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**20.01 INTRODUCTION**

This benefit is a Home and Community Based Waiver for Adults with Other Related Conditions (ORC) who are 21 or older, meet institutional level of care and choose to live in the community with the support of this waiver. This Home and Community Based Waiver is designed to maximize the opportunity for members to achieve the greatest degree of self-sufficiency and independence chosen by the member. Member choice in all services and components of services is a primary goal of this waiver. Additionally, the principles of conflict-free care coordination, services provided in the least restrictive modality and effective use of assistive technology for communication, environmental control and safety are inherent to this waiver.

This benefit has been designed and will be implemented in such a manner so as to ensure that every waiver service setting:

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* Is integrated in and supports full access to the greater community;
* Is selected by the member from among setting options;
* Ensures members’ rights of privacy, dignity and respect, and freedom from coercion and restraint;
* Optimizes autonomy and independence in making life choices; and
* Facilitates choice regarding services and who provides them.

**20.02 DEFINITIONS**

**20.02-1** **Abuse** means the infliction of injury, unreasonable confinement, intimidation or cruel punishment that causes or is likely to cause physical harm or pain or mental anguish; sexual abuse or sexual exploitation; or the intentional, knowing or reckless deprivation of essential needs as defined in 22 M.R.S. §3472.

**20.02-2** **Assessing Services Agency (ASA)** is an Authorized Entity of the Department of Health and Human Services (DHHS) for Medical Eligibility Determinations that conducts face-to-face assessments, using DHHS Medical Eligibility Determination form or other DHHS approved form.

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**20.02-3** **Authorized Entity** is the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.

**20.02-4** **BMS 99** is the assessment tool used to determine functional limitations of the member.

**20.02 DEFINITIONS** (cont.)

**20.02-5** **Care Coordinator** is a provider organization staff person who is responsible for the development and ongoing support of the implementation of the Care Plan. This includes monitoring of the health, welfare and safety of the participant.

**20.02-6** **Care Monitor** is the Department of Health and Human Services (DHHS) professional who assists the member with the member’s enrollment in the waiver services and monitors the services received to assure they are meeting the health and safety needs of the member.

**20.02-7 Care Plan** is a comprehensive document that specifies the services a member will receive under this section and the manner in which those services will be provided.

**20.02-8** **Exploitation** means the illegal or improper use of an incapacitated or dependent member or that member’s resources for another’s profit or advantage as defined in 22 M.R.S. §3472.

**20.02-9 Habilitation** is a service that is provided in order to assist a member to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising or retaining the level of physical, mental, and social functioning of a member. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.

**20.02-10** **Intellectual Disability** means a diagnosis of Mental Retardation as defined in Section 317-319 in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 34-B M.R.S. §5001. The terms “mental retardation” and “intellectual disability” are used interchangeably in these regulations.

**20.02-11** **Medical Eligibility Determination (MED) Tool** means the form approved by DHHS to assess the medical service needs of the member. The information provided by the MED tool will be used in determining the eligibility for the waiver and authorizing services.

**20.02-12** **Member** is a person determined to be eligible for MaineCare benefits by the Office for Family Independence (OFI) in accordance with the eligibility standards published by the OFI in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type and amount of services they are eligible to receive.

**20.02-13 Money Follows the Person-Homeward Bound Transition Coordinator** is the person who is chosen by the member to provide transition Assistance from the

**20.02 DEFINITIONS** (cont.)

agencies contracted by the Department for the Money Follows the Person-Homeward Bound program.

**20.02-14** **Natural Supports** include the relatives, friends, neighbors, and community resources that a member or family goes to for support. They may participate in the treatment team, but are not MaineCare reimbursable.

**20.02-15** **Neglect** means a threat to an member’s health or welfare by physical or mental injury or impairment, deprivation of essential needs or lack of protection from these as defined in 22 M.R.S. §3472.

**20.02-16 Prior Authorization** **(PA)** is the process of obtaining prior approval as to the medical necessity and eligibility for a service.

**20.02-17 Utilization Review** is a formal assessment of the medical necessity, efficiency and appropriateness of services and Care Plans on a prospective, concurrent or retrospective basis. The provider is required to notify DHHS or its Authorized Entity upon initiation of all services provided under Section 20 in order for the Authorized Entity to begin utilization review.

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**20.03 DETERMINATION OF ELIGIBILITY**

**20.03-1** **Approved Opening**

The number of MaineCare members who can receive services under this section is limited to the number of openings approved by the Centers for Medicare and Medicaid Services (CMS). Persons who would otherwise be eligible for services under this section are not eligible to receive services if all of the approved openings are filled.

**20.03-2** **General Eligibility Criteria**

Consistent with Subsection 20.03-1, a person is eligible for services under this section if the person:

A. Is age twenty one (21) or older; and

B. Has a Related Condition within the meaning of 42 C.F.R. §435.1010. A “Related Condition” must meet all of the following conditions:

1. It is attributable to;

**20.03 DETERMINATION OF ELIGIBILITY** (cont.)

a. Cerebral Palsy or Epilepsy; or

b. Any other condition, other than mental illness, found to be closely related to Intellectual Disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with Intellectual Disabilities and requires treatment or services similar to those required for these persons. These conditions include but are not limited to Neurofibromatosis, Other Choreas, Anoxic Brain Damage, Cerebral Laceration and Contusion, Subarachnoid- Subdural and Extradural Hemorrhage following injury, Other and Unspecified Intracranial Hemorrhage following injury or Intracranial injury and unspecified nature, Muscular Dystrophy, Huntington’s, Spina Bifida or other rare developmentally- based conditions.

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2. It is manifested before the person reaches age twenty two (22).

3. It is likely to continue indefinitely.

4. It results in substantial functional limitation in three (3) or more of the following areas of major life activity:

a. Self-care.

b. Understanding and use of language.

c. Learning.

d. Mobility.

e. Self-direction.

f. Capacity for independent living; and

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

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

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

F. The estimated annual cost of the member’s services under the waiver is equal to or less than one hundred percent (100%) of the state-wide average annual cost of care for a member in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by DHHS; and

**20.03 DETERMINATION OF ELIGIBILITY** (cont.)

G. Can have his or her health and welfare needs assured in the community setting as stated in §20.08-2(E) (1) and (2).

**20.03-3** **Establishing Medical Eligibility**

Determination of the member’s medical eligibility for services under this Section requires the following:

A. Completion of a Medical Eligibility Determination (MED) assessment by the Assessing Services Agency (ASA);

B. Completion of the BMS 99 or current functional assessment, as approved by DHHS, by the Care Monitor; and

C. Documentation from a physician that the waiver services are medically necessary.

The member and Care Monitor are responsible for working with DHHS to ensure that each of these items is completed. DHHS shall notify each member or the member’s guardian in writing of any decision regarding the member’s medical eligibility, and the availability of benefit openings under this section. The notice will include information about the member’s right to appeal any of these decisions. Rights for notice and appeal are further described in Chapter I of the *MaineCare Benefits Manual*.

**20.03-4 Priority**

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

A. **Priority 1:** A member shall be identified as Priority 1: (1) if the member is currently residing in a facility of more than 16 beds that is engaged in providing diagnosis, treatment or care of persons with related conditions, which typically includes: medical attention; nursing care and related services: 24-hour supervision: and coordination and integration of health or rehabilitative services, and (2) the member continues to meet the financial and medical eligibility criteria at the time that an approved opening becomes available. Order of enrollment will be based on date of application; an application will be considered complete on the date upon which items A. through D. from Section 20.04-1, Procedures for Developing the Care Plan, have been completed to DHHS satisfaction and DHHS has received all documents. If there are two applications received on the same day, the

**20.03 DETERMINATION OF ELIGIBILITY** (cont.)

applicant with the longest continuous stay in institutional care will be prioritized first.

B. **Priority 2:** All other members shall be identified as Priority 2. A higher priority will be given to those members who are at imminent risk of abuse, neglect or exploitation followed by those at anticipated risk of abuse, neglect or exploitation or homelessness and institutionalization with the next year.

If applications exceed approved openings in any given year, a waiting list will be established. The list will be prioritized, as specified above, such that when there is a funded opening an individual will be selected from priority one first and then immediately from priority two if there are not any completed and approved applicants from priority one.

**20.03-5** **Redetermination of Eligibility**

Eligibility for services under this section must be redetermined annually. When determining continuing eligibility, the Care Coordinator will initiate an updated

Medical Assessment tool and updated BMS 99 form or current functional assessment, as approved by DHHS. This assessment will be conducted by DHHS or its Authorized Entity. Updated assessments must be completed twelve (12) months from the date of initial approval, and every twelve (12) months thereafter. Once the assessment has been updated, the Care Plan will be updated annually. If the updated Assessment Referral is received after the due date, reimbursement for services will resume upon completion of the assessment. Whenever there is a significant change in the member condition that requires an alteration in the level of care, the Care Coordinator will provide notice to DHHS or its Authorized Entity and request an updated assessment. See 20.04-3 regarding updating of the Care Plan.

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**20.04 CARE PLAN DEVELOPMENT**

**20.04-1 Procedures for Developing the Care Plan**

A member’s Care Plan will be developed as part of the process of applying to receive services under the ORC waiver. The process for applying is as follows:

A. **Choice Letter:** The process begins by the member signing and submitting a “choice letter” to the Office of Aging and Disability Services (OADS) requesting services under the ORC waiver. The choice letter is a form that DHHS sends to individuals who may be eligible for services under this section requesting that the individual indicate their preference between

**20.04 CARE PLAN DEVELOPMENT** (cont.)

receiving services in an institutional setting (such as a nursing facility) or receiving services in a community setting under this section.

B. **Application:** After receiving the choice letter, the DHHS Care Monitor will meet with the member and guardian or legal representative (where applicable) and complete the initial ORC application. If the member appears to qualify and is interested in Money Follows the Person/ Homeward Bound MFP/HB, the member will be referred for MFP/HB determination for Money Follows the Person/ Homeward Bound MFP/HB. Enrollment and Transition coordination through MFP/HB will be provided per Money Follows the Person/ Homeward Bound MFP/HB program requirements as outlined in the CMS approved Operational Protocol for Money Follows the Person/ Homeward Bound MFP/HB.

C. **Functional and Medical Assessments:** The Care Monitor will complete the BMS 99 (or current functional assessment, as approved by the DHHS). In addition, the Care Monitor will request the MED assessment to be completed by the ASA.

D. **Safety/Risk Assessment and Preliminary Care Plan:** The Care Monitor will work with the member and guardian or legal representative (where applicable) and the MFP/HB Transition Coordinator (where applicable) to complete DHHS-approved safety/risk assessment and create a preliminary Care Plan to address all safety/risks needs identified by DHHS-approved safety/risk assessment, the MED assessment, and the BMS 99 (or current functional assessment approved by DHHS). Each safety/risk need identified will require a plan to safely support the member in the community with two forms of back-up support. The member will also select the member’s service package and preliminary budget.

E. **Selection of Residential Option and Development of Final Care Plan:** The final Care Plan must be developed by the member, the Care Monitor, guardian or legal representative (where applicable), the MFP/HB Transition Coordinator (where applicable), the provider for the Residential Option (where applicable) and the Care Coordinator. The member will work with the Care Monitor, guardian or legal representative (where applicable), and the MFP/HB Transition Coordinator (where applicable) to select an approved residential option as outlined in 20.05-9 and to select a Care Coordinator as outlined in 20.05-2. Once the residential option (where applicable) and Care Coordinator are selected, the provider for Care Coordination and Home Support or Personal Care (where applicable) will assist the member in developing the final Care Plan including the budget, selection of services, and safety/risk plan. The final Care Plan must:

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**20.04 CARE PLAN DEVELOPMENT** (cont.)

1. Include people chosen by the individual;

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1. Provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
2. Be timely and occur at times and locations of convenience to the individual.

F. **Signatures:** In order for the final Care Plan to be approved, the Care Plan must include signatures of (1) the member, or guardian, where applicable, and (2) the Care Coordinator.

G. **Department Review and Approval:** All services must be Prior Authorized by OADS. Prior to implementation or start of residential services, the Care Plan must be reviewed and approved by OADS, and OADS must determine that the member is eligible for services as outlined in Section 20.03-1, 2 and 3.

H. **Utilization Review:** All Care Plans must be reviewed and approved by OADS. OADS makes the determination that the member continues to be eligiblefor services as outlined in 20.03-1, 2 and 3.

**20.04-2 Content of the Care Plan**

At a minimum the Care Plan must:

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A. Describe all MaineCare Benefit services determined medically necessary by DHHS;

B. Include the frequency of provision of the services;

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

D. Include a safety/risk plan, which shall describe the potential risks to the member’s health and welfare while living in the community and the reasonable steps to alleviate those risks. Each identified safety need must be addressed by two back-up strategies for meeting the member’s safety needs;

E. Describe the member’s goals for strengthening and cultivating personal, community, family, and professional relationships;

F. Describe the role and responsibility of the member’s providers in supporting the member’s goals, including goals for strengthening natural and supportive personal, family, community and professional relationships;

G. Include a budget for the services to be provided under this section.

H. Reflect cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 C.F.R. §435.905(b).

**20.04 CARE PLAN DEVELOPMENT** (cont.)

I. Include strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.

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J. Record the alternative home and community-based settings that were considered by the individual.

The Care Plan may include other services not covered under this section that the member may choose to pursue.

**20.04-3 Review and Updating of the Care Plan**

The Care Plan must be reviewed and updated at a minimum annually, or when the member requests it, or when there are significant changes in the member’s condition sufficient to warrant a review whether the services in place are adequate.

**20.05 COVERED SERVICES**

**20.05-1** **Assistive Technology Device and Services**- Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of members. Assistive Technology service means a service that directly assists a member in the selection, acquisition, or use of an Assistive Technology device. Assistive Technology includes:

(A) the evaluation of the Assistive Technology needs of a member, including a functional evaluation of the impact of the provision of appropriate Assistive Technology Devices and appropriate Assistive Technology Services to the member in the customary environment of the member;

(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of Assistive Technology Devices for members;

(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining/upkeep, repairing, or replacing Assistive Technology Devices;

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(D) coordination and use of necessary therapies, interventions, or services with Assistive Technology Devices, such as therapies, interventions, or services associated with other services in the Care Plan;

(E) training or technical assistance for the member, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the member;

(F) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of members; and

**20.05 COVERED SERVICES** (cont.)

(G) transmission of data required for use of the Assistive Technology Device via internet or cable utility.

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The components above are subject to the following limits:

* The Assistive Technology Device and services described above in paragraphs (B) and (C) are subject to a combined limit of $6,000.00 annually.
* The services described above in paragraphs (A), (D), (E) and (F) are subject to a combined limit of 32 units (8 hours) annually.
* The data transmission utility costs described above in paragraph (G) are limited to $50.00 per month.

Assistive Technology Services excludes services available under the State Plan.

**20.05-2 Care Coordination Services**- consists of service that assist members in gaining access to needed waiver and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is sought. Care Coordination Services are provided by Care Coordinators. Care Coordinators are responsible for assisting the member to access and coordinate natural supports. Care Coordinators are responsible for the monitoring and assurance of the implementation of the Care Plan. This includes monitoring of the health, welfare and safety of the member. This service requires face-to-face contact between the Care Coordinator and the member, at a minimum, every thirty days. A member who has this service may not receive Section 13, Targeted Case Management under the State Plan.

**20.05-3 Career Planning-** Career Planning is a person-centered, comprehensive employment planning and direct support service that provides assistance for a waiver program participant to obtain, maintain, or advance in competitive employment or self-employment at or above the state’s minimum wage. It is a focused, time limited service engaging a member in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the member’s stated career objective and a Career Plan used to guide individual employment support. This service assists in identifying skills, priorities, and capabilities determined through an individualized discovery process. This may include a referral to benefits planning, referral of assessment for use of assistive technology to increase independence in the workplace, development of experiential learning opportunities, and career options consistent with the member’s skills and interests. Career Planning may be used in

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**20.05 COVERED SERVICES** (cont.)

preparation to gather information to be used as part of a referral to Vocational Rehabilitation.

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Career planning furnished under the waiver may not include services available under a program funded under section 110 of the *Rehabilitation Act of 1973* or under the *Individuals with Disabilities Education Act* (20 U.S.C. §1401, *et seq*.).

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

The service requires submission of the Career Plan at three (3) intervals to DHHS in order to ensure that the service is provided in a manner that will result in competitive, integrated employment or self-employment at or above the states minimum wage.

Career Planning services can be provided within a variety of community settings such as a Career Center or a local business.

**20.05-4** **Communication Aids**- consists of devices or services necessary to assist members with hearing, speech or vision impairments to effectively communicate with service providers, family, friends, and other community members.

Communication Aids include:

(A) communicators (including repair and maintenance) such as direct selection, alphanumeric, scanning and encoding communicators, if not otherwise covered for reimbursement under other sections of the *MaineCare Benefits Manual*;

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

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**20.05-5** **Community Support Services**- consists of the assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non- residential setting, separate from the member's private residence or other residential living arrangement; however this service can originate or terminate in the member’s private residence or other residential living arrangement. Community

**20.05 COVERED SERVICES** (cont.)

Support Services expose the member to activities and environments designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week or as specified in the member’s Care Plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Community Support Services focus on enabling the member to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the Care Plan. In addition, Community Support Services may serve to reinforce skills or lessons taught in other settings.

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

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**20.05-6** **Consultation Services and Assessment**- consists of the clinical and therapeutic services that assist unpaid caregivers and/or paid support staff in carrying out Care Plans, and that are not covered by the Medicaid State Plan, and are necessary to improve the member’s independence and inclusion in their community. Consultation Services and Assessments are provided by professionals in Psychology, Occupational Therapy, Physical Therapy, Speech Therapy, and Behavioral Health. The service may include assessment, the development of a Care Plan, training and technical assistance to carry out the Care Plan and monitoring of the member and the provider in the implementation of the Care Plan. This service may be delivered in the member’s home or in the community as described in the Care Plan.

Consultation Services consists of:

(A) Reviews of evaluations and assessments of the member's present and potential level of psychological, physical, and social functioning made through professional assessment techniques; direct interviews with the member and others involved in the Care Plan; review and analysis of previous reports and evaluations, and review of current treatment modalities and the particular applications to the member.

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

(C) Assistance in the design and integration of individual development objectives as part of the Care Plan, and training persons providing direct service in carrying out special habilitative strategies identified in the member's Care Plan.

**20.05 COVERED SERVICES** (cont.)

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

(E) Providing of information and assistance to the member and other persons responsible for developing the overall Care Plan.

Consultation is available in the following specialties: Occupational Therapy, Physical Therapy, Speech Therapy, Behavioral and Psychological services.

Reimbursement for Consultation Services shall be made only to those providers not already reimbursed for consultation as part of another service. Personnel who provide services under Care Coordination may not be reimbursed for Consultation Services.

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**20.05-7 Employment Specialist Services**- consists of services necessary to support a member in maintaining employment. Services include:

(A) periodic interventions on the job site to identify a member’s opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion;

(B) assistance in transitioning between employers when a member’s goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the member in acclimating to a new job. Employment Specialist Services are provided by an Employment Specialist who may work either independently or under the auspices of a Supported Employment agency. The need for continued Employment Services must be documented in the Care Plan as necessary to maintain employment over time.

Employment Specialist Services are provided at work locations where non-disabled individuals are employed as well as in entrepreneurial situations.

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

A member cannot receive these services while working under a Special Minimum Wage Certificate issued by the Department of Labor under the *Fair Labor Standards Act*.

**20.05 COVERED SERVICES** (cont.)

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**20.05-8** **Home Accessibility Adaptations**- consists of those physical adaptations to the private residence of the member or the member’s family, required by the member's Care Plan, that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the member. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

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**20.05-9 Home Support Services-** There are three types of Home Support Services:

(A) **Home Support Services (Per Diem)** -consists of services for a member who requires 24/7 care typically provided in a provider- owned facility with not more than 4 members. The service offers individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living in the community as defined in the Care Plan. The Care Plan will specify the minimum number of 1:1 direct support hours a member needs on a daily basis. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, and social and leisure skill development, that assist the member to reside in the most integrated setting appropriate to his/her needs. These supports also include personal care and protective oversight and supervision.

(B) **Home Support Services** **(1/4 hour )**- consists of services for a member who does not require 24/7 care; the services may be provided in the member’s home. The service offers individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the member to reside in the most integrated setting appropriate to his/her needs. These supports also include personal care and protective oversight and supervision.

**20.05 COVERED SERVICES** (cont.)

(C) **Home Support Services (Remote Support)** - consists of services for a member who does not require face-to-face care but would benefit from electronic communication to ensure health and safety. The service is designed to work in concert with Home Support Services (1/4 hour) to provide habilitation support and to assist the member in achieving the most integrated setting possible and increase the member’s independence through assistive technology. Whereas members served under this waiver have physical limitations that inhibit their ability to communicate, control their environment, and maintain their personal safety, this service provides real-time remote communication and support through a wide range of technological options including electronic sensors, video conferencing, environmental sensors (movement, door, temperature, smoke, carbon monoxide, etc.), video cameras, microphones and speakers, as well as health monitoring equipment. This assistive technology links each member’s residence to the residential service provider. The residential service provider must have staff available 24 hours per day 7 days per weeks to deliver direct 1:1 care when needed. Two levels of emergency back-up are required for any Care Plan that includes Home Support Services (Remote Support).

The use of this service is based upon the member’s assessed needs and the resulting Care Plan. The Care Plan must reflect the member’s and, where applicable, his or her guardian’s informed consent and commitment to the Care Plan elements including all assistive communication, environmental control and safety components. A thorough evaluation of all Assistive Technology must be completed prior to the finalization of the Care Plan with the assistance of the Care Coordinator and use of appropriate Assistive Technology consultants. The member must be provided educational support in order to fully understand the risks and benefits of all elements of the Care Plan and this must be documented and acknowledged by the member served. All assistive devices and systems must allow the member served to “opt out.” The member must be informed as to the methods for ending a service, either on a short-term basis or permanently. These options must be delineated in the member’s Care Plan. If a member served experiences a change in support needs or status, the provider must immediately adjust the direct support services to meet those needs.

All Remote Support Services must be provided in real time. All electronic systems must have back-up power connections to insure functionality in case of loss of electric power. Providers must comply with all federal, state and local regulations that apply to its business including but not limited to the *Electronic Communications Privacy Act of 1986*.

**20.05 COVERED SERVICES** (cont.)

Any services that use networked services must comply with HIPAA requirements.

Remote Support has two components, Monitor only and Interactive Support. Monitor only means that the member is being electronically monitored for over sight and supervision purposes. Interactive Support means that the member and the staff person monitoring the member electronically are interacting back and forth with the use of cameras.

For all three types of Home Support services:

Effective March 1, 2017

* Payment is not made under this section for the cost of room and board, including the cost of building maintenance, upkeep and improvement.
* A provider may provide Home Support to more than one member at a time. An individual Personal Care Assistant, Personal Support Specialist, or Direct Support Professional shall not be reimbursed for providing more than a total of 40 hours per week of services delivered to any one individual waiver member.
* The cost of transportation related to the provision of Home Support is a component of the rate paid for the service.

**20.05-10** **Non-emergency Transportation Services** consists of services to enable members to gain access to Section 20 services, as specified by the Care Plan. Transportation services for Section 20 services are provided under the *MaineCare Benefits Manual*, Section 113 Non-emergency Transportation Services. Whenever possible, family, friends or community agencies, which can provide this service without charge, are utilized.

Effective March 1, 2017

**20.05-11** **Non-Traditional Communication Assessments**- consists of assessments to determine the member’s level of communication present via gesture, sign language or unique individual communication style. The assessment examines signed or gestured vocabulary for everyday objects or actions and the ability to combine gestures as well as the ability to understand similar communication. Assessment recommendations are made to optimize communication to maximize social integration.

**20.05-12 Non-Traditional Communication Consultation**- consists of a consultation provided to members, their direct support staff and others to assist the member to maximize communication ability as determined from a Non-Traditional Communication Assessment. The goal is to allow for greater participation in the Care Planning process and to enhance communication within the member’s environment. This service is intended to enable members of the team to communicate expressively and

Effective March 1, 2017

**20.05 COVERED SERVICES** (cont.)

receptively with the member during all day-to-day activities, which helps the member to actively participate in his/her Care Plan.

**20.05-13** **Occupational Therapy (Maintenance) Services-** These services consist of direct therapy and consultation services to maintain the member's optimal level of functioning within the member's current environment. The intent is to prevent regression, loss of movement, injury and medical complications that would result in a higher level of skilled care.

Effective March 1, 2017

Evaluative and rehabilitative therapy is included in the State Plan and is not a covered service.

Effective March 1, 2017

**20.05-14** **Personal Care Services**- consist of a range of assistance to enable waiver members to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the member to perform a task. Personal Care Services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law. An individual Personal Care Assistant, Personal Support Specialist or Direct Support Professional shall not be reimbursed for providing more than a total of 40 hours per week of services delivered to any one individual waiver member. Personal Care may be provided outside the member's home.

Personal Care is available to members who do not require protective oversight and supervision that is provided in Home Support. In order to avoid duplication, Home Support (Per diem, ¼ hour or Remote Support), Community Support or Personal Care Services are not available at the same time as other Home Support (Per diem, ¼ hour or Remote Support) Community Support or Personal Care Services. This service must be delivered in the state of Maine. Services out of state are not covered unless authorized as required by Chapter I of the *MaineCare Benefits Manual*.

Effective March 1, 2017

**20.05-15** **Physical Therapy (Maintenance) Services-** consist of direct therapy and consultation services to maintain the member's optimal level of functioning within the member's current environment. The intent is to prevent regression, loss of movement, injury and medical complications that would result in a higher level of skilled care.

Evaluative and Rehabilitative Therapy is included in the State Plan and is not a covered service under this waiver.

**20.05 COVERED SERVICES** (cont.)

Effective March 1, 2017

**20.05-16** **Specialized Medical Equipment**- Specialized Medical Equipment and supplies consist of: (a) devices, controls, or appliances, specified in the Care Plan, that enable members to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the member to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State Plan that is necessary to address member functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the member. All items shall meet applicable standards of manufacture, design and installation.

Effective March 1, 2017

**20.05-17 Speech Therapy (Maintenance) Services-** Consist of direct therapy and consultation services to maintain the member's optimal level of functioning within the member's current environment. The intent is to prevent regression, loss of movement, injury and medical complications that would result in a higher level of skilled care.

Evaluative and Rehabilitative Therapy is included in the State Plan and is not a covered service under this waiver.

**20.05-18** **Work Support Services**- consist of intensive, ongoing supports that enable members, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting, to work in a regular work setting. Work Support Services may include assisting the member to locate a job or developing a job on behalf of the member. Work Support Services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Work Support Services includes activities needed to sustain paid work by members, including supervision and training. When Work Support Services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by members receiving waiver services as a result of their disabilities and not for the supervisory activities rendered as a normal part of the business setting.

Effective March 1, 2017

This service is only available in the absence of a program funded under section 110 of the *Rehabilitation Act of 1973* or the Individuals with *Disabilities Education Act* (20 U.S. C. 1401 *et seq*.). Members cannot receive these services while working

**20.05 COVERED SERVICES** (cont.)

under a Special Minimum Wage Certificate issued by the Department of Labor under the *Fair Labor Standards Act*.

Documentation must be maintained in the file of each member receiving this service that the service is not available under such a program.

Work Support Services may not be used for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in Work Support Services;
2. Payments that are passed through to users of Work Support Services; or
3. Payments for training that is not directly related to an individual's Work Support Services.

Work Support Services must be delivered on an individualized basis and not in a group format. The cost of transportation related to the provision of Work Support Services is a component of the rate paid for the service.

**20.06 NONCOVERED SERVICES**

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

**20.06-1** Services not authorized by the Care Plan.

**20.06-2** Services to any member who is hospitalized, a nursing facility resident, or ICF/IID resident.

**20.06-3** Any service otherwise reimbursable under the *Rehabilitation Act of 1973* or the *Individuals with* *Disabilities Education Act*, including but not limited to job development and vocational assessment or evaluations.

**20.06-4** Room and board; The term “room” means shelter-type expenses, including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term “board” means three meals a day or any other full nutritional regimen.

**20.06-5** Services provided directly or indirectly by the legal guardian.

**20.06-6** Work Support or Employment Specialist Services when the member is not engaged in employment. Employment means traditional employment or telecommuting that is

**20.06 NONCOVERED SERVICES** (cont.)

compensated at a competitive wage, or self-employment or business ownership. A competitive wage is a wage at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an employee without a disability. Employment does not include work in a setting in which the member has little or no interaction with customers or other employees not having a disability, unless the member is telecommuting, self-employed, or owns his or her own business.

**20.06-7** Specialized Medical Equipment and Supplies, Communication Aids, or Home Accessibility Adaptations unless the service has been determined non-reimbursable under Section 60, Medical Supplies and Durable Medical Equipment or other sections of the *MaineCare Benefits Manual.*

**20.06-8** Non-Duplication of Services; Services as defined under this section if the member is receiving comparable or duplicative services under this or another section of the *MaineCare Benefits Manual*. A member may not receive services under this section, if the member is in a residential treatment facility or if the member is receiving services in an institution, including, but not limited to Section 2, Adult Family Care Services; Section 45, Hospital Services; Section 46, Psychiatric Hospital Services; Section 50, ICF/IID; Section 67, Nursing Facilities and Section 97, Private Non-Medical Institutions. A member may not receive services if they are in another Home and Community Based Waiver such as Section 19, Home and Community-Based Benefits for the Elderly and for Adults with Disabilities, Section 21, Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder, Section 22, Home and Community Benefits for the Physically Disabled, Section 29, Support Benefits for Adults with Intellectual Disabilities or Autistic Disorder and Section 32, Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders.

**20.07 LIMITS**

The following service limits apply to each member:

**20.07-1 Assistive Technology Services**- Each system or device will be reviewed based on medical necessity, efficiency and whether it meets compatibility with safety needs. Assistive Technology Services are limited to as described in the covered service 20.05-1.

Effective March 1, 2017

* The Assistive Technology Device and services described in 20.05-1(B) and (C) are subject to a combined limit of $6,000.00 annually.

**20.07 LIMITS** (cont.)

* The services described in 20.05-1(A), (D), (E) and (F) are subject to a combined limit of 32 units (8 hours) annually.

Effective March 1, 2017

* The data transmission utility costs described in 20.05-1(G) are limited to $50.00 per month.

**20.07-2 Care Coordination Services**- Care Coordination Services are limited to 400 units per year. The Care Coordination provider may not offer any other services to the member under this Section.

**20.07-3** **Communication Aids**- Communication Aids are limited to $6000.00 per service year. Each system or device will be reviewed based on medical necessity, efficiency and whether it meets compatibility with safety needs.

**20.07-4** **Community Support Services**- Community Support Services are limited to 128 units per week, for an annual total of 6656 units per service year. The maximum weekly allowance for Work Support Services is 128 units, for an annual total of 6656 units. When members use a combination of both services, there is a weekly limit of 128 units per week and an annual limit of 6656 units on the total combined expenditures for the services.

**20.07-5** **Consultation Services**- Consultation Services are limited to 64 units per service year, each type of Consultation Service.

**20.07-6** **Employment Specialist Services**- Employment Specialist Services are limited to 72 units per service year.

**20.07-7** **Home Accessibility Adaptions**- Home Accessibility Adaptions are limited to $3,000.00 per service year.

**20.07-8 Home Support Services**- Home Support (1/4 hour) is limited to 64 units per day. Home Support (Remote Support) is limited to 64 units per day.

**20.07-9 Non-Traditional Communication Assessment**- Non-Traditional Communication Assessment is limited to 64 units per service year.

**20.07-10 Non-Traditional Communication Consultation**- Non-Traditional Communication Consultation is limited to 64 units per service year.

**20.07-11** **Occupational Therapy Maintenance**- Occupational Therapy Maintenance is limited to 8 units per week up to 416 units per service year.

**20.07 LIMITS** (cont.)

**20.07-12 Personal Care Services**- Personal Care Services are limited to 52 units per day.

**20.07-13 Physical Therapy Maintenance**- Physical Therapy Maintenance is limited to 8 units per week up to 416 units per service year.

**20.07-14** **Specialized Medical Equipment and Supplies**- Any item over $500.00 requires documentation from a physician, an Occupational Therapist, Physical Therapist or Speech Therapist.

**20.07-15** **Speech Therapy Maintenance**- Speech Therapy Maintenance is limited to 8 units per week up to 416 units per service year.

**20.07-16** **Work Support** **Services**-Work Support Services are limited to 128 units per week up to 6656 units per service year. The maximum weekly allowance for Community Support is 128 units, for an annual total of 6656 units. When members use a combination of both services there is an annual limit of 6656 units on the total combined expenditures for the services.

**20.07-17** **Section 20 Home and Community Based Services for Adults with Other Related Conditions** may not be provided in a residence where other Home and Community Based Waiver services are provided. Exceptions to this limit will be considered on a case-by-case basis by the Department. Consideration of this exception will be contingent on the member’s Care Plan ensuring that all identified services will be delivered without compromising the quality of care, and on all aspects of the costs of services being clearly delineated in order to demonstrate that there is not blending of financial benefits between the members served.

**20.08 DURATION OF CARE**

**20.08-1 Voluntary Termination**- A member who currently receives the benefit, but no longer wants to receive the benefit, will be terminated from waiver services, after DHHS receives written notice from the member that he or she no longer wants the benefit.

**20.08-2 Involuntary Termination**- DHHS will give written notice of termination from waiver services to a member at least thirty (30) days prior to the effective date of the termination, providing the reason for the termination, and the member’s right to appeal such decision. A member may be terminated from this benefit for any of the reasons listed below:

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

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

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

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

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

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

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

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

3. There is no approved Care Plan.

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

G. The annual cost of the member’s services under this waiver exceeds one hundred percent (100%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by DHHS.

**20.08-3 Suspension of Services**- Services may be suspended for up to sixty (60) days if requested by the member and approved by DHHS. If such circumstances extend beyond 60 day**s**, the member’s service coverage under this section will be terminated and the member will need to be reassessed to determine medical eligibility for these services.

**20.09 RECORDS**

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

The member’s records must contain:

**20.09-1** The member's name, address, birth date, and MaineCare identification number;

**20.09 RECORDS** (cont.)

**20.09-2** The member's social and medical history, and diagnoses;

**20.09-3** The member’s Care Plan;

**20.09-4** A summary of authorized services; and

**20.09-5** Written progress notes that identify any progress toward the achievement of the goals, identify activities and identify needs established by the member’s Care Plan. Written progress notes must be signed and dated by the staff performing the service.

The provider must document each service provided including; the date of each service, the type of service, the activity, the need or goal to which the service relates, the length of time of the service, and the signature of the individual performing the service.

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

**20.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS**

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

**20.10-1** **Assistive Technology Services**-In order to provide Assistive Technology Services, a provider must be an OADS approved agency and employ:

A. A Licensed Occupational Therapist; or

B. A Licensed Speech Pathologist; or

C. A certified Direct Support Professional (DSP) who is also certified as a Rehabilitation Engineering Technologist (RET) or an Assistive Technology Professional (ATP).

**20.10-2** **Care Coordination Services**- In order to provide Care Coordination Services, a provider must be an OADS- approved agency and employ:

1. A Registered Nurse; or
2. A Registered Occupational Therapist; or
3. A Licensed Social Service or health professional with four years of education in health or social services field and one year of community experience in providing the direct service.

**20.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

**20.10-3 Career Planning** – In order to provide Career Planning Services, a provider must be an OADS-approved Provider Agency and the individual providing the service must meet one of the following training requirements and must have completed an additional 12 hours of Career Planning and Discovery training provided through Maine’s Workforce Development System:

Effective March 1, 2017

1. Certificate as a Direct Support Professional (DSP) as detailed in 20.10-6; or
2. Employment Specialist National Certification approved by the Association of Community Rehabilitation Educators (ACRE).

**20.10-4 Communication Aids-** In order to provide Communication Aids, an independent (non-agency) provider must possess a Certificate of Clinical Competence-Speech Pathology (CCC-SP) or be a Licensed Speech Language Pathologist (SLP), or a Licensed Audiologist. An agency provider of Communication Aids must be a licensed speech and hearing agency or licensed Home Health Agency and the staff person must possess a Certificate of Clinical Competence-Speech Pathology (CCC-SP).

**20.10-5** **Consultation Services-** In order to provide Consultation Services a provider must:

A. Possess a certificate of Clinical Competence in Speech Pathology for Speech Consultation; or

B. Be a Licensed Occupational Therapist for Occupational Therapy Consultation; or

C. Be a Physical Therapist for Physical Therapy Consultation; or

D. Be a Psychological Examiner or Be a Licensed Clinical Psychologist for Psychological Consultation; or

E. Be a Licensed Clinical Social Worker (LCSW) or Be a Licensed Clinical Professional Counselor (LCPC) for Behavioral Consultation.

Effective March 1, 2017

**20.10-6** **Community Support, Home Support, Work Support Services-** Community Support, Home Support, and Work Support Services must be provided by a Direct Support Professional (DSP), a Personal Support Specialist (PSS) or a Personal Care Assistant (PCA), and the individual providing the services must:

A. Meet one of the following training requirements:

1. Have successfully completed the appropriate training as a Direct Support Professional curriculum as adopted by DHHS, or
2. Demonstrated proficiency through DHHS’s approved Assessment of Prior Learning, or

**20.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

1. Have successfully completed the curriculum from the Maine College of Direct Support within 90 days of date of hire and completed the following five modules from the College of Direct Support prior to providing services to a member alone:

1. Safety at Home and in the Community

2. Personal Care.

3. Professionalism

4. Individual Rights and Choice

5. Maltreatment; or

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

v. Be a PCA or PSS who successfully completed a Department-approved curriculum prior to September 1, 2003. Such individuals will be grandfathered as a qualified PCA or PSS; and

Documentation of completion must be retained in the personnel record.

B. Have a background check consistent with Section 20.10-16;

C. Have a valid driver’s license, if transporting members;

D. Be at least 18 years of age;

E. Have graduated from high school or acquired a GED;

F. Have completed Reportable Events and Behavior Regulations Training.

Effective March 1, 2017

**20.10-7** **Employment Specialist Services**- In order to provide Employment Specialist Services, a provider must:

1. Possess a national certification by the Association of Community Rehabilitation Educators (ACRE); and
2. Pass a background check consistent with Section 20.10-16; and
3. Possess a valid driver’s license, if transporting members; and
4. Be at least 18 years of age; and
5. Possess a high school degree or GED; and

**20.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

1. Have one year of experience working with people with disabilities in a work setting.

**20.10-8** **Home Accessibility Adaptations**- In order to provide Home Accessibility Adaptations, a provider must be approved by the Office of Aging and Disability Services (OADS).

Effective March 1, 2017

**20.10-9** **Non Traditional Communication Assessment and Consultation**- In order to provide Non Traditional Communication Assessment and Consultation, a provider must;

A. Possess a Houston Certificate or other training approved by DHHS; or

B. Be a Licensed Speech Language Pathologist.

**20.10-10** **Occupational Therapy (Maintenance)**- In order to provide Occupational Therapy (Maintenance) Services, a provider must be a Licensed Occupational Therapist.

**20.10-11** **Personal Care-** In order to provide Personal Care Services, a provider must;

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

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

C. If a CNA’s status on the Maine Registry of Certified Nursing Assistants has lapsed, or an individual holds a valid certificate of training meeting the standards of the Maine State Board of Nursing nursing assistant program issued more than three (3) years ago, the individual must have passed the competency-based examination of didactic and demonstrated skills from the Department’s approved personal support specialist curriculum. A certificate of training as a personal care assistant/personal support specialist is awarded upon passing this examination; or

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

**20.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

E. Be a PCA or PSS who successfully completed a Department-approved curriculum prior to September 1, 2003. Such individuals will be grandfathered as a qualified personal care assistant/PSS; or

F. Be qualified as a DSP as described in 20.10-6.

Effective March 1, 2017

**20.10-12** **Physical Therapy (Maintenance) Services**- In order to provide Physical Therapy (Maintenance) Services, a provider must be a Licensed Physical Therapist.

**20.10-13** **Specialized Medical Equipment-** In order to provide Specialized Medical Equipment, a provider must be approved by the Office of Aging and Disability Services (OADS).

**20.10-14** **Speech Therapy (Maintenance) Services**- In order to provide Speech Therapy (Maintenance) Services, a provider must possess a Certificate of Clinical Competence in Speech Pathology (CCC-SP).

**20.10-15 Emergency Intervention-** Providers must meet training requirements on approved behavioral interventions procedures (e.g.,Mandt) if applicable and indicated as a need in the member’s Care Plan.

**20.10-16** **Background Check** **Criteria**- Providers must conduct background checks on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide services under this Section. Background checks on persons professionally licensed by the State of Maine will include a confirmation that the licensee is in good standing with the appropriate licensing board or entity.

The provider shall not hire or retain in any capacity any person who may directly provide services to a member under this section if that person has a record of:

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

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

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

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

E. any criminal conviction within Title 29-A, chapter 23, subchapter 2, article 1, or Title 29-A, chapter 23, subchapter 5. Employment of individuals with

**20.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

records of such convictions more than five (5) years prior to the time of the background check is a matter within the provider's discretion after consideration of the individual's criminal record in relation to the nature of the position. The member receiving services must approve the employment of such staff in writing if the provider decides to hire a staff person with a conviction.

The provider shall contact child and adult protective services (including the Office of Aging and Disability Services) units within DHHS to obtain any record of substantiated allegations of abuse, neglect or exploitation against an employment applicant before hiring the same. In the case of a child or adult protective services investigation substantiating abuse, neglect or exploitation by a prospective employee of the provider, it is the provider’s responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with licensing standards.

Effective March 1, 2017

**20.10-17** **Informed Consent Policy**

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

**20.10-18 Reportable Events**

Effective March 1, 2017

Providers shall comply with all terms and conditions of the Department’s Regulations Governing Reportable Events, Adult Protective Investigations and Substantiation Hearings**.** All staff must receive training in mandatory reporting/reportable events before they provide any services under this waiver.

**20.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

Effective March 1, 2017

**20.10-19 Requirements for Residential Settings Owned or Controlled by a Provider**

Where the member receives Home Support Services in a residential setting owned or controlled by the provider, the provider must ensure that the following requirements are met:

A. The member must occupy the residence pursuant to a lease or other written, legally enforceable agreement providing comparable protections, including eviction and appeal processes required under Maine law;

B. The member must have privacy in his or her unit, including doors lockable by the member, with only appropriate staff having keys to such doors;

C. Where members share a unit, each member must have choice of roommates;

D. The member must have the freedom to furnish or decorate the unit;

E. The member must control his or her own schedule and activities;

F. The member must have access to food at any time;

G. The member must be allowed to receive visitors of his or her choosing at any time; and

H. The setting must be physically accessible.

These requirements may only be modified where necessary to respond to a specific assessed need. Modifications require clinical documentation supporting the need, and must be identified and justified in the Care Plan.

The following requirements must be documented in the member’s Care Plan in order to modify the Requirements for Residential Settings Owned or Controlled by a Provider:

1. Identify a specific and individualized assessed need;
2. Document the positive interventions and supports used prior to any modifications to the Care Plan;
3. Document less intrusive methods of meeting the need that have been tried but did not work;
4. Include a clear description of the condition that is directly proportionate to the specific assessed need;
5. Include a regular collection and review of data to measure the ongoing effectiveness of the modification;
6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
7. Include informed consent of the member; and
8. Include an assurance that the interventions and supports will cause no harm to the member.

**20.11 APPEALS**

In accordance with Chapter I of the *MaineCare Benefits Manual*, members have the right to appeal in writing or orally any decision made by DHHS to reduce, deny or terminate services provided under this benefit. The right to appeal does not extend to changes in law or policy adversely affecting some or all recipients. The appeal must be (a) requested in writing and mailed to the address below, or (b) requested by telephone by calling Local: 207-287-6598, Toll Free: 1‑800-606-0215 or TTY: 711.

Office of Aging and Disability Services

Department of Health and Human Services

11 State House Station

Augusta, ME 04333-0011

**20.12 REIMBURSEMENT**

Reimbursement methodology for covered services shall be the amount listed in Chapter III, Section 20, Allowances for Home and Community Based Services for Adults with Other Related Conditions or the provider’s usual and customary charge, whichever is lower. In accordance with Chapter I, it is the responsibility of the provider to seek payment from any other insurance, including Medicare that is available for payment of the rendered service prior to billing MaineCare.

**20.13 BILLING INSTRUCTIONS**

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

**20.14 QUALITY REPORTING**

In order to assure quality of care within the ORC waiver services, DHHS requires providers to comply with all quality reporting requests. The report shall include:

A. The Care Plan

1. Meeting member’s personal goals

Effective March 1, 2017

2. Meeting health and safety needs

3. Member receiving services outlined in the Care Plan

4. Freedom of choice is offered both for services and provider selection

5. Reviewed and Approved on an annual basis

B. The member completes an annual Experience/Satisfaction Survey.

**20.14 QUALITY REPORTING** (cont.)

Effective March 1, 2017

C. Reportable Events are reported by providers within the required timeframe in the Enterprise Information System (EIS).

D. Care Coordination Reporting

E. Home Support Reporting

F. Assistive Technology Reporting