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Providers who hold license(s) and certification(s) have ongoing responsibility for monitoring participant medication regimens. The methods for conducting and monitoring depend on the level of license and

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

(a) The State utilizes the Reportable Events procedure outlined in G-1 to receive information relative to inappropriate medication management.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

- c. **Medication Administration by Waiver Providers**

- i. **Provider Administration of Medications.** *Select one:*

- Not applicable.** (do not complete the remaining items)  
 **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** (complete the remaining items)

- ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Anyone assisting in the administration of medication in a licensed residence must complete a Certified Residential Medication Assistant (CRMA) training and be re-certified every two years. This training is

iii. **Medication Error Reporting.** *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

*Complete the following three items:*

(a) Specify State agency (or agencies) to which errors are reported:

DHHS

(b) Specify the types of medication errors that providers are required to *record*:

Medication Error or Refusal:  Medication error  includes wrong person, wrong dose, wrong medication, wrong time (over one hour variance), wrong route, wrong method of administration or

(c) Specify the types of medication errors that providers must *report* to the State:

same as above.

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Monitoring is done either through the State Medicaid Agency through the reportable event system, or through the participant's case manager's review of the MARs when using the home visit tool. Reports

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Health and Welfare**

*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

**i. Sub-Assurances:**

- a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)**

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and Percent of all participants & legal guardians who received information and education about how to report abuse, neglect, exploitation and other critical incidents. Num: Total # of all participants and legal guardians who received information and education about how to report abuse, neglect, exploitation and other critical incidents. Denominator: Tot # of participants & legal guardians.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="text"/>	<input type="text"/>

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Performance Measure:**  
**Number and Percent of participants surveyed who reported that they do not feel safe where they live.**

**Data Source** (Select one):  
**Analyzed collected data (including surveys, focus group, interviews, etc)**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Random sampling of <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and Percent of participants who have required and had an annual dental exam.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and Percent of all critical incident reviews/investigations initiated within the required timeframes. Numerator: Total number of investigations initiated within the required timeframes. Denominator: Total number of investigations of critical incidents.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and Percent of all critical incidents reported within the required timeframes. Numerator: Total number of all critical incidents reported within the required timeframes. Denominator: Total number of critical incidents.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and Percent of participants surveyed who reported that they are not treated with respect and dignity.

**Data Source (Select one):**

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

<i>(check each that applies):</i>		
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 30% of each <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and Percent of all participants receiving preventative health care.**

**Numerator: Total number of all participants receiving age-appropriate,**

preventative health care. Denominator: Total number of all waiver participants.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
--	--

**Performance Measure:**  
**Number and Percent of all participants receiving a physical health exam by their primary care provider on an annual basis. Numerator: Total number of all participants receiving a physical health exam by their primary care provider on an annual basis. Denominator: Total number of waiver participants.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input style="width: 50%;" type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. **Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.**

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- d. **Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Maine is committed to utilizing the National Core Indicators Project on an annual basis in order to receive information directly from participants regarding the quality and satisfaction of services they receive.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

OADS Adult Protective Unit reviews each reported event. The Office of Quality Improvement within DHHS will identify individual problems from survey data and send any issues/concerns raised to regional

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix H: Quality Improvement Strategy (1 of 2)**

---

Under 1915(c) of the Social Security Act and 42 CFR 441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it

operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

**Appendix H: Quality Improvement Strategy (2 of 2)**

**H-1: Systems Improvement**

**a. System Improvements**

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The primary goals for the Quality Improvement Strategy (QIS) are to administer and evaluate a quality improvement system that ensures participants have choice from a variety of waiver services and available

**ii. System Improvement Activities**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of Monitoring and Analysis</b> (check each that applies):
---	--

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Quality Improvement Committee</b>	<input type="checkbox"/> <b>Annually</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**b. System Design Changes**

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

OADS uses data to determine the level of success a service is achieving in improving the health and well-being of participants: to assist and monitor quality; to inform and guide reimbursement decision; and to

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

OADS engages with other Offices within the State and contracted entities to review, assess and make recommendations for quality improvements. A Quality Management team works independently within

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a- The State of Maine does not require independent audits specific to this waiver.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

**a. Methods for Discovery: Financial Accountability**

*State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

**i. Sub-Assurances:**

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)**

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and Percent of waiver service claims submitted for FFP that are specified in the participant's service plan.**

**Data Source** (Select one):

**Financial records (including expenditures)**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**  
 Number and Percent of correctly completed provider claims that will be processed through the MMIS and paid in accordance with reimbursement methodology outlined in policy.

**Data Source (Select one):**  
**Financial records (including expenditures)**  
 If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input checked="" type="checkbox"/> <b>Other</b> Specify: <input type="text" value="Controls in the MMIS system will assure that claims are"/>

**Performance Measure:**

**Number and Percent of all claims coded and paid correctly in accordance with reimbursement methodology specified in the approved waiver. Numerator: Total number of all claims coded and paid Denominator: Total number of all claims.**

**Data Source** (Select one):

**Financial audits**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:

	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

- b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The current MMIS system limits all services provided under the waiver to what is permitted by the policy for each classification group. Claims are denied if improper rates are billed or units of service are billed

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

If concerns are raised by a provider regarding claims, the provider contacts the provider relations specialist through the Medicaid agency. If additional policy issues are identified, OADS requests data

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: <input type="text" value="As needed"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (1 of 3)**

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Waiver services are reimbursed on a prospective, fee-for-service basis, with a few exceptions discussed below. The provider fee schedule is published in the MaineCare Benefits Manual, Section 21, Chapter III.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver billings flow directly from service providers to the State's claims processing system. The claims system is Maine Integrated Health Management Solution (MIHMS) which was fully functional as related to claims

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

c. **Certifying Public Expenditures** (*select one*):

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

*Select at least one:*

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

(a) The claims system has an internal capacity to determine whether people are eligible as of the date of service as part of processing claim. Claims are not paid to a provider if an individual has not yet been determined

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

**Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

a. Transportation is reimbursed through a 1915b Me.19 Maine Non-emergency Transportation Waiver capitated system with contracted brokers outside the MMIS system. b. The process for making the payments

**Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

For Transportation Services- The limited fiscal agent is selected through an rfp process. The waiver services that the fiscal agent will make payment for are Transportation Services. The fiscal agent pays through a

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

	-
--	---

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

	-
--	---

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

	-
--	---

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

- e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

**Answers provided in Appendix I-3-d indicate that you do not need to complete this section.**

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

## Appendix I: Financial Accountability

---

### I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

---

### I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDs and how these entities qualify for designation as an OHCDs; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDs; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDs arrangement is employed, including the selection of providers not affiliated with the OHCDs; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDs meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:***

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the

mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

*Check each that applies:*

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

*Check each that applies:*

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

--

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The rate structure for services delivered in residential settings is based solely on the cost of delivering the service and does not include room and board costs. Cost of room and board is paid for separately by a combination of
--

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

--

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.
  - i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

**Charges Associated with the Provision of Waiver Services** (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. **Co-Payment Requirements.**
  - ii. **Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. **Co-Payment Requirements.**
  - iii. **Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. **Co-Payment Requirements.**
  - iv. **Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

- b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver**

participants.

- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	103747.31	9676.00	113423.31	187894.00	7702.00	195596.00	82172.69
2	103747.31	9772.00	113519.31	189773.00	7779.00	197552.00	84032.69
3	103747.31	9870.00	113617.31	191671.00	7857.00	199528.00	85910.69
4	103747.31	9969.00	113716.31	193587.00	7935.00	201522.00	87805.69
5	103747.31	10069.00	113816.31	195523.00	8015.00	203538.00	89721.69

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

- Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	2990		2990
Year 2	2990		2990
Year 3	2990		2990
Year 4	2990		2990
Year 5	2990		2990

## Appendix J: Cost Neutrality Demonstration

**J-2: DERIVATION OF ESTIMATES (3 of 9)**

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The estimated average length of stay is 356.6 days. This is calculated based on the 372 report for 2010-11 (current waiver year 4).

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (3 of 9)**

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.
  - i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The Factor D estimates are based on projected utilization data from paid claims for Year 5 of the current waiver period. In addition, the SIS evaluations were completed on all waiver individuals for actual care

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The basis for Factor D' is the actual cost of non-waiver MaineCare services for waiver participants for State fiscal year 2012. It has been increased by a factor of 1% for each year of the waiver period. Part D

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The basis for Factor G is the actual cost for ICF/IID services for State fiscal year 2012. It has been increased by a factor of 1% for each year of the waiver period.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The basis for Factor G' is the actual cost of all other MaineCare services for ICF/IID residents for State fiscal year 2012. It has been increased by a factor of 1% for each year of the waiver period.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (4 of 9)**

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Community Support	
Home Support (1/4 hour)	
Per Diem Home Support	
Respite	
Work Support-Group	
Adult Foster Care/ Shared Living	
Assistive Technology	
Career Planning	

Communication Aids
Consultation
Counseling
Crisis Assessment
Crisis Intervention
Employment Specialist Services
Home Accessibility Adaptations
Home Support-Remote Support
Home Support-Residential Habilitation-Family Centered Support
Non Traditional Communication Consultation
Non-Medical Transportation
Non-traditional Communication Assessment
Occupational Therapy (Maintenance)
Physical Therapy (Maintenance)
Qualified Extra Support Service
Semi-Independent Supported Living (SISL) (Residential Habilitation)
Skilled Nursing Service for Persons with Intellectual Disabilities and Autism Spectrum Disorder
Specialized Medical Equipment and Supplies
Speech Therapy (maintenance)
Work Support-Individual

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Support Total:</b>							<b>37499704.12</b>
Community Support	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00	
Community Support 1:1	<input type="checkbox"/>	1/4 hour	605	1040.00	7.98	5021016.00	
Community Support-Facility Based-Level 1	<input type="checkbox"/>	1/4 hour	444	2598.00	3.53	4071897.36	
Community Support-Facility Based-Level 2 & 3	<input type="checkbox"/>	1/4 hour	1184	2598.00	3.91	12027285.12	
Community Support-Facility Based-Level 4 & 5	<input type="checkbox"/>	1/4 hour	388	2598.00	4.98	5019959.52	
Community Support-Community Only-Level 1	<input type="checkbox"/>	1/4 hour	444	1113.00	4.67	2307783.24	
Community							

Support-Community Only-Level 2 & 3	<input type="checkbox"/>	1/4 hour	1184	1113.00	4.67	6154088.64	
Community Support-Community Only-Level 4 & 5	<input type="checkbox"/>	1/4 hour	388	1113.00	6.71	2897673.24	
<b>Home Support (1/4 hour) Total:</b>							11740354.50
Home Support 1/4 hour Short Term	<input type="checkbox"/>	1/4 hour	325	1290.00	7.42	3110835.00	
Home Support 1/4 hour Long Term	<input type="checkbox"/>	1/4 hour	325	3870.00	6.18	7772895.00	
Home Support 1/4 hour Short Term Group of 2	<input type="checkbox"/>	1/4 hour	20	3870.00	4.08	315792.00	
Home Support 1/4 hour Short Term Group of 3	<input type="checkbox"/>	1/4 hour	20	3870.00	2.97	229878.00	
Home Support 1/4 hour Long Term Group of 2	<input type="checkbox"/>	1/4 hour	20	3870.00	3.40	263160.00	
Home Support 1/4 hour Long Term Group of 3	<input type="checkbox"/>	1/4 hour	5	3870.00	2.47	47794.50	
<b>Per Diem Home Support Total:</b>							202990685.06
Per Diem Home Support	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Home Support Level 1 One Participant	<input type="checkbox"/>	day	26	326.00	502.90	4262580.40	
Home Support Level 1 Two Participants	<input type="checkbox"/>	day	105	326.00	307.59	10528805.70	
Home Support Level 1 Three Participants	<input type="checkbox"/>	day	35	326.00	232.55	2653395.50	
Home Support Level 1 Four Participants	<input type="checkbox"/>	day	26	326.00	188.57	1598319.32	
Home Support Level 2 & 3 One Participant	<input type="checkbox"/>	day	98	326.00	504.19	16107862.12	
Home Support Level 2 & 3 Two Participants	<input type="checkbox"/>	day	411	326.00	320.50	42942513.00	
Home Support Level 2 & 3 Three Participants	<input type="checkbox"/>	day	214	326.00	245.47	17124969.08	
Home Support Level 2 & 3 Four Participants	<input type="checkbox"/>	day	285	326.00	230.23	21390669.30	
Home Support Level 4 One Participant	<input type="checkbox"/>	day	65	326.00	573.69	12156491.10	
Home Support Level 4 Two Participants	<input type="checkbox"/>	day	132	326.00	392.91	16907703.12	
Home Support Level 4 Three Participants	<input type="checkbox"/>	day	66	326.00	359.14	7727256.24	
Home Support Level 4 Four Participants	<input type="checkbox"/>	day	112	326.00	349.39	12756927.68	
Home Support Level 5 One Participant	<input type="checkbox"/>	day	32	326.00	573.69	5984734.08	
Home Support Level 5 Two							14217841.26

Participants	<input type="checkbox"/>	day	111	326.00	392.91		
Home Support Level 5 Three Participants	<input type="checkbox"/>	day	72	326.00	359.14	8429734.08	
Home Support Level 5 Four Participants	<input type="checkbox"/>	day	72	326.00	349.39	8200882.08	
<b>Respite Total:</b>							1871245.00
Respite	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00	
Respite-Short Term- 1 member	<input type="checkbox"/>	1/4 hour	300	354.00	6.24	662688.00	
Respite-Long Term- 1 member	<input type="checkbox"/>	1/4 hour	300	177.00	5.59	296829.00	
Respite-Short Term- 2 members	<input type="checkbox"/>	1/4 hour	300	354.00	3.43	364266.00	
Respite-Short Term- 3 members	<input type="checkbox"/>	1/4 hour	300	354.00	2.50	265500.00	
Respite-Long Term- 2 members	<input type="checkbox"/>	1/4 hour	300	177.00	3.07	163017.00	
Respite-Long Term- 3 members	<input type="checkbox"/>	1/4 hour	300	177.00	2.24	118944.00	
<b>Work Support-Group Total:</b>							5320608.12
Work Support-Group	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00	
Work Support-Group- Two Participants	<input type="checkbox"/>	1/4 hour	437	1814.00	5.40	4280677.20	
Work Support-Group- Three Participants	<input type="checkbox"/>	1/4 hour	49	1814.00	4.09	363543.74	
Work Support-Group- Four Participants	<input type="checkbox"/>	1/4 hour	35	1814.00	3.36	213326.40	
Work Support-Group- Five Participants	<input type="checkbox"/>	1/4 hour	3	1814.00	2.94	15999.48	
Work Support-Group- Six Participants	<input type="checkbox"/>	1/4 hour	93	1814.00	2.65	447060.30	
<b>Adult Foster Care/ Shared Living Total:</b>							21573881.20
Adult Foster Care/ Shared Living	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Shared Living-One Participant	<input type="checkbox"/>	day	135	324.00	126.19	5519550.60	
Shared Living-Two Participants	<input type="checkbox"/>	day	135	324.00	63.10	2759994.00	
Shared Living-One Participant-Increased Level of Support	<input type="checkbox"/>	day	135	324.00	183.52	8027164.80	
Shared Living-Two Participants-Increased Level of Support	<input type="checkbox"/>	day	135	324.00	120.42	5267170.80	
<b>Assistive Technology Total:</b>							750722.00
Assistive Technology-Monthly Transmission Utility Services	<input type="checkbox"/>	per month	50	12.00	50.00	30000.00	

Assistive Technology-Assessment	<input type="checkbox"/>	1/4 hour	50	1.00	14.44	722.00	
Assistive Technology-Device	<input type="checkbox"/>	per month	10	12.00	6000.00	72000.00	
<b>Career Planning Total:</b>							40.48
Career Planning	<input type="checkbox"/>	per hour	1	1.00	40.48	40.48	
<b>Communication Aids Total:</b>							71720.00
Communication Aids	<input type="checkbox"/>	cost	50	1.00	1428.00	71400.00	
Communication Aids, Assistive Devices V5274	<input type="checkbox"/>	cost	50	1.00	1.00	50.00	
Communications Aids, Ongoing Visual-gestural and Facilitated Communication T1013 GN	<input type="checkbox"/>	cost	50	1.00	5.40	270.00	
<b>Consultation Total:</b>							256728.78
Consultation	<input type="checkbox"/>	1/4 hour	108	66.00	13.50	96228.00	
Consultative Services-Behavioral	<input type="checkbox"/>	1/4 hour	1	66.00	18.99	1253.34	
Consultative Services-Occupational Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Speech Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Physical Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Psychological	<input type="checkbox"/>	1/4 hour	107	66.00	22.05	155717.10	
<b>Counseling Total:</b>							49261.50
Counseling	<input type="checkbox"/>	1/4 hr	41	89.00	13.50	49261.50	
<b>Crisis Assessment Total:</b>							11250.00
Crisis Assessment	<input type="checkbox"/>	per encounter	5	1.00	2250.00	11250.00	
<b>Crisis Intervention Total:</b>							1841462.00
Crisis Intervention	<input type="checkbox"/>	1/4 hour	500	476.00	5.77	1373260.00	
Crisis Intervention-Short Term	<input type="checkbox"/>	1/4 hour	50	631.00	7.73	243881.50	
Crisis Intervention-Long Term	<input type="checkbox"/>	1/4 hour	50	631.00	7.11	224320.50	
<b>Employment Specialist Services Total:</b>							62220.00
Employment Specialist Services	<input type="checkbox"/>	1/4 hr	85	75.00	9.76	62220.00	
<b>Home Accessibility Adaptations Total:</b>							51207.00

Home Accessibility Adaptations	<input type="checkbox"/>	cost	11	1.00	4655.00	51205.00	
Home Accessibility Adaptations-Repairs	<input type="checkbox"/>	cost	1	1.00	1.00	1.00	
Home Accessibility Adaptations-Home Modifications	<input type="checkbox"/>	cost	1	1.00	1.00	1.00	
<b>Home Support-Remote Support Total:</b>							7.89
Monitor only	<input type="checkbox"/>	1/4 hour	1	1.00	1.62	1.62	
Interactive Support	<input type="checkbox"/>	1/4 hour	1	1.00	6.27	6.27	
<b>Home Support-Residential Habilitation-Family Centered Support Total:</b>							8168577.00
Home Support-Residential Habilitation-Family Centered Support	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Family Centered Support-One Participant	<input type="checkbox"/>	day	40	325.00	104.17	1354210.00	
Family Centered Support-One Participant-Increased Level of Support	<input type="checkbox"/>	day	40	325.00	216.96	2820480.00	
Family Centered Support-Two Participants	<input type="checkbox"/>	day	23	325.00	85.80	641355.00	
Family Centered Support-Two Participants-Increased Level of Support	<input type="checkbox"/>	day	23	325.00	196.78	1470930.50	
Family Centered Support-Three Participants	<input type="checkbox"/>	day	7	325.00	73.15	166416.25	
Family Centered Support-Three Participants-Increased Level of Support	<input type="checkbox"/>	day	7	325.00	178.40	405860.00	
Family Centered Support-Four Participants	<input type="checkbox"/>	day	5	325.00	61.99	100733.75	
Family Centered Support-Four Participants-Increased Level of Support	<input type="checkbox"/>	day	5	325.00	162.16	263510.00	
Family Centered Support-Five Participants	<input type="checkbox"/>	day	14	325.00	55.29	251569.50	
Family Centered Support-Five Participants-Increased Level of Support	<input type="checkbox"/>	day	14	325.00	152.42	693511.00	
<b>Non Traditional Communication Consultation Total:</b>							6966.00
Non Traditional Communication Consultation	<input type="checkbox"/>	1/4 hour	9	86.00	9.00	6966.00	

<b>Non-Medical Transportation Total:</b>							35521.20
Non-Medical Transportation - PMPM	<input checked="" type="checkbox"/>	PMPM	2990	12.00	0.99	35521.20	
<b>Non-traditional Communication Assessment Total:</b>							6390.00
Non-traditional Communication Assessment	<input type="checkbox"/>	1/4 hour	10	71.00	9.00	6390.00	
<b>Occupational Therapy (Maintenance) Total:</b>							3989.97
Occupational Therapy Maintenance OTR/L	<input type="checkbox"/>	1/4 hr	2	48.00	17.83	1711.68	
Occupational Therapy Maintenance COTA	<input type="checkbox"/>	1/4 hr	4	40.00	14.05	2248.00	
Occupational Therapy Maintenance OTR/L Group-2 participants	<input type="checkbox"/>	1/4 hr	1	1.00	9.81	9.81	
Occupational Therapy Maintenance OTR/L Group-3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.13	7.13	
Occupational Therapy Maintenance COTA Group 2 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.73	7.73	
Occupational Therapy Maintenance COTA Group 3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	5.62	5.62	
<b>Physical Therapy (Maintenance) Total:</b>							61050.61
Physical Therapy (Maintenance)	<input type="checkbox"/>	1/4 hr	14	126.00	15.87	27994.68	
Physical Therapy Maintenance 1:1	<input type="checkbox"/>	1/4 hour	17	109.00	17.83	33038.99	
Physical Therapy Maintenance Group-2	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Physical Therapy Maintenance Group-3	<input type="checkbox"/>	1/4 hour	1	1.00	7.13	7.13	
<b>Qualified Extra Support Service Total:</b>							7690579.00
Qualified Extra Support Service	<input type="checkbox"/>	per hour	130	2890.00	20.47	7690579.00	
<b>Semi-Independent Supported Living (SISL) (Residential Habilitation) Total:</b>							2943062.80
Semi-Independent Supported Living (SISL) (Residential Habilitation)	<input type="checkbox"/>	per diem	1	326.00	1.00	326.00	
Tier I	<input type="checkbox"/>	per diem	30	326.00	156.27	1528320.60	
Tier II	<input type="checkbox"/>	per diem	10	326.00	193.47	630712.20	

Tier III	<input type="checkbox"/>	per diem	10	326.00	240.40	783704.00	
<b>Skilled Nursing Service for Persons with Intellectual Disabilities and Autism Spectrum Disorder Total:</b>							2559598.08
Registered Nurse	<input type="checkbox"/>	1/4 hr	186	416.00	15.92	1231825.92	
Licensed Practical Nurse	<input type="checkbox"/>	1/4 hr	186	624.00	11.44	1327772.16	
<b>Specialized Medical Equipment and Supplies Total:</b>							45819.00
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	cost	27	1.00	1697.00	45819.00	
<b>Speech Therapy (maintenance) Total:</b>							68705.44
Speech Therapy (maintenance)	<input type="checkbox"/>	1/4 hr	4	40.00	15.87	2539.20	
Speech Therapy Maintenance 1:1	<input type="checkbox"/>	1/4 hr	35	106.00	17.83	66149.30	
Speech Therapy Maintenance Group 2 participants	<input type="checkbox"/>	1/4 hr	1	1.00	9.81	9.81	
Speech Therapy Maintenance Group 3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.13	7.13	
<b>Work Support-Individual Total:</b>							4523103.60
Work Support-Individual	<input type="checkbox"/>	1/4 hr	617	820.00	8.94	4523103.60	
<b>GRAND TOTAL:</b>						310204460.35	
Total: Services included in capitation:						35521.20	
Total: Services not included in capitation:						310168939.15	
<b>Total Estimated Unduplicated Participants:</b>						2990	
<b>Factor D (Divide total by number of participants):</b>						103747.31	
Services included in capitation:						11.88	
Services not included in capitation:						103735.43	
<b>Average Length of Stay on the Waiver:</b>						351	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Support Total:							37499704.12

Community Support	<input type="checkbox"/>	1/4 Hour	1	1.00	1.00	1.00	
Community Support 1:1	<input type="checkbox"/>	1/4 hour	605	1040.00	7.98	5021016.00	
Community Support-Facility Based-Level 1	<input type="checkbox"/>	1/4 hour	444	2598.00	3.53	4071897.36	
Community Support-Facility Based-Level 2 & 3	<input type="checkbox"/>	1/4 hour	1184	2598.00	3.91	12027285.12	
Community Support-Facility Based-Level 4 & 5	<input type="checkbox"/>	1/4 hour	388	2598.00	4.98	5019959.52	
Community Support-Community Only-Level 1	<input type="checkbox"/>	1/4 hour	444	1113.00	4.67	2307783.24	
Community Support-Community Only-Level 2 & 3	<input type="checkbox"/>	1/4 hour	1184	1113.00	4.67	6154088.64	
Community Support-Community Only-Level 4 & 5	<input type="checkbox"/>	1/4 hour	388	1113.00	6.71	2897673.24	
<b>Home Support (1/4 hour) Total:</b>							11740354.50
Home Support 1/4 hour Short Term	<input type="checkbox"/>	1/4 hour	325	1290.00	7.42	3110835.00	
Home Support 1/4 hour Long Term	<input type="checkbox"/>	1/4 hour	325	3870.00	6.18	7772895.00	
Home Support 1/4 hour Short Term Group of 2	<input type="checkbox"/>	1/4 hour	20	3870.00	4.08	315792.00	
Home Support 1/4 hour Short Term Group of 3	<input type="checkbox"/>	1/4 hour	20	3870.00	2.97	229878.00	
Home Support 1/4 hour Long Term Group of 2	<input type="checkbox"/>	1/4 hour	20	3870.00	3.40	263160.00	
Home Support 1/4 hour Long Term Group of 3	<input type="checkbox"/>	1/4 hour	5	3870.00	2.47	47794.50	
<b>Per Diem Home Support Total:</b>							202990685.06
Per Diem Home Support	<input type="checkbox"/>	Day	1	1.00	1.00	1.00	
Home Support Level 1 One Participant	<input type="checkbox"/>	day	26	326.00	502.90	4262580.40	
Home Support Level 1 Two Participants	<input type="checkbox"/>	day	105	326.00	307.59	10528805.70	
Home Support Level 1 Three Participants	<input type="checkbox"/>	day	35	326.00	232.55	2653395.50	
Home Support Level 1 Four Participants	<input type="checkbox"/>	day	26	326.00	188.57	1598319.32	
Home Support Level 2 & 3 One Participant	<input type="checkbox"/>	day	98	326.00	504.19	16107862.12	
Home Support Level 2 & 3 Two Participants	<input type="checkbox"/>	day	411	326.00	320.50	42942513.00	
Home Support Level 2 & 3 Three Participants	<input type="checkbox"/>	day	214	326.00	245.47	17124969.08	
Home Support Level 2 & 3 Four Participants	<input type="checkbox"/>	day	285	326.00	230.23	21390669.30	

Home Support Level 4 One Participant	<input type="checkbox"/>	day	65	326.00	573.69	12156491.10	
Home Support Level 4 Two Participants	<input type="checkbox"/>	day	132	326.00	392.91	16907703.12	
Home Support Level 4 Three Participants	<input type="checkbox"/>	day	66	326.00	359.14	7727256.24	
Home Support Level 4 Four Participants	<input type="checkbox"/>	day	112	326.00	349.39	12756927.68	
Home Support Level 5 One Participant	<input type="checkbox"/>	day	32	326.00	573.69	5984734.08	
Home Support Level 5 Two Participants	<input type="checkbox"/>	day	111	326.00	392.91	14217841.26	
Home Support Level 5 Three Participants	<input type="checkbox"/>	day	72	326.00	359.14	8429734.08	
Home Support Level 5 Four Participants	<input type="checkbox"/>	day	72	326.00	349.39	8200882.08	
<b>Respite Total:</b>							<b>1871245.00</b>
Respite	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00	
Respite-Short Term- 1 member	<input type="checkbox"/>	1/4 hour	300	354.00	6.24	662688.00	
Respite-Long Term- 1 member	<input type="checkbox"/>	1/4 hour	300	177.00	5.59	296829.00	
Respite-Short Term- 2 members	<input type="checkbox"/>	1/4 hour	300	354.00	3.43	364266.00	
Respite-Short Term- 3 members	<input type="checkbox"/>	1/4 hour	300	354.00	2.50	265500.00	
Respite-Long Term- 2 members	<input type="checkbox"/>	1/4 hour	300	177.00	3.07	163017.00	
Respite-Long Term- 3 members	<input type="checkbox"/>	1/4 hour	300	177.00	2.24	118944.00	
<b>Work Support-Group Total:</b>							<b>5320608.12</b>
Work Support-Group	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00	
Work Support-Group- Two Participants	<input type="checkbox"/>	1/4 hour	437	1814.00	5.40	4280677.20	
Work Support-Group- Three Participants	<input type="checkbox"/>	1/4 hour	49	1814.00	4.09	363543.74	
Work Support-Group- Four Participants	<input type="checkbox"/>	1/4 hour	35	1814.00	3.36	213326.40	
Work Support-Group- Five Participants	<input type="checkbox"/>	1/4 hour	3	1814.00	2.94	15999.48	
Work Support-Group- Six Participants	<input type="checkbox"/>	1/4 hour	93	1814.00	2.65	447060.30	
<b>Adult Foster Care/ Shared Living Total:</b>							<b>21573881.20</b>
Adult Foster Care/ Shared Living	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Shared Living-One Participant	<input type="checkbox"/>	day	135	324.00	126.19	5519550.60	

Shared Living- Two Participants	<input type="checkbox"/>	day	135	324.00	63.10	275994.00	
Shared Living- One Participant- Increased Level of Support	<input type="checkbox"/>	day	135	324.00	183.52	8027164.80	
Shared Living- Two Participants- Increased Level of Support	<input type="checkbox"/>	day	135	324.00	120.42	5267170.80	
<b>Assistive Technology Total:</b>							750722.00
Assistive Technology-Monthly Transmission Utility Services	<input type="checkbox"/>	per month	50	12.00	50.00	30000.00	
Assistive Technology- Assessment	<input type="checkbox"/>	1/4 hour	50	1.00	14.44	722.00	
Assistive Technology-Device	<input type="checkbox"/>	per month	10	12.00	6000.00	720000.00	
<b>Career Planning Total:</b>							40.48
Career Planning	<input type="checkbox"/>	per hour	1	1.00	40.48	40.48	
<b>Communication Aids Total:</b>							71720.00
Communication Aids	<input type="checkbox"/>	cost	50	1.00	1428.00	71400.00	
Communication Aids, Assistive Devices V5274	<input type="checkbox"/>	cost	50	1.00	1.00	50.00	
Communications Aids, Ongoing Visual-gestural and Facilitated Communication T1013 GN	<input type="checkbox"/>	cost	50	1.00	5.40	270.00	
<b>Consultation Total:</b>							256728.78
Consultation	<input type="checkbox"/>	1/4 hour	108	66.00	13.50	96228.00	
Consultative Services-Behavioral	<input type="checkbox"/>	1/4 hour	1	66.00	18.99	1253.34	
Consultative Services- Occupational Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Speech Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Physical Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services- Psychological	<input type="checkbox"/>	1/4 hour	107	66.00	22.05	155717.10	
<b>Counseling Total:</b>							49261.50
Counseling	<input type="checkbox"/>	1/4 hour	41	89.00	13.50	49261.50	
<b>Crisis Assessment Total:</b>							11250.00
Crisis Assessment	<input type="checkbox"/>	per encounter	5	1.00	2250.00	11250.00	
<b>Crisis Intervention Total:</b>							1841462.00

Crisis Intervention	<input type="checkbox"/>	1/4 hour	500	476.00	5.77	1373260.00	
Crisis Intervention-Short Term	<input type="checkbox"/>	1/4 hour	50	631.00	7.73	243881.50	
Crisis Intervention-Long Term	<input type="checkbox"/>	1/4 hour	50	631.00	7.11	224320.50	
<b>Employment Specialist Services Total:</b>							62220.00
Employment Specialist Services	<input type="checkbox"/>	1/4 hour	85	75.00	9.76	62220.00	
<b>Home Accessibility Adaptations Total:</b>							51207.00
Home Accessibility Adaptations	<input type="checkbox"/>	cost	11	1.00	4655.00	51205.00	
Home Accessibility Adaptations-Repairs	<input type="checkbox"/>	cost	1	1.00	1.00	1.00	
Home Accessibility Adaptations-Home Modifications	<input type="checkbox"/>	cost	1	1.00	1.00	1.00	
<b>Home Support-Remote Support Total:</b>							7.89
Monitor only	<input type="checkbox"/>	1/4 hour	1	1.00	1.62	1.62	
Interactive Support	<input type="checkbox"/>	1/4 hour	1	1.00	6.27	6.27	
<b>Home Support-Residential Habilitation-Family Centered Support Total:</b>							8168577.00
Home Support-Residential Habilitation-Family Centered Support	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Family Centered Support-One Participant	<input type="checkbox"/>	day	40	325.00	104.17	1354210.00	
Family Centered Support-One Participant-Increased Level of Support	<input type="checkbox"/>	day	40	325.00	216.96	2820480.00	
Family Centered Support-Two Participants	<input type="checkbox"/>	day	23	325.00	85.80	641355.00	
Family Centered Support-Two Participants-Increased Level of Support	<input type="checkbox"/>	day	23	325.00	196.78	1470930.50	
Family Centered Support-Three Participants	<input type="checkbox"/>	day	7	325.00	73.15	166416.25	
Family Centered Support-Three Participants-Increased Level of Support	<input type="checkbox"/>	day	7	325.00	178.40	405860.00	
Family Centered Support-Four Participants	<input type="checkbox"/>	day	5	325.00	61.99	100733.75	
Family Centered Support-Four							

Participants- Increased Level of Support	<input type="checkbox"/>	day	5	325.00	162.16	263510.00	
Family Centered Support-Five Participants	<input type="checkbox"/>	day	14	325.00	55.29	251569.50	
Family Centered Support-Five Participants- Increased Level of Support	<input type="checkbox"/>	day	14	325.00	152.42	693511.00	
<b>Non Traditional Communication Consultation Total:</b>							6966.00
Non Traditional Communication Consultation	<input type="checkbox"/>	1/4 hour	9	86.00	9.00	6966.00	
<b>Non-Medical Transportation Total:</b>							35521.20
Non-Medical Transportation - PMPM	<input checked="" type="checkbox"/>	PMPM	2990	12.00	0.99	35521.20	
<b>Non-traditional Communication Assessment Total:</b>							6390.00
Non-traditional Communication Assessment	<input type="checkbox"/>	1/4 Hour	10	71.00	9.00	6390.00	
<b>Occupational Therapy (Maintenance) Total:</b>							3989.97
Occupational Therapy Maintenance OTR/L	<input type="checkbox"/>	1/4 hr	2	48.00	17.83	1711.68	
Occupational Therapy Maintenance COTA	<input type="checkbox"/>	1/4 hour	4	40.00	14.05	2248.00	
Occupational Therapy Maintenance OTR/LGroup-2 participants	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Occupational Therapy Maintenance OTR/LGroup-3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.13	7.13	
Occupational Therapy Maintenance COTA Group 2 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.73	7.73	
Occupational Therapy Maintenance COTA Group 3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	5.62	5.62	
<b>Physical Therapy (Maintenance) Total:</b>							61050.61
Physical Therapy (Maintenance)	<input type="checkbox"/>	1/4 hour	14	126.00	15.87	27994.68	
Physical Therapy Maintenance 1:1	<input type="checkbox"/>	1/4 hour	17	109.00	17.83	33038.99	
Physical Therapy Maintenance Group- 2	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Physical Therapy Maintenance Group- 3	<input type="checkbox"/>	1/4 hour	1	1.00	7.13	7.13	
<b>Qualified Extra Support Service</b>							

<b>Total:</b>							<b>7690579.00</b>
Qualified Extra Support Service	<input type="checkbox"/>	per hour	130	2890.00	20.47	7690579.00	
<b>Semi-Independent Supported Living (SISL) (Residential Habilitation) Total:</b>							<b>2943062.80</b>
Semi-Independent Supported Living (SISL) (Residential Habilitation)	<input type="checkbox"/>	per diem	1	326.00	1.00	326.00	
Tier I	<input type="checkbox"/>	per diem	30	326.00	156.27	1528320.60	
Tier II	<input type="checkbox"/>	per diem	10	326.00	193.47	630712.20	
Tier III	<input type="checkbox"/>	per diem	10	326.00	240.40	783704.00	
<b>Skilled Nursing Service for Persons with Intellectual Disabilities and Autism Spectrum Disorder Total:</b>							<b>2559598.08</b>
Registered Nurse	<input type="checkbox"/>	1/4 hour	186	416.00	15.92	1231825.92	
Licensed Practical Nurse	<input type="checkbox"/>	1/4 hour	186	624.00	11.44	1327772.16	
<b>Specialized Medical Equipment and Supplies Total:</b>							<b>45819.00</b>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	cost	27	1.00	1697.00	45819.00	
<b>Speech Therapy (maintenance) Total:</b>							<b>68705.44</b>
Speech Therapy (maintenance)	<input type="checkbox"/>	1/4 hour	4	40.00	15.87	2539.20	
Speech Therapy Maintenance 1:1	<input type="checkbox"/>	1/4 hour	35	106.00	17.83	66149.30	
Speech Therapy Maintenance Group 2 participants	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Speech Therapy Maintenance Group 3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.13	7.13	
<b>Work Support-Individual Total:</b>							<b>4523103.60</b>
Work Support-Individual	<input type="checkbox"/>	1/4 hour	617	820.00	8.94	4523103.60	
<b>GRAND TOTAL:</b>							<b>310204460.35</b>
Total: Services included in capitation:							35521.20
Total: Services not included in capitation:							310168939.15
<b>Total Estimated Unduplicated Participants:</b>							<b>2990</b>
<b>Factor D (Divide total by number of participants):</b>							<b>103747.31</b>
Services included in capitation:							11.88
Services not included in capitation:							103735.43
<b>Average Length of Stay on the Waiver:</b>							<b>351</b>

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (7 of 9)**

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Support Total:</b>							<b>37499704.12</b>
Community Support	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00	
Community Support 1:1	<input type="checkbox"/>	1/4 hour	605	1040.00	7.98	5021016.00	
Community Support-Facility Based-Level 1	<input type="checkbox"/>	1/4 hour	444	2598.00	3.53	4071897.36	
Community Support-Facility Based-Level 2 & 3	<input type="checkbox"/>	1/4 hour	1184	2598.00	3.91	12027285.12	
Community Support-Facility Based-Level 4 & 5	<input type="checkbox"/>	1/4 hour	388	2598.00	4.98	5019959.52	
Community Support-Community Only-Level 1	<input type="checkbox"/>	1/4 hour	444	1113.00	4.67	2307783.24	
Community Support-Community Only-Level 2 & 3	<input type="checkbox"/>	1/4 hour	1184	1113.00	4.67	6154088.64	
Community Support-Community Only-Level 4 & 5	<input type="checkbox"/>	1/4 hour	388	1113.00	6.71	2897673.24	
<b>Home Support (1/4 hour) Total:</b>							<b>11740354.50</b>
Home Support 1/4 hour Short Term	<input type="checkbox"/>	1/4 hour	325	1290.00	7.42	3110835.00	
Home Support 1/4 hour Long Term	<input type="checkbox"/>	1/4 hour	325	3870.00	6.18	7772895.00	
Home Support 1/4 hour Short Term Group of 2	<input type="checkbox"/>	1/4 hour	20	3870.00	4.08	315792.00	
Home Support 1/4 hour Short Term Group of 3	<input type="checkbox"/>	1/4 hour	20	3870.00	2.97	229878.00	
Home Support 1/4 hour Long Term Group of 2	<input type="checkbox"/>	1/4 hour	20	3870.00	3.40	263160.00	
Home Support 1/4 hour Long Term Group of 3	<input type="checkbox"/>	1/4 hour	5	3870.00	2.47	47794.50	
<b>Per Diem Home Support Total:</b>							<b>202990685.06</b>
Per Diem Home Support	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Home Support Level 1 One Participant	<input type="checkbox"/>	day	26	326.00	502.90	4262580.40	
Home Support Level 1 Two Participants	<input type="checkbox"/>	day	105	326.00	307.59	10528805.70	
Home Support							

Level 1 Three Participants	<input type="checkbox"/>	day	35	326.00	232.55	2653395.50
Home Support Level 1 Four Participants	<input type="checkbox"/>	day	26	326.00	188.57	1598319.32
Home Support Level 2 & 3 One Participant	<input type="checkbox"/>	day	98	326.00	504.19	16107862.12
Home Support Level 2 & 3 Two Participants	<input type="checkbox"/>	day	411	326.00	320.50	42942513.00
Home Support Level 2 & 3 Three Participants	<input type="checkbox"/>	day	214	326.00	245.47	17124969.08
Home Support Level 2 & 3 Four Participants	<input type="checkbox"/>	day	285	326.00	230.23	21390669.30
Home Support Level 4 One Participant	<input type="checkbox"/>	day	65	326.00	573.69	12156491.10
Home Support Level 4 Two Participants	<input type="checkbox"/>	day	132	326.00	392.91	16907703.12
Home Support Level 4 Three Participants	<input type="checkbox"/>	day	66	326.00	359.14	7727256.24
Home Support Level 4 Four Participants	<input type="checkbox"/>	day	112	326.00	349.39	12756927.68
Home Support Level 5 One Participant	<input type="checkbox"/>	day	32	326.00	573.69	5984734.08
Home Support Level 5 Two Participants	<input type="checkbox"/>	day	111	326.00	392.91	14217841.26
Home Support Level 5 Three Participants	<input type="checkbox"/>	day	72	326.00	359.14	8429734.08
Home Support Level 5 Four Participants	<input type="checkbox"/>	day	72	326.00	349.39	8200882.08
<b>Respite Total:</b>						<b>1871245.00</b>
Respite	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00
Respite-Short Term- 1 member	<input type="checkbox"/>	1/4 hour	300	354.00	6.24	662688.00
Respite-Long Term- 1 member	<input type="checkbox"/>	1/4 hour	300	177.00	5.59	296829.00
Respite-Short Term- 2 members	<input type="checkbox"/>	1/4 hour	300	354.00	3.43	364266.00
Respite-Short Term- 3 members	<input type="checkbox"/>	1/4 hour	300	354.00	2.50	265500.00
Respite-Long Term- 2 members	<input type="checkbox"/>	1/4 hour	300	177.00	3.07	163017.00
Respite-Long Term- 3 members	<input type="checkbox"/>	1/4 hour	300	177.00	2.24	118944.00
<b>Work Support-Group Total:</b>						<b>5320608.12</b>
Work Support-Group	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00
Work Support-Group- Two Participants	<input type="checkbox"/>	1/4 hour	437	1814.00	5.40	4280677.20
Work Support-Group- Three Participants	<input type="checkbox"/>	1/4 hour	49	1814.00	4.09	363543.74

Work Support-Group- Four Participants	<input type="checkbox"/>	1/4 hour	35	1814.00	3.36	213326.40	
Work Support-Group- Five Participants	<input type="checkbox"/>	1/4 hour	3	1814.00	2.94	15999.48	
Work Support-Group- Six Participants	<input type="checkbox"/>	1/4 hour	93	1814.00	2.65	447060.30	
<b>Adult Foster Care/ Shared Living Total:</b>							21573881.20
Adult Foster Care/ Shared Living	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00	
Shared Living-One Participant	<input type="checkbox"/>	day	135	324.00	126.19	5519550.60	
Shared Living-Two Participants	<input type="checkbox"/>	day	135	324.00	63.10	2759994.00	
Shared Living-One Participant-Increased Level of Support	<input type="checkbox"/>	day	135	324.00	183.52	8027164.80	
Shared Living-Two Participants-Increased Level of Support	<input type="checkbox"/>	day	135	324.00	120.42	5267170.80	
<b>Assistive Technology Total:</b>							750722.00
Assistive Technology-Monthly Transmission Utility Services	<input type="checkbox"/>	per month	50	12.00	50.00	30000.00	
Assistive Technology-Assessment	<input type="checkbox"/>	1/4 hour	50	1.00	14.44	722.00	
Assistive Technology-Device	<input type="checkbox"/>	per month	10	12.00	6000.00	720000.00	
<b>Career Planning Total:</b>							40.48
Career Planning	<input type="checkbox"/>	per hour	1	1.00	40.48	40.48	
<b>Communication Aids Total:</b>							71720.00
Communication Aids	<input type="checkbox"/>	cost	50	1.00	1428.00	71400.00	
Communication Aids, Assistive Devices V5274	<input type="checkbox"/>	cost	50	1.00	1.00	50.00	
Communications Aids, Ongoing Visual-gestural and Facilitated Communication T1013 GN	<input type="checkbox"/>	cost	50	1.00	5.40	270.00	
<b>Consultation Total:</b>							256728.78
Consultation	<input type="checkbox"/>	1/4 hour	108	66.00	13.50	96228.00	
Consultative Services-Behavioral	<input type="checkbox"/>	1/4 hour	1	66.00	18.99	1253.34	
Consultative Services-Occupational Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Speech Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative							

Services-Physical Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Psychological	<input type="checkbox"/>	1/4 hour	107	66.00	22.05	155717.10	
<b>Counseling Total:</b>							49261.50
Counseling	<input type="checkbox"/>	1/4 hour	41	89.00	13.50	49261.50	
<b>Crisis Assessment Total:</b>							11250.00
Crisis Assessment	<input type="checkbox"/>	per occurrence	5	1.00	2250.00	11250.00	
<b>Crisis Intervention Total:</b>							1841462.00
Crisis Intervention	<input type="checkbox"/>	1/4 hour	500	476.00	5.77	1373260.00	
Crisis Intervention-Short Term	<input type="checkbox"/>	1/4 hour	50	631.00	7.73	243881.50	
Crisis Intervention-Long Term	<input type="checkbox"/>	1/4 hour	50	631.00	7.11	224320.50	
<b>Employment Specialist Services Total:</b>							62220.00
Employment Specialist Services	<input type="checkbox"/>	1/4 hour	85	75.00	9.76	62220.00	
<b>Home Accessibility Adaptations Total:</b>							51207.00
Home Accessibility Adaptations	<input type="checkbox"/>	cost	11	1.00	4655.00	51205.00	
Home Accessibility Adaptations-Repairs	<input type="checkbox"/>	cost	1	1.00	1.00	1.00	
Home Accessibility Adaptations-Home Modifications	<input type="checkbox"/>	cost	1	1.00	1.00	1.00	
<b>Home Support-Remote Support Total:</b>							7.89
Monitor only	<input type="checkbox"/>	1/4 hour	1	1.00	1.62	1.62	
Interactive Support	<input type="checkbox"/>	1/4 hour	1	1.00	6.27	6.27	
<b>Home Support-Residential Habilitation-Family Centered Support Total:</b>							8168577.00
Home Support-Residential Habilitation-Family Centered Support	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Family Centered Support-One Participant	<input type="checkbox"/>	day	40	325.00	104.17	1354210.00	
Family Centered Support-One Participant-Increased Level of Support	<input type="checkbox"/>	day	40	325.00	216.96	2820480.00	
Family Centered Support-Two Participants	<input type="checkbox"/>	day	23	325.00	85.80	641355.00	
Family Centered Support-Two							

Participants- Increased Level of Support	<input type="checkbox"/>	day	23	325.00	196.78	1470930.50	
Family Centered Support-Three Participants	<input type="checkbox"/>	day	7	325.00	73.15	166416.25	
Family Centered Support-Three Participants- Increased Level of Support	<input type="checkbox"/>	day	7	325.00	178.40	405860.00	
Family Centered Support-Four Participants	<input type="checkbox"/>	day	5	325.00	61.99	100733.75	
Family Centered Support-Four Participants- Increased Level of Support	<input type="checkbox"/>	day	5	325.00	162.16	263510.00	
Family Centered Support-Five Participants	<input type="checkbox"/>	day	14	325.00	55.29	251569.50	
Family Centered Support-Five Participants- Increased Level of Support	<input type="checkbox"/>	day	14	325.00	152.42	693511.00	
<b>Non Traditional Communication Consultation Total:</b>							6966.00
Non Traditional Communication Consultation	<input type="checkbox"/>	1/4 hour	9	86.00	9.00	6966.00	
<b>Non-Medical Transportation Total:</b>							35521.20
Non-Medical Transportation - PMPM	<input checked="" type="checkbox"/>	PMPM	2990	12.00	0.99	35521.20	
<b>Non-traditional Communication Assessment Total:</b>							6390.00
Non-traditional Communication Assessment	<input type="checkbox"/>	per occurrence	10	71.00	9.00	6390.00	
<b>Occupational Therapy (Maintenance) Total:</b>							3989.97
Occupational Therapy Maintenance OTR/L	<input type="checkbox"/>	1/4 hour	2	48.00	17.83	1711.68	
Occupational Therapy Maintenance COTA	<input type="checkbox"/>	1/4 hour	4	40.00	14.05	2248.00	
Occupational Therapy Maintenance OTR/LGroup-2 participants	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Occupational Therapy Maintenance OTR/LGroup-3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.13	7.13	
Occupational Therapy Maintenance COTA Group 2 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.73	7.73	
Occupational Therapy Maintenance COTA Group 3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	5.62	5.62	

<b>Physical Therapy (Maintenance) Total:</b>							61050.61
Physical Therapy (Maintenance)	<input type="checkbox"/>	1/4 hour	14	126.00	15.87	27994.68	
Physical Therapy Maintenance 1:1	<input type="checkbox"/>	1/4 hour	17	109.00	17.83	33038.99	
Physical Therapy Maintenance Group-2	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Physical Therapy Maintenance Group-3	<input type="checkbox"/>	1/4 hour	1	1.00	7.13	7.13	
<b>Qualified Extra Support Service Total:</b>							7690579.00
Qualified Extra Support Service	<input type="checkbox"/>	per hour	130	2890.00	20.47	7690579.00	
<b>Semi-Independent Supported Living (SISL) (Residential Habilitation) Total:</b>							2943062.80
Semi-Independent Supported Living (SISL) (Residential Habilitation)	<input type="checkbox"/>	per diem	1	326.00	1.00	326.00	
Tier I	<input type="checkbox"/>	per diem	30	326.00	156.27	1528320.60	
Tier II	<input type="checkbox"/>	per diem	10	326.00	193.47	630712.20	
Tier III	<input type="checkbox"/>	per diem	10	326.00	240.40	783704.00	
<b>Skilled Nursing Service for Persons with Intellectual Disabilities and Autism Spectrum Disorder Total:</b>							2559598.08
Registered Nurse	<input type="checkbox"/>	1/4 hour	186	416.00	15.92	1231825.92	
Licensed Practical Nurse	<input type="checkbox"/>	1/4 hour	186	624.00	11.44	1327772.16	
<b>Specialized Medical Equipment and Supplies Total:</b>							45819.00
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	cost	27	1.00	1697.00	45819.00	
<b>Speech Therapy (maintenance) Total:</b>							68705.44
Speech Therapy (maintenance)	<input type="checkbox"/>	1/4 hour	4	40.00	15.87	2539.20	
Speech Therapy Maintenance 1:1	<input type="checkbox"/>	1/4 hour	35	106.00	17.83	66149.30	
Speech Therapy Maintenance Group 2 participants	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Speech Therapy Maintenance Group 3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.13	7.13	
<b>Work Support-Individual Total:</b>							4523103.60
Work Support-Individual	<input type="checkbox"/>	1/4 hour	617	820.00	8.94	4523103.60	
<b>GRAND TOTAL:</b>							310204460.35

Total: Services included in capitation:	35521.20
Total: Services not included in capitation:	310168939.15
<b>Total Estimated Unduplicated Participants:</b>	<b>2990</b>
<b>Factor D (Divide total by number of participants):</b>	<b>103747.31</b>
Services included in capitation:	11.88
Services not included in capitation:	103735.43
<b>Average Length of Stay on the Waiver:</b>	<b>351</b>

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Support Total:</b>							<b>37499704.12</b>
Community Support	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00	
Community Support 1:1	<input type="checkbox"/>	1/4 hour	605	1040.00	7.98	5021016.00	
Community Support-Facility Based-Level 1	<input type="checkbox"/>	1/4 hour	444	2598.00	3.53	4071897.36	
Community Support-Facility Based-Level 2 & 3	<input type="checkbox"/>	1/4 hour	1184	2598.00	3.91	12027285.12	
Community Support-Facility Based-Level 4 & 5	<input type="checkbox"/>	1/4 hour	388	2598.00	4.98	5019959.52	
Community Support-Community Only-Level 1	<input type="checkbox"/>	1/4 hour	444	1113.00	4.67	2307783.24	
Community Support-Community Only-Level 2 & 3	<input type="checkbox"/>	1/4 hour	1184	1113.00	4.67	6154088.64	
Community Support-Community Only-Level 4 & 5	<input type="checkbox"/>	1/4 hour	388	1113.00	6.71	2897673.24	
<b>Home Support (1/4 hour) Total:</b>							<b>11740354.50</b>
Home Support 1/4 hour Short Term	<input type="checkbox"/>	1/4 hour	325	1290.00	7.42	3110835.00	
Home Support 1/4 hour Long Term	<input type="checkbox"/>	1/4 hour	325	3870.00	6.18	7772895.00	
Home Support 1/4 hour Short Term Group of 2	<input type="checkbox"/>	1/4 hour	20	3870.00	4.08	315792.00	
Home Support 1/4 hour Short Term Group of 3	<input type="checkbox"/>	1/4 hour	20	3870.00	2.97	229878.00	
Home Support 1/4 hour Long Term Group of 2	<input type="checkbox"/>	1/4 hour	20	3870.00	3.40	263160.00	

Home Support 1/4 hour Long Term Group of 3	<input type="checkbox"/>	1/4 hour	5	3870.00	2.47	47794.50	
<b>Per Diem Home Support Total:</b>							202990685.06
Per Diem Home Support	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Home Support Level 1 One Participant	<input type="checkbox"/>	day	26	326.00	502.90	4262580.40	
Home Support Level 1 Two Participants	<input type="checkbox"/>	day	105	326.00	307.59	10528805.70	
Home Support Level 1 Three Participants	<input type="checkbox"/>	day	35	326.00	232.55	2653395.50	
Home Support Level 1 Four Participants	<input type="checkbox"/>	day	26	326.00	188.57	1598319.32	
Home Support Level 2 & 3 One Participant	<input type="checkbox"/>	day	98	326.00	504.19	16107862.12	
Home Support Level 2 & 3 Two Participants	<input type="checkbox"/>	day	411	326.00	320.50	42942513.00	
Home Support Level 2 & 3 Three Participants	<input type="checkbox"/>	day	214	326.00	245.47	17124969.08	
Home Support Level 2 & 3 Four Participants	<input type="checkbox"/>	day	285	326.00	230.23	21390669.30	
Home Support Level 4 One Participant	<input type="checkbox"/>	day	65	326.00	573.69	12156491.10	
Home Support Level 4 Two Participants	<input type="checkbox"/>	day	132	326.00	392.91	16907703.12	
Home Support Level 4 Three Participants	<input type="checkbox"/>	day	66	326.00	359.14	7727256.24	
Home Support Level 4 Four Participants	<input type="checkbox"/>	day	112	326.00	349.39	12756927.68	
Home Support Level 5 One Participant	<input type="checkbox"/>	day	32	326.00	573.69	5984734.08	
Home Support Level 5 Two Participants	<input type="checkbox"/>	day	111	326.00	392.91	14217841.26	
Home Support Level 5 Three Participants	<input type="checkbox"/>	day	72	326.00	359.14	8429734.08	
Home Support Level 5 Four Participants	<input type="checkbox"/>	day	72	326.00	349.39	8200882.08	
<b>Respite Total:</b>							1871245.00
Respite	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00	
Respite-Short Term- 1 member	<input type="checkbox"/>	1/4 hour	300	354.00	6.24	662688.00	
Respite-Long Term- 1 member	<input type="checkbox"/>	1/4 hour	300	177.00	5.59	296829.00	
Respite-Short Term- 2 members	<input type="checkbox"/>	1/4 hour	300	354.00	3.43	364266.00	
Respite-Short Term- 3 members	<input type="checkbox"/>	1/4 hour	300	354.00	2.50	265500.00	

Respite-Long Term- 2 members	<input type="checkbox"/>	1/4 hour	300	177.00	3.07	163017.00	
Respite-Long Term- 3 members	<input type="checkbox"/>	1/4 hour	300	177.00	2.24	118944.00	
<b>Work Support-Group Total:</b>							5320608.12
Work Support-Group	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00	
Work Support-Group- Two Participants	<input type="checkbox"/>	1/4 hour	437	1814.00	5.40	4280677.20	
Work Support-Group- Three Participants	<input type="checkbox"/>	1/4 hour	49	1814.00	4.09	363543.74	
Work Support-Group- Four Participants	<input type="checkbox"/>	1/4 hour	35	1814.00	3.36	213326.40	
Work Support-Group- Five Participants	<input type="checkbox"/>	1/4 hour	3	1814.00	2.94	15999.48	
Work Support-Group- Six Participants	<input type="checkbox"/>	1/4 hour	93	1814.00	2.65	447060.30	
<b>Adult Foster Care/Shared Living Total:</b>							21573881.20
Adult Foster Care/ Shared Living	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Shared Living-One Participant	<input type="checkbox"/>	day	135	324.00	126.19	5519550.60	
Shared Living-Two Participants	<input type="checkbox"/>	day	135	324.00	63.10	2759994.00	
Shared Living-One Participant-Increased Level of Support	<input type="checkbox"/>	day	135	324.00	183.52	8027164.80	
Shared Living-Two Participants-Increased Level of Support	<input type="checkbox"/>	day	135	324.00	120.42	5267170.80	
<b>Assistive Technology Total:</b>							750722.00
Assistive Technology-Monthly Transmission Utility Services	<input type="checkbox"/>	per month	50	12.00	50.00	30000.00	
Assistive Technology-Assessment	<input type="checkbox"/>	1/4 hour	50	1.00	14.44	722.00	
Assistive Technology-Device	<input type="checkbox"/>	per month	10	12.00	6000.00	720000.00	
<b>Career Planning Total:</b>							40.48
Career Planning	<input type="checkbox"/>	per hour	1	1.00	40.48	40.48	
<b>Communication Aids Total:</b>							71720.00
Communication Aids	<input type="checkbox"/>	cost	50	1.00	1428.00	71400.00	
Communication Aids, Assistive Devices V5274	<input type="checkbox"/>	cost	50	1.00	1.00	50.00	
Communications Aids, Ongoing Visual-gestural and Facilitated Communication	<input type="checkbox"/>	cost	50	1.00	5.40	270.00	

T1013 GN							
<b>Consultation Total:</b>							256728.78
Consultation	<input type="checkbox"/>	1/4 hr	108	66.00	13.50	96228.00	
Consultative Services-Behavioral	<input type="checkbox"/>	1/4 hour	1	66.00	18.99	1253.34	
Consultative Services-Occupational Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Speech Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Physical Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Psychological	<input type="checkbox"/>	1/4 hour	107	66.00	22.05	155717.10	
<b>Counseling Total:</b>							49261.50
Counseling	<input type="checkbox"/>	1/4 hour	41	89.00	13.50	49261.50	
<b>Crisis Assessment Total:</b>							11250.00
Crisis Assessment	<input type="checkbox"/>	per occurrence	5	1.00	2250.00	11250.00	
<b>Crisis Intervention Total:</b>							1841462.00
Crisis Intervention	<input type="checkbox"/>	1/4 hour	500	476.00	5.77	1373260.00	
Crisis Intervention-Short Term	<input type="checkbox"/>	1/4 hour	50	631.00	7.73	243881.50	
Crisis Intervention-Long Term	<input type="checkbox"/>	1/4 hour	50	631.00	7.11	224320.50	
<b>Employment Specialist Services Total:</b>							62220.00
Employment Specialist Services	<input type="checkbox"/>	1/4 hour	85	75.00	9.76	62220.00	
<b>Home Accessibility Adaptations Total:</b>							51207.00
Home Accessibility Adaptations	<input type="checkbox"/>	cost	11	1.00	4655.00	51205.00	
Home Accessibility Adaptations-Repairs	<input type="checkbox"/>	cost	1	1.00	1.00	1.00	
Home Accessibility Adaptations-Home Modifications	<input type="checkbox"/>	cost	1	1.00	1.00	1.00	
<b>Home Support-Remote Support Total:</b>							7.89
Monitor only	<input type="checkbox"/>	1/4 hour	1	1.00	1.62	1.62	
Interactive Support	<input type="checkbox"/>	1/4 hour	1	1.00	6.27	6.27	
<b>Home Support-Residential Habilitation-Family Centered Support Total:</b>							8168577.00

Home Support-Residential Habilitation-Family Centered Support	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Family Centered Support-One Participant	<input type="checkbox"/>	day	40	325.00	104.17	1354210.00	
Family Centered Support-One Participant-Increased Level of Support	<input type="checkbox"/>	day	40	325.00	216.96	2820480.00	
Family Centered Support-Two Participants	<input type="checkbox"/>	day	23	325.00	85.80	641355.00	
Family Centered Support-Two Participants-Increased Level of Support	<input type="checkbox"/>	day	23	325.00	196.78	1470930.50	
Family Centered Support-Three Participants	<input type="checkbox"/>	day	7	325.00	73.15	166416.25	
Family Centered Support-Three Participants-Increased Level of Support	<input type="checkbox"/>	day	7	325.00	178.40	405860.00	
Family Centered Support-Four Participants	<input type="checkbox"/>	day	5	325.00	61.99	100733.75	
Family Centered Support-Four Participants-Increased Level of Support	<input type="checkbox"/>	day	5	325.00	162.16	263510.00	
Family Centered Support-Five Participants	<input type="checkbox"/>	day	14	325.00	55.29	251569.50	
Family Centered Support-Five Participants-Increased Level of Support	<input type="checkbox"/>	day	14	325.00	152.42	693511.00	
<b>Non Traditional Communication Consultation Total:</b>							6966.00
Non Traditional Communication Consultation	<input type="checkbox"/>	1/4 hour	9	86.00	9.00	6966.00	
<b>Non-Medical Transportation Total:</b>							35521.20
Non-Medical Transportation - PMPM	<input checked="" type="checkbox"/>	PMPM	2990	12.00	0.99	35521.20	
<b>Non-traditional Communication Assessment Total:</b>							6390.00
Non-traditional Communication Assessment	<input type="checkbox"/>	1/4 hour	10	71.00	9.00	6390.00	
<b>Occupational Therapy (Maintenance) Total:</b>							3989.97
Occupational Therapy Maintenance OTR/L	<input type="checkbox"/>	1/4 hr	2	48.00	17.83	1711.68	
Occupational Therapy Maintenance COTA	<input type="checkbox"/>	1/4 hour	4	40.00	14.05	2248.00	

Occupational Therapy Maintenance OTR/LGroup-2 participants	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Occupational Therapy Maintenance OTR/LGroup-3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.13	7.13	
Occupational Therapy Maintenance COTA Group 2 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.73	7.73	
Occupational Therapy Maintenance COTA Group 3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	5.62	5.62	
<b>Physical Therapy (Maintenance) Total:</b>							61050.61
Physical Therapy (Maintenance)	<input type="checkbox"/>	1/4 hr	14	126.00	15.87	27994.68	
Physical Therapy Maintenance 1:1	<input type="checkbox"/>	1/4 hour	17	109.00	17.83	33038.99	
Physical Therapy Maintenance Group-2	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Physical Therapy Maintenance Group-3	<input type="checkbox"/>	1/4 hour	1	1.00	7.13	7.13	
<b>Qualified Extra Support Service Total:</b>							7690579.00
Qualified Extra Support Service	<input type="checkbox"/>	per hour	130	2890.00	20.47	7690579.00	
<b>Semi-Independent Supported Living (SISL) (Residential Habilitation) Total:</b>							2943062.80
Semi-Independent Supported Living (SISL) (Residential Habilitation)	<input type="checkbox"/>	per diem	1	326.00	1.00	326.00	
Tier I	<input type="checkbox"/>	per diem	30	326.00	156.27	1528320.60	
Tier II	<input type="checkbox"/>	per diem	10	326.00	193.47	630712.20	
Tier III	<input type="checkbox"/>	per diem	10	326.00	240.40	783704.00	
<b>Skilled Nursing Service for Persons with Intellectual Disabilities and Autism Spectrum Disorder Total:</b>							2559598.08
Registered Nurse	<input type="checkbox"/>	1/4 hour	186	416.00	15.92	1231825.92	
Licensed Practical Nurse	<input type="checkbox"/>	1/4 hour	186	624.00	11.44	1327772.16	
<b>Specialized Medical Equipment and Supplies Total:</b>							45819.00
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	cost	27	1.00	1697.00	45819.00	
<b>Speech Therapy (maintenance) Total:</b>							68705.44
Speech Therapy							

(maintenance)	<input type="checkbox"/>	1/4 hr	4	40.00	15.87	2539.20	
Speech Therapy Maintenance 1:1	<input type="checkbox"/>	1/4 hour	35	106.00	17.83	66149.30	
Speech Therapy Maintenance Group 2 participants	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Speech Therapy Maintenance Group 3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.13	7.13	
<b>Work Support-Individual Total:</b>							<b>4523103.60</b>
Work Support-Individual	<input type="checkbox"/>	1/4 hour	617	820.00	8.94	4523103.60	
<b>GRAND TOTAL:</b>						<b>310204460.35</b>	
Total: Services included in capitation:						35521.20	
Total: Services not included in capitation:						310168939.15	
<b>Total Estimated Unduplicated Participants:</b>						<b>2990</b>	
<b>Factor D (Divide total by number of participants):</b>						<b>103747.31</b>	
Services included in capitation:						11.88	
Services not included in capitation:						103735.43	
<b>Average Length of Stay on the Waiver:</b>						<b>357</b>	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

#### d. Estimate of Factor D.

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Community Support Total:</b>							<b>37499704.12</b>
Community Support	<input type="checkbox"/>	1/4 Hour	1	1.00	1.00	1.00	
Community Support 1:1	<input type="checkbox"/>	1/4 hour	605	1040.00	7.98	5021016.00	
Community Support-Facility Based-Level 1	<input type="checkbox"/>	1/4 hour	444	2598.00	3.53	4071897.36	
Community Support-Facility Based-Level 2 & 3	<input type="checkbox"/>	1/4 hour	1184	2598.00	3.91	12027285.12	
Community Support-Facility Based-Level 4 & 5	<input type="checkbox"/>	1/4 hour	388	2598.00	4.98	5019959.52	
Community Support-Community Only-Level 1	<input type="checkbox"/>	1/4 hour	444	1113.00	4.67	2307783.24	
Community Support-Community Only-Level 2 & 3	<input type="checkbox"/>	1/4 hour	1184	1113.00	4.67	6154088.64	
Community Support-Community	<input type="checkbox"/>	1/4 hour	388	1113.00	6.71	2897673.24	

Only-Level 4 & 5							
<b>Home Support (1/4 hour) Total:</b>							<b>11740354.50</b>
Home Support 1/4 hour Short Term	<input type="checkbox"/>	1/4 hour	325	1290.00	7.42	3110835.00	
Home Support 1/4 hour Long Term	<input type="checkbox"/>	1/4 hour	325	3870.00	6.18	7772895.00	
Home Support 1/4 hour Short Term Group of 2	<input type="checkbox"/>	1/4 hour	20	3870.00	4.08	315792.00	
Home Support 1/4 hour Short Term Group of 3	<input type="checkbox"/>	1/4 hour	20	3870.00	2.97	229878.00	
Home Support 1/4 hour Long Term Group of 2	<input type="checkbox"/>	1/4 hour	20	3870.00	3.40	263160.00	
Home Support 1/4 hour Long Term Group of 3	<input type="checkbox"/>	1/4 hour	5	3870.00	2.47	47794.50	
<b>Per Diem Home Support Total:</b>							<b>202990685.06</b>
Per Diem Home Support	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Home Support Level 1 One Participant	<input type="checkbox"/>	day	26	326.00	502.90	4262580.40	
Home Support Level 1 Two Participants	<input type="checkbox"/>	day	105	326.00	307.59	10528805.70	
Home Support Level 1 Three Participants	<input type="checkbox"/>	day	35	326.00	232.55	2653395.50	
Home Support Level 1 Four Participants	<input type="checkbox"/>	day	26	326.00	188.57	1598319.32	
Home Support Level 2 & 3 One Participant	<input type="checkbox"/>	day	98	326.00	504.19	16107862.12	
Home Support Level 2 & 3 Two Participants	<input type="checkbox"/>	day	411	326.00	320.50	42942513.00	
Home Support Level 2 & 3 Three Participants	<input type="checkbox"/>	day	214	326.00	245.47	17124969.08	
Home Support Level 2 & 3 Four Participants	<input type="checkbox"/>	day	285	326.00	230.23	21390669.30	
Home Support Level 4 One Participant	<input type="checkbox"/>	day	65	326.00	573.69	12156491.10	
Home Support Level 4 Two Participants	<input type="checkbox"/>	day	132	326.00	392.91	16907703.12	
Home Support Level 4 Three Participants	<input type="checkbox"/>	day	66	326.00	359.14	7727256.24	
Home Support Level 4 Four Participants	<input type="checkbox"/>	day	112	326.00	349.39	12756927.68	
Home Support Level 5 One Participant	<input type="checkbox"/>	day	32	326.00	573.69	5984734.08	
Home Support Level 5 Two Participants	<input type="checkbox"/>	day	111	326.00	392.91	14217841.26	
Home Support Level 5 Three Participants	<input type="checkbox"/>	day	72	326.00	359.14	8429734.08	

Home Support Level 5 Four Participants	<input type="checkbox"/>	day	72	326.00	349.39	8200882.08	
<b>Respite Total:</b>							1871245.00
Respite	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00	
Respite-Short Term- 1 member	<input type="checkbox"/>	1/4 hour	300	354.00	6.24	662688.00	
Respite-Long Term- 1 member	<input type="checkbox"/>	1/4 hour	300	177.00	5.59	296829.00	
Respite-Short Term- 2 members	<input type="checkbox"/>	1/4 hour	300	354.00	3.43	364266.00	
Respite-Short Term- 3 members	<input type="checkbox"/>	1/4 hour	300	354.00	2.50	265500.00	
Respite-Long Term- 2 members	<input type="checkbox"/>	1/4 hour	300	177.00	3.07	163017.00	
Respite-Long Term- 3 members	<input type="checkbox"/>	1/4 hour	300	177.00	2.24	118944.00	
<b>Work Support- Group Total:</b>							5320608.12
Work Support- Group	<input type="checkbox"/>	1/4 hour	1	1.00	1.00	1.00	
Work Support- Group- Two Participants	<input type="checkbox"/>	1/4 hour	437	1814.00	5.40	4280677.20	
Work Support- Group- Three Participants	<input type="checkbox"/>	1/4 hour	49	1814.00	4.09	363543.74	
Work Support- Group- Four Participants	<input type="checkbox"/>	1/4 hour	35	1814.00	3.36	213326.40	
Work Support- Group- Five Participants	<input type="checkbox"/>	1/4 hour	3	1814.00	2.94	15999.48	
Work Support- Group- Six Participants	<input type="checkbox"/>	1/4 hour	93	1814.00	2.65	447060.30	
<b>Adult Foster Care/ Shared Living Total:</b>							21573881.20
Adult Foster Care/ Shared Living	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Shared Living- One Participant	<input type="checkbox"/>	day	135	324.00	126.19	5519550.60	
Shared Living- Two Participants	<input type="checkbox"/>	day	135	324.00	63.10	2759994.00	
Shared Living- One Participant- Increased Level of Support	<input type="checkbox"/>	day	135	324.00	183.52	8027164.80	
Shared Living- Two Participants- Increased Level of Support	<input type="checkbox"/>	day	135	324.00	120.42	5267170.80	
<b>Assistive Technology Total:</b>							750722.00
Assistive Technology-Monthly Transmission Utility Services	<input type="checkbox"/>	per month	50	12.00	50.00	30000.00	
Assistive Technology- Assessment	<input type="checkbox"/>	1/4 hour	50	1.00	14.44	722.00	
Assistive Technology-Device	<input type="checkbox"/>	per month	10	12.00	6000.00	720000.00	

<b>Career Planning Total:</b>							40.48
Career Planning	<input type="checkbox"/>	per hour	1	1.00	40.48	40.48	
<b>Communication Aids Total:</b>							71720.00
Communication Aids	<input type="checkbox"/>	Cost	50	1.00	1428.00	71400.00	
Communication Aids, Assistive Devices V5274	<input type="checkbox"/>	cost	50	1.00	1.00	50.00	
Communications Aids, Ongoing Visual-gestural and Facilitated Communication T1013 GN	<input type="checkbox"/>	cost	50	1.00	5.40	270.00	
<b>Consultation Total:</b>							256728.78
Consultation	<input type="checkbox"/>	1/4 hour	108	66.00	13.50	96228.00	
Consultative Services-Behavioral	<input type="checkbox"/>	1/4 hour	1	66.00	18.99	1253.34	
Consultative Services-Occupational Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Speech Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Physical Therapy	<input type="checkbox"/>	1/4 hour	1	66.00	17.83	1176.78	
Consultative Services-Psychological	<input type="checkbox"/>	1/4 hour	107	66.00	22.05	155717.10	
<b>Counseling Total:</b>							49261.50
Counseling	<input type="checkbox"/>	1/4 hour	41	89.00	13.50	49261.50	
<b>Crisis Assessment Total:</b>							11250.00
Crisis Assessment	<input type="checkbox"/>	per occurrence	5	1.00	2250.00	11250.00	
<b>Crisis Intervention Total:</b>							1841462.00
Crisis Intervention	<input type="checkbox"/>	1/4 Hour	500	476.00	5.77	1373260.00	
Crisis Intervention-Short Term	<input type="checkbox"/>	1/4 hour	50	631.00	7.73	243881.50	
Crisis Intervention-Long Term	<input type="checkbox"/>	1/4 hour	50	631.00	7.11	224320.50	
<b>Employment Specialist Services Total:</b>							62220.00
Employment Specialist Services	<input type="checkbox"/>	1/4 Hour	85	75.00	9.76	62220.00	
<b>Home Accessibility Adaptations Total:</b>							51207.00
Home Accessibility Adaptations	<input type="checkbox"/>	Cost	11	1.00	4655.00	51205.00	
Home Accessibility Adaptations-Repairs	<input type="checkbox"/>	cost	1	1.00	1.00	1.00	

Home Accessibility Adaptations-Home Modifications	<input type="checkbox"/>	cost	1	1.00	1.00	1.00	
<b>Home Support-Remote Support Total:</b>							7.89
Monitor only	<input type="checkbox"/>	1/4 hour	1	1.00	1.62	1.62	
Interactive Support	<input type="checkbox"/>	1/4 hour	1	1.00	6.27	6.27	
<b>Home Support-Residential Habilitation-Family Centered Support Total:</b>							8168577.00
Home Support-Residential Habilitation-Family Centered Support	<input type="checkbox"/>	day	1	1.00	1.00	1.00	
Family Centered Support-One Participant	<input type="checkbox"/>	day	40	325.00	104.17	1354210.00	
Family Centered Support-One Participant-Increased Level of Support	<input type="checkbox"/>	day	40	325.00	216.96	2820480.00	
Family Centered Support-Two Participants	<input type="checkbox"/>	day	23	325.00	85.80	641355.00	
Family Centered Support-Two Participants-Increased Level of Support	<input type="checkbox"/>	day	23	325.00	196.78	1470930.50	
Family Centered Support-Three Participants	<input type="checkbox"/>	day	7	325.00	73.15	166416.25	
Family Centered Support-Three Participants-Increased Level of Support	<input type="checkbox"/>	day	7	325.00	178.40	405860.00	
Family Centered Support-Four Participants	<input type="checkbox"/>	day	5	325.00	61.99	100733.75	
Family Centered Support-Four Participants-Increased Level of Support	<input type="checkbox"/>	day	5	325.00	162.16	263510.00	
Family Centered Support-Five Participants	<input type="checkbox"/>	day	14	325.00	55.29	251569.50	
Family Centered Support-Five Participants-Increased Level of Support	<input type="checkbox"/>	day	14	325.00	152.42	693511.00	
<b>Non Traditional Communication Consultation Total:</b>							6966.00
Non Traditional Communication Consultation	<input type="checkbox"/>	1/4 Hour	9	86.00	9.00	6966.00	
<b>Non-Medical Transportation Total:</b>							35521.20
Non-Medical Transportation - PMPM	<input checked="" type="checkbox"/>	PMPM	2990	12.00	0.99	35521.20	

<b>Non-traditional Communication Assessment Total:</b>							<b>6390.00</b>
Non-traditional Communication Assessment	<input type="checkbox"/>	1/4 hour	10	71.00	9.00	6390.00	
<b>Occupational Therapy (Maintenance) Total:</b>							<b>3989.97</b>
Occupational Therapy Maintenance OTR/L	<input type="checkbox"/>	1/4 hr	2	48.00	17.83	1711.68	
Occupational Therapy Maintenance COTA	<input type="checkbox"/>	1/4 hour	4	40.00	14.05	2248.00	
Occupational Therapy Maintenance OTR/L Group-2 participants	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Occupational Therapy Maintenance OTR/L Group-3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.13	7.13	
Occupational Therapy Maintenance COTA Group 2 participants	<input type="checkbox"/>	1/4 hr	1	1.00	7.73	7.73	
Occupational Therapy Maintenance COTA Group 3 participants	<input type="checkbox"/>	1/4 hr	1	1.00	5.62	5.62	
<b>Physical Therapy (Maintenance) Total:</b>							<b>61050.61</b>
Physical Therapy (Maintenance)	<input type="checkbox"/>	1/4 hr	14	126.00	15.87	27994.68	
Physical Therapy Maintenance 1:1	<input type="checkbox"/>	1/4 hour	17	109.00	17.83	33038.99	
Physical Therapy Maintenance Group-2	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Physical Therapy Maintenance Group-3	<input type="checkbox"/>	1/4 hour	1	1.00	7.13	7.13	
<b>Qualified Extra Support Service Total:</b>							<b>7690579.00</b>
Qualified Extra Support Service	<input type="checkbox"/>	per hour	130	2890.00	20.47	7690579.00	
<b>Semi-Independent Supported Living (SISL) (Residential Habilitation) Total:</b>							<b>2943062.80</b>
Semi-Independent Supported Living (SISL) (Residential Habilitation)	<input type="checkbox"/>	per diem	1	326.00	1.00	326.00	
Tier I	<input type="checkbox"/>	per diem	30	326.00	156.27	1528320.60	
Tier II	<input type="checkbox"/>	per diem	10	326.00	193.47	630712.20	
Tier III	<input type="checkbox"/>	per diem	10	326.00	240.40	783704.00	
<b>Skilled Nursing Service for Persons with Intellectual Disabilities and</b>							<b>2559598.08</b>

<b>Autism Spectrum Disorder Total:</b>							
Registered Nurse	<input type="checkbox"/>	1/4 hour	186	416.00	15.92	1231825.92	
Licensed Practical Nurse	<input type="checkbox"/>	1/4 hour	186	624.00	11.44	1327772.16	
<b>Specialized Medical Equipment and Supplies Total:</b>							<b>45819.00</b>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	cost	27	1.00	1697.00	45819.00	
<b>Speech Therapy (maintenance) Total:</b>							<b>68705.44</b>
Speech Therapy (maintenance)	<input type="checkbox"/>	1/4 hr	4	40.00	15.87	2539.20	
Speech Therapy Maintenance 1:1	<input type="checkbox"/>	1/4 hr	35	106.00	17.83	66149.30	
Speech Therapy Maintenance Group 2 participants	<input type="checkbox"/>	1/4 hour	1	1.00	9.81	9.81	
Speech Therapy Maintenance Group 3 participants	<input type="checkbox"/>	1/4 hour	1	1.00	7.13	7.13	
<b>Work Support-Individual Total:</b>							<b>4523103.60</b>
Work Support-Individual	<input type="checkbox"/>	1/4 hour	617	820.00	8.94	4523103.60	
<b>GRAND TOTAL:</b>						<b>310204460.35</b>	
Total: Services included in capitation:						35521.20	
Total: Services not included in capitation:						310168939.15	
<b>Total Estimated Unduplicated Participants:</b>						<b>2990</b>	
<b>Factor D (Divide total by number of participants):</b>						<b>103747.31</b>	
Services included in capitation:						11.88	
Services not included in capitation:						103735.43	
<b>Average Length of Stay on the Waiver:</b>						<b>357</b>	