Department of Health and Human Services
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DATE: July 17, 2012

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Proposed Rule: MaineCare Benefits Manual, Chapter 101, Section 21, Chapter II, Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorders

This letter gives notice of a proposed rule: MaineCare Benefits Manual, Section 21, Chapter II, Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorders.

The Department is proposing to remove language from 21.02-7 Employment Setting, as required by Resolve Chapter 49, LD 28, passed by the 125th Legislature that states that "Members with disabilities should constitute no more than 50% of the business's workforce at any given worksite or location." The Department is proposing to add language to clarify that a Licensed Clinical Social Worker (LCSW) or Licensed Clinical Professional Counselor (LCPC) can provide psychological or behavioral consultation. Additionally, if approved by CMS, the Department is proposing to add a Board Certified Behavior Analyst (BCBA) as a qualified provider who can provide psychological or behavioral consultation. Limits are being proposed to be added; no one member Agency Home Support placements will be approved after this rule has been adopted. Also, Home Support ¼ hour- T2017 is not to exceed three hundred and thirty six (336) quarter hour units or eighty four (84) hours a week. And, lastly for limits, authorizations for services to be provided out-of-state will not exceed sixty (60) days of service within a given fiscal year, and not exceed sixty (60) days within any six (6) month period. Language that had previously been in provider contracts or riders is also being proposed to be added to the policy. Technical language changes are also being proposed.

Rules and related rulemaking documents may be reviewed at, and printed, from the MaineCare Services website at, http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html or for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. TTY users call Maine relay 711.

A concise summary of the proposed rule is provided in the Notice of Agency Rule-making Proposal. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency Rule-making Proposal.

Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services, MaineCare Services

RULE TITLE OR SUBJECT: MaineCare Benefits Manual, Section 21, Chapter II, Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorders

PROPOSED RULE NUMBER:

CONCISE SUMMARY: The Department is proposing to remove language from 21.02-7 Employment Setting, as required by Resolve Chapter 49, LD 28, passed by the 125th Legislature that states that "Members with disabilities should constitute no more than 50% of the business's workforce at any given worksite or location." The Department is proposing to add language to clarify that a Licensed Clinical Social Worker (LCSW) or Licensed Clinical Professional Counselor (LCPC) can provide psychological or behavioral consultation. Additionally, if approved by CMS, the Department is proposing to add a Board Certified Behavior Analyst (BCBA) as a qualified provider who can provide psychological or behavioral consultation. Limits are being proposed to be added; no one member Agency Home Support placements will be approved after this rule has been adopted. Also, Home Support ¼ hour- T2017 is not to exceed three hundred and thirty six (336) quarter hour units or eighty four (84) hours a week. And, lastly for limits, authorizations for services to be provided out-of-state will not exceed sixty (60) days of service within a given fiscal year, and not exceed sixty (60) days within any six (6) month period. Language that had previously been in provider contracts or riders is also being proposed to be added to the policy. Technical language changes are also being proposed.

SEE http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html **for rules and related rulemaking documents.**

THIS RULE WILL X WILL NOT ___ HAVE A FISCAL IMPACT ON MUNICIPALITIES.

STATUTORY AUTHORITY: 22 MRSA §§ 42, 3173.

PUBLIC HEARING:
Date: August 16, 2012 11:00AM to 1:00 PM
Location: Conference Room # 1
Department of Health and Human Services
Office of MaineCare Services
242 State Street
Augusta, ME

The Department requests that any interested party requiring special arrangements to attend the hearing contact the agency person listed above before August 3, 2012.

DEADLINE FOR COMMENTS: Comments must be received by midnight Sunday, August 26, 2012.

AGENCY CONTACT PERSON: Ginger Roberts-Scott, Comprehensive Health Planner
AGENCY NAME: MaineCare Services
ADDRESS: 11 State House Station
242 State Street
Augusta, Maine 04333-0011
Ginger.roberts-scott@maine.gov
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PLEASE APPROVE BOTTOM PORTION OF THIS FORM AND ASSIGN APPROPRIATE MFASIS NUMBER

APPROVED FOR PAYMENT _____ **DATE:** _____

Authorized Signature

FUND	013	**AGENCY**	10A	**ORG**	3026	**APP**	012	**JOB**		**OBJT**		**AMOUNT**			
FUND	010	**AGENCY**	10A	**ORG**	3026	**APP**	012	**JOB**		**OBJT**		**AMOUNT**			

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HOME AND COMMUNITY BENEFITS FOR MEMBERS
WITH INTELLECTUAL DISABILITIES OR AUTISTIC DISORDER

SECTION 21 ESTABLISHED 11/1/83
LAST UPDATED 7/1/10

21.01 INTRODUCTION

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

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

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

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

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

21.02 DEFINITIONS

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

21.02-2 **Agency Home Support** means a facility that routinely employs direct care staff to provide direct support services in an agency operated facility.

21.02-3 **Autistic Disorder** means a diagnosis that falls within the category of Pervasive Developmental Disorders, as defined in Section 299.0-299.80 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association), that manifested during the

21.02 DEFINITIONS (Cont.)

developmental period, in accordance with the definition of autism codified in 34-B MRSA § 6002 and accompanying rules.

21.02-4 **Case Manager** is a person responsible for assuring the timely convening of the service planning team, developing the Personal Plan, monitoring the planned services received by the member, and for insuring that those services meet the requirements set forth in the member's Personal Plan. This person may also be referred to as an Individual Support Coordinator.

21.02-5 **Correspondent** is a person who acts as an ally to a person who has no actively involved family or private guardian.

21.02-6 **Designated Representative** means the DHHS staff authorized by DHHS to perform specified functions.

21.02-7 **Direct supports** are a range of activities that contribute to the health and well being of the member and his or her ability to live in or be part of the community. Direct support activities may include personal assistance or activities that support personal development, or activities that support personal well being. Direct support activities are provided as Home Support, Community Support, Employment Specialist Services or Work Support. The emphasis and purpose of the direct support provided may vary depending on the type of service.

Direct support activities include the following:

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

Self-care includes assistance with eating, bathing, dressing, mobility, personal hygiene, and other activities of daily living; assistance with light housework, laundry, meal preparation, transportation, grocery shopping, and assistance with health and nutrition maintenance, including assessing well-being and identifying need for medical assistance; complying with nutritional requirements as specified in the Personal Plan; administration of non-prescription medication that are ordinarily self-administered; and administration of prescription medication, when provided by a person legally authorized to assist with the administration of medication.

Self-management includes assistance with managing safe and responsible behavior; exercising judgment with respect to the member's health and well-being; communication, including conveying information, interpreting information, and advocating in the member's interests; managing money including paying bills,

21.02 DEFINITIONS (Cont.)

making choices on how to spend money, keeping receipts, and expending funds with the permission of a member's representative payee. Self-management also includes teaching coping skills, giving emotional support, and guidance to other resources the member may need to access.

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

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

21.02-8 **Employment Setting** must be one with the highest level of integration possible. The job must be one that is available to a non-disabled employee with the same expectations for the member's job performance and attendance. The member works under similar work conditions as others without disabilities in similar positions; including access to lunchrooms, restrooms, and breaks. The member performs work duties with ongoing interaction with other workers without disabilities, and has contact with customers, suppliers and the public to the same degree as workers without disabilities in the same or comparable occupations. The member cannot be excluded from participation in company-wide events such as holiday parties, outings and social activities. Provider owned/operated businesses are subject to the same integration standards as other businesses. Staff providing employment services at the worksite are not considered non-disabled employees in determining the level of integration. For those agencies that currently operate under an award from AbilityOne (http://AbilityOne.org),

21.02 DEFINITIONS (Cont.)

the federal workforce guidelines associated with this funding source will apply to the services funded by the contract. The member can be on the employer's payroll or the provider agency payroll. Members may receive additional employment supports from

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

21.02-9 **Exploitation** means the illegal or improper use of an incapacitated or dependent member or that member's resources for another's profit or advantage as defined in 22 MRSA §3472.

21.02-10 **Family-Centered Support** is a model designed to provide enhanced home support to a member in a family environment, with the family and the member sharing a home that is not owned by the member or member's family. No more Family Centered Support will be approved after December 30, 2007.

21.02-11 **Habilitation** is a service that is provided in order to assist a member to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising the level of physical, mental, and social functioning of a member. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.

21.02-12 **Intellectual Disability** means a diagnosis of Mental Retardation as defined in Section 317-319 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 34-B MRSA § 5001. The terms "mental retardation" and "intellectual disability" are used interchangeably in these regulations. Use of the term "intellectual disability" in no way alters the criteria for eligibility set forth in s. 21.03-3(B).

21.02-13 **Medical Add On** is a component of Home Support, Community Support, Employment Specialist Services and Work Support and is included in the established authorization (as described in Section 21.04-1). It is not a separately billable activity. Billing may not exceed the Home Support, Community Support, Employment Specialist Services or Work Support authorized units of service. Documentation must clearly identify and support periods of such activity. Refer to Appendix II for more information.

21.02 DEFINITIONS (Cont.)

21.02-14 **Member** is a person determined to be eligible for MaineCare benefits by the Office of Family Independence(OFI) in accordance with the eligibility standards published by the OFI in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

21.02-15 **Mental Retardation** means a diagnosis of Mental Retardation as defined in Section 317-319 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association), that manifested during the

developmental period, in accordance with the definition of Intellectual Disability codified in 34-B MRSA § 5001. The terms "mental retardation" and "intellectual disability" are used interchangeably in these regulations. Use of the term "intellectual disability" in no way alters the criteria for eligibility set forth in s. 21.03-3(B).

21.02-16 **Neglect** means a threat to an member's health or welfare by physical or mental injury or impairment, deprivation of essential needs or lack of protection from these as defined in 22 MRSA §3472.

21.02-17 **On behalf Of** is billable activity that is provided for individual members and is not necessarily a direct face-to-face service. On Behalf Of is a component of Home Support, Community Support, Employment Specialist Services and Work Support. It is included in the established authorization and is not a separately billable activity. Documentation detail must clearly identify and support periods of such activity. Refer to Appendix III for more information.

21.02-18 **Personal Plan** is a member's plan developed at least annually that lists the services offered under the waiver benefit. The Personal Plan may also include services not covered by the waiver but identified by the member. Only services included on the Personal Plan are reimbursable. The Personal Plan may also be known as a person centered plan, a service plan, an individual support plan, or an individual education plan, as long as the requirements of Section 21.04-2 are met.

21.02-19 **Qualified Intellectual Disability Professional (QIDP)** is a person who has at least one year of experience working directly with persons with intellectual disabilities or other developmental disabilities and is one of the following: 1) a doctor of medicine or osteopathy; 2) a registered nurse; or 3) an individual who holds at least a bachelor's degree as specified in title 42 Code of Federal Regulations (CFR) 483.430, paragraph B5.

21.02 DEFINITIONS (Cont.)

21.02-20 **Qualified Vendor** is a provider approved by DHHS to provide waiver services to eligible members receiving services under this Section. DHHS requires agencies to provide high quality services that, at a minimum, meet the expectations of the members who utilize those services. DHHS may authorize agencies to provide services under this Section after an application, along with supporting documentation, has been submitted to a Designated Representative for review and approval. The Designated Representative will authorize only agencies that meet DHHS expectations in the areas of organization and operation, operation of individual programs or services, personnel administration, environment and safety, and quality management. Only Qualified Vendors will receive DHHS referrals and authorizations for reimbursement.

21.02-21 **Shared Living** is a model in which Home Support services are provided to a member by a person who meets all of the requirements of a Direct Support Professional with

whom that member also shares a home. The home may belong to the provider or the member, but the provider must enter into a contractual relationship with an agency in order to provide Home Support services under this model. Only one member may receive Home Support services in any one Shared Living arrangement at the same time, unless a relationship is established prior to the service arrangement and approved by DHHS. In such case, no more than two members may be served in any one Shared Living arrangement concurrently.

DHHS refers a member to an agency for the provision of Home Support in a Shared Living arrangement when that need is identified in the Personal Plan. The Direct Support Professional must enter into a contractual relationship with the agency in order to provide Home Support services in a Shared Living arrangement. The agency supports the provider in fulfilling the requirements and obligations agreed upon by the DHHS, the agency and the Personal Plan.

21.02-22 **Shared Living Provider** is a provider who subcontracts with an agency to provide direct support to a member, with whom they share a home.

21.02-23 **Summary of Authorized Services (SAS)** is a list of the medically necessary services identified through the planning process that the parties signing the Personal Plan have agreed will meet the habilitation needs of the member. The SAS shall identify the nature and timing of the services as identified in the member's Personal Plan, including the MaineCare rates for each service. A DHHS Designated Representative shall sign (electronic or original) and date the SAS as a means to authorize payment for services provided. The Personal Plan may contain service needs that the member may pursue, but which are not covered by MaineCare, and are, therefore, not reflected on the SAS for HCB services. The SAS is a component of the Personal Plan. The SAS was formerly known as the CHECKLIST.

21.03 DETERMINATION OF ELIGIBILITY

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

21.03-1 Funded Opening

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

21.03-2 Reserved Capacity

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

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

Meet the needs of those individuals who choose to leave an ICF/MR or other institutional setting.

The number reserved associated with Section 21.03-2 above is an average based on the DHHS's data for those in need of adult protective services in recent years. The number reserved for ICF/MR or other institutional residents is based on currently known referrals.

21.03-3 General Eligibility Criteria

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

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

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

21.03 DETERMINATION OF ELIGIBILITY (Cont.)

the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM) IV; and

C. Meets the medical eligibility criteria for admission to an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) 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

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 are equal to or less than two hundred percent (200%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR), as determined by the Department.

21.03-4 Establishing Medical Eligibility

In order to determine medical eligibility, the member and case manager must provide to DHHS the following:

A. A completed copy of the assessment referral form (BMS99); and

B. A copy of the member's Personal Plan approved and signed by the member or guardian and the case manager and any other relevant material indicating the member's service needs.

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

DHHS shall notify each member or the member's guardian in writing of any decision regarding the member's medical eligibility, and the availability of benefit openings under this Section. The notice will include information about the member's right to appeal any of these decisions. Rights for notice and appeal are further described in Chapter I of the MaineCare Benefits Manual.

If the member is found to be medically eligible, DHHS must send the member or guardian written notice that the member can receive ICF/MR services or services under this Section. The member or guardian must submit to the case manager a

21.03 DETERMINATION OF ELIGIBILITY (Cont.)

signed choice letter documenting the member's choice to receive services under this section.

21.03-5 Priority

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

A. **Priority 1:** Any member on the waiting list shall be identified as Priority 1 if the member has been determined by DHHS to be in need of adult protective services in accordance with 22 M.R.S.A. §3473 *et seq.*, and if the member

continues to meet the financial and medical eligibility criteria at the time that need for adult protective services is determined.

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

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

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

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

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

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

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

21.03 DETERMINATION OF ELIGIBILITY (Cont.)

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

21.03-6 Choosing Whom to Serve Within the Same Priority

If the number of openings is insufficient to serve all members on the waiting list who have been determined, at the time that any opening is determined to be available, to be within the same priority group, DHHS shall first determine whether each member continues to meet the financial and medical eligibility criteria to be served through this benefit. For those who continue to meet such criteria, the Department will utilize

the most current assessment that is entered into the Enterprise Information System (EIS) and submitted by the individual member, guardian or Case Manager.
Upon review of information concerning all members within the same priority group who continue to meet financial and medical eligibility criteria and for whom current service plans have been redeveloped, DHHS shall determine which members to serve. The determination will be based on a comparison of the members' known needs, the availability of capable service providers who can adequately meet those needs, and the comparative degree of abuse, neglect or exploitation or risk of abuse, neglect or exploitation that each member will likely experience in the absence of the provision of the benefit.

21.03-7 Waiting List

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

21.03-8 Redetermination of Eligibility

When determining continued eligibility, the case manager will submit an updated Assessment Referral Form (BMS 99) to DHHS twelve (12) months from the date of initial approval, and every twelve (12) months thereafter. The Summary of Authorized Services will be updated annually, when the assessment referral form is submitted. If the updated Assessment Referral Form is received after the due date, reimbursement for services will resume upon receipt of the assessment form. Whenever significant changes occur that alters level of care, the case manager will submit an updated Assessment Referral Form to DHHS.

21.04 PERSONAL PLAN

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

21.04-1 Authorization for Reimbursable Services

Medically necessary services and units of services must be identified in the Personal Plan. Requests for services must be submitted to DHHS. Requests will be reviewed and negotiated by DHHS, and may be examined and evaluated by DHHS, before

units of service are authorized and entered on the SAS. Compliance to the authorization is determined if the average of actual delivered services fall within the range established for that setting or member. If the average falls within the range, then billing at the approved level is authorized. If the average falls below the pre-set level, then billing must reflect the lower level of service provided.

21.04-2 Plan Requirements

The Case Manager will ensure that the Planning Team is convened to initiate development of the Personal Plan prior to services being initiated. The plan must be less than six (6) months old at the time of the member's eligibility determination or redetermination. If older than six (6) months, supporting documentation must accompany the plan that discusses the current services being provided under this section, subject to Case Manager approval. The Personal Plan must describe at a minimum:

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

B. The frequency of provision of the services;

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

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

E. The role and responsibility of the Direct Support Professional, the Employment Specialist and the member's other service providers in

21.04 PERSONAL PLAN (Cont.)

supporting the member's goals, including goals for strengthening natural and supportive personal, family, community and professional relationships; and

F. Signatures of the participants, in order for the Plan to be authorized the Plan must include signatures of the member, or guardian, if applicable, and case manager.

The Personal Plan will be used by DHHS to develop the Summary of Authorized Services (SAS), which is a component of the Plan, and which identifies the type and units of authorized services the member may receive under this Section. If more than one provider is reimbursed for the same category of direct support activities, an explanation of the differences in roles and responsibilities of each provider and how services will not be duplicated is required.

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

21.04-3 Planning Team Composition

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

A. Plan facilitator;

B. Case manager;

C. The member;

D. The member's parent, guardian or Correspondent;

E. The member's advocate or friend or any additional individual invited by the member;

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

G. Staff from the member's Community Support, Work Support or Employment Specialist Services Provider; and

21.04 PERSONAL PLAN (Cont.)

H. Any professionals involved or likely to be involved with the member's Personal Plan.

21.04-4 Updating the Personal Plan

The member's Personal Plan must be reviewed, revised and updated at least annually, when there is a revision or update to the member's SAS, or when other significant changes occur relating to the member's physical, social, or psychological needs, or the member's significant progress toward his or her goals. The Case Manager will reconvene the Planning Team to revise and update the Personal Plan. Planning meetings shall be held both prior to and subsequent to the planned move of a member to a new residence in order to coordinate supports and services and to evaluate the member's satisfaction with the change.

21.05 COVERED SERVICES

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

21.05-1 **Home Support** is direct support provided in the member's home, by a Direct Support Professional to improve and maintain a member's ability to live as independently as possible in his or her home. Home Support is direct support to a member and includes primarily habilitative training and/or personal assistance (self-care, self management), development and personal well-being.

There are different models of home support. Home Support may be provided by an Agency (Agency ¼ hour and Agency per diem), in a Shared Living arrangement, or in a Family Centered-Support Model. Home Support may be provided as either a regularly scheduled "round the clock" service or as individual hours, or blocks of hours, of service.

There is an additional level of support for members in Shared Living and Family Centered Support based on the documented needs of the member. The member must require an increased level of Home Support as documented in the member's Personal Plan and the Summary of Authorized Services (SAS). This increased support is for the purposes of additional staff for those members who have lack of access to Community Support, those members who have not been successful in the past in Community Support, or those members who have challenging behavioral issues or high medical and safety needs. The Department will consider adding increased support to a member's Personal Plan based on the written submitted documentation description of need of the member, including but not limited to evaluations, assessments, planning team recommendations, reportable events, Adult Protective Reports, and consultations from behavioral and medical providers. The member's

21.05 COVERED SERVICES (Cont.)

record must document that the increased level of support was provided. Refer to Appendix I for more information.

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

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

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

21.05-2 **Community Support** is Direct Support provided by a Direct Support Professional in order to increase or maintain a member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well being. This is a habilitative service with a focus on community inclusion, personal development, and support in areas of daily living skills if necessary. Community Support is intended to be flexible, responsive and provided to members consistent with his or her personal plan.

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

Within the scope of Community Support, there may be activities that require that the service be provided in the member's home; most commonly, this will involve the origination or termination of a period of the service. This is allowable as long as it does not duplicate Home Support.

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

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

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

21.05 COVERED SERVICES (Cont.)

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

21.05-3 **Employment Specialist Services** include services necessary to support a member in maintaining employment. Services include: (1) periodic interventions on the job site to identify a member's opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion; (2) assistance in transitioning between employers when a member's goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the member in acclimating to a new job. An Employment Specialist may work either independently or under the auspices of a Supported Employment agency but must have completed the approved Employment Specialist training as outlined by DHHS in order to provide

Employment Specialist Services. The need for continued Employment Specialist Services must be documented in a Personal Plan as necessary to maintain employment over time. Employment Specialist Services are provided at work locations where non-disabled individuals are employed as well as in entrepreneurial situations. The cost of transportation related to the provision of Employment Specialist Services is a component of the rate paid for the service.

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

Employment Services are provided on an intermittent basis with a maximum of 10 (ten) hours each month. Nothing in this rule prohibits a member from working under a Special Minimum Wage Certificate issued by the Department of Labor under the Fair Labor Standards Act.

21.05-4 **Work Support** is Direct Support provided by a Direct Support Professional or an Employment Specialist to improve a member's ability to independently maintain productivity and employment. This service is commonly provided after a period of stabilization and encompasses adherence to workplace policies and productivity. It may also include hygiene, self-care, dress code, work schedule and related issues. Work Support is usually provided in a member's place of employment, but may be provided in a member's home in preparation for work if it does not duplicate services already reimbursed as Home Support. The cost of transportation related to the provision of Work Support is a component of the rate paid for the service.

On Behalf Of is a component of Work Support and is included in the established authorization, and is not a separate billable activity. The maximum annual allowance for work support is eight hundred fifty (850) hours. Nothing in this rule prohibits a member from working under a Special Minimum Wage Certificate issued by the Department of Labor under the Fair Labor Standards Act.

21.05 COVERED SERVICES (Cont.)

21.05-5 **Home Accessibility Adaptations** are those physical adaptations to the private residence of the member or the member's family required by the member's service plan, that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home. These include adaptations that are not covered under other sections of the MaineCare Benefits Manual and are determined medically necessary as documented by a licensed physician and approved by DHHS.

Adaptations commonly include:

Bathroom modifications;
Widening of doorways;
Light, motion, voice and electronically activated devices;
Fire safety adaptations;

Air filtration devices;
Ramps and grab-bars;
Lifts (can include barrier-free track lifts);
Specialized electric and plumbing systems for medical equipment and supplies;
Lexan windows (non-breakable for health & safety purposes);
Specialized flooring (to improve mobility and sanitation).

DHHS does not cover those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are also excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). In-floor radiant heating is not allowable. General household repairs are not included in this benefit.

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

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

The limit for adaptations is ten thousand dollars ($10,000) in a five (5) year period, with an additional annual allowance up to three hundred dollars ($300) for repairs and replacement per year. All items in excess of five hundred dollars ($500) require documentation from a physician or other appropriate professionals such as OT, PT or Speech therapists that the purchase is appropriate and medically necessary to meet the member's need. Medically necessary home modifications that cannot be obtained

21.05 COVERED SERVICES (Cont.)

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

21.05-6 **Specialized medical equipment and supplies** include devices, controls, or appliances specified in the plan of care that enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This benefit also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and nondurable medical equipment not available under the MaineCare Benefits Manual. Items reimbursed under this waiver benefit are in addition to any medical equipment and supplies furnished under the MaineCare Benefits Manual. All items must meet applicable standards of manufacture, design and installation. If used in vehicle modification, this benefit applies to member owned or a member's family owned vehicle only; it is not available in agency owned,

leased or operated vehicles. All items shall be considered the property of the member and must remain at the member's disposal at all times regardless of where the member resides.

All items in excess of five hundred dollars ($500) require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the member's need. Medically necessary adaptive aids that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this section if they meet all the requirements of this Section.

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

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

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

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

D. other devices necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment that are not otherwise covered for reimbursement in the MaineCare Benefits Manual.

21.05 COVERED SERVICES (Cont.)

21.05-7 Communication Aids are devices or services necessary to assist individuals with hearing, speech or vision impairments to effectively communicate with service providers, family, friends, and other community members. Communication Aids include:

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

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

C. Facilitated communication. Providers must submit a written plan for DHHS's approval defining the facilitated communication services that will be offered

to the member. The provider of this service must have a Certificate of Clinical Competence-Speech Pathology (CCC-SP).

Only communication aids that cannot be obtained as a covered service under other sections of the MaineCare Benefits Manual may be reimbursed under this Section. For communication aids costing more than five hundred dollars ($500), the member must obtain documentation from a licensed speech-language pathologist assuring the medical necessity of the devices or services.

21.05-8 **Non-Traditional Communication Consultation** is provided to members and their direct support staff and others to assist them in order to maximize communication ability as determined from assessment. The goal is to allow for greater participation in the service planning process and to enhance communication within the member's environment. The provider of this service must be a Visual Gestural Communicator approved by DHHS.

21.05-9 **Non-Traditional Communication Assessments** determine the level of communication present via gesture, sign language or unique individual communication style. The assessment examines signed or gestured vocabulary for everyday objects or actions, as well as the ability to combine gestures and the ability to understand similar communication. Assessment recommendations are made to optimize communication to maximize social integration. The provider of this service must be approved by The DHHS Office of Multi-Cultural Affairs.

21.05-10 **Consultation Services** are services provided to persons responsible for developing or carrying out a member's Personal Plan. Consultation Services include**:**

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

21.05 COVERED SERVICES (Cont.)

through professional assessment techniques; direct interviews with the member and others involved in the Personal Plan; review and analysis of previous reports and evaluations, and review of current treatment modalities and the particular applications to the individual member;

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

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

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

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

Consultation is available in the following specialties: Occupational Therapy, Physical Therapy, Speech Therapy and Psychological services. The provider of this service must be an Occupational Therapist, Registered (OTR) for Occupational Therapy Consultation or a Registered Physical Therapist (RPT) for Physical Therapy consultation or have a Certificate of Clinical Competence-Speech Pathology (CCC-SP) for Speech Therapy Consultation. The provider of this service must be a Licensed Psychological Examiner, Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC) or, if CMS approves, a Board Certified Behavior Analyst (BCBA) for Psychological or Behavioral Consultation. Reimbursement for Consultation Services may only be made to those providers not already reimbursed for consultation as part of another service. Personnel who provide services under Targeted Case Management, Section 13 of the MaineCare Benefits Manual may not be reimbursed for Consultation Services.

21.05-11 **Counseling** is a direct service to assist the member in the resolution of the member's behavioral, social, mental health, and alcohol or drug abuse issues. Counseling services, as recommended in the Personal Plan, must be approved by DHHS. The provider of this service must be a Licensed Clinical Social Worker (LCSW) or a Licensed Clinical Professional Counselor (LCPC).

21.05 COVERED SERVICES (Cont.)

21.05-12 **Crisis Intervention Services** are direct intensive supports provided to members who are experiencing a psychological, behavioral, or emotional crisis. The scope, intensity, duration, intent and outcome of Crisis Intervention must be documented in the Personal Plan. Crisis Intervention is commonly provided on a short-term intermittent basis.

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

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

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

21.05-13 **Crisis Assessment** is a comprehensive clinical assessment of a member who has required intervention by the DHHS Crisis Team on at least three occasions within a two-week period. The assessment includes: a clinical evaluation to identify causes or conditions that may precipitate the crisis, specific crisis prevention activities, and to develop a plan for early intervention and stabilization in the event of a crisis. The required members of a clinical team are a psychiatrist or licensed psychologist and a clinical liaison. Depending upon client need, other team members may include a physician, occupational, physical or speech therapist.

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

21.05-14 **Transportation Service** may be provided in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the Personal Plan. This is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services in the MaineCare Benefits Manual, defined at 42 CFR §440.170 (a) (if applicable), and does not replace them. Transportation services under this waiver are offered in accordance with the member's Personal Plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized.

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

21.05 COVERED SERVICES (Cont.)

Relatives and legal guardians may only be reimbursed for transportation if they indicate that they are unable to transport at no charge, there is no other viable option, and there is a recommendation by the planning team to reimburse the transportation.

21.05-15 **Occupational Therapy (Maintenance)** is a service that has maintenance of current abilities and functioning level as its goal. Evaluative and rehabilitative Occupational Therapy is included under other Sections of the MaineCare Benefits Manual and is not covered as a component of maintenance therapy under this Section. The provider of this service must be an Occupational Therapist, Registered (OTR) for Occupational Therapy Maintenance.

21.05-16 **Physical Therapy (Maintenance)** is a service that has maintenance of current abilities and functioning level as its goal. Evaluative and rehabilitative Physical Therapy is included under other Sections of the MaineCare Benefits Manual and is

not covered as a component of maintenance therapy under this Section. The provider of this service must be a Registered Physical Therapist (RPT) for Physical Therapy Maintenance.

21.05-17 **Speech Therapy (Maintenance)** is a service that has maintenance of current abilities and functioning level as its goal. Evaluative and rehabilitative Speech Therapy is included under other Sections of the MaineCare Benefits Manual and is not covered as a component of maintenance therapy under this Section. The provider of this service must have a Certificate of Clinical Competence-Speech Pathology (CCC-SP) for Speech Therapy Maintenance.

21.06 NON-COVERED SERVICES

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

21.06-1 Services not identified by the Personal Plan;

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

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

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

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

21.06 NON-COVERED SERVICES (cont.)

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

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

21.06-8 Work Support or Employment Services when the member is not engaged in employment. Employment means traditional employment or telecommuting that is 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;

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

21.07 LIMITS

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

21.07-2 When used in combination, Community Support Services and Work Support Services are limited as outlined in Appendix IV. The maximum annual allowance for Community Support is eleven hundred twenty-five (1,125) hours per year.

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

21.07 LIMITS (Cont.)

21.07-4 All items in excess of five hundred dollars ($500) require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the member's need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this section only if they meet all requirements of this Section. This benefit applies to personal homes only; it is not available in agency owned or operated homes.

21.07-5 For Specialized Medical Equipment and Supplies costing more than five hundred dollars ($500), the member must obtain documentation from a physician or other appropriate professional such as an OT, PT or Speech therapist assuring that the purchase is appropriate to meet the member's need and is medically necessary. Specialized Medical Equipment and Supplies are limited to only specialized medical equipment and supplies that cannot be obtained, as a covered service under other

sections of the MaineCare Benefits Manual will be reimbursed under this Section. These services are to be considered the property of the member.

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

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

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

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

21.07-10 A member may not receive Community Support, Employment Specialist Services or Work Support while enrolled in high school. A member may have services authorized while still enrolled in high school; however, the start date of the service may only begin after the date of graduation or termination of enrollment.

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

21.07 LIMITS (Cont.)

21.07-12 No Family Centered Support will be approved after this rule has been adopted.

21.07-13 If a current waiver recipient enters a nursing facility or a hospital, payment under the waiver will be temporarily suspended. If the waiver recipient remains in the nursing facility or hospital for more than thirty (30) consecutive days, enrollment in this waiver will be terminated unless there is a written request to the Department to continue holding the funded opening.

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

21.07-15 As of the effective date of this rule, Agency Home Support placements will only be approved at sites where at a minimum two (2) members reside.

21.07-16 Home Support ¼ hour- T2017 may not to exceed three hundred and thirty six (336) quarter hour units or eighty four (84) hours a week.

21.07-17 Authorizations for services to be provided out of state will not exceed sixty (60) days of service within a given fiscal year and not exceed sixty (60) days within any six (6) month period except as provided in title 42 Code of Federal Regulations (CFR) 431.52 (B).

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

21.08 DURATION OF CARE

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

21.08-2 Involuntary Termination-DHHS will give written notice of termination to a member at least ten (10) days prior to the effective date of the termination, providing the reason for the termination, and the member's right to appeal such decision. A member may be terminated from this benefit for any of the reasons listed below:

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

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

21.08 DURATION OF CARE

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

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

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

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

2. The home or home environment of the member becomes unsafe to the extent that benefit services cannot be provided without risk of

harm or injury to the member or to individuals providing covered services to the member; or

3. There is no approved Personal Plan.

F. The member fails to pay his/her cost of care for two (2) consecutive months.

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

H. The annual cost of the member's services under this waiver exceeds two hundred percent (200%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR), as determined by the Department.

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

21.09 MEMBER RECORDS

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

In addition, the member's records must contain:

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

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

21.09-3 The member's Personal Plan.

21.09 MEMBER RECORDS (cont)

21.09-4 The Summary of Authorized Services; and

21.09-5 Written progress notes that identify any progress toward the achievement of the goals, activities and needs established by the member's Personal Plan signed by the staff performing the service.

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

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

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

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

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

21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS

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

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

A. Has successfully completed the Direct Support Professional curriculum as adopted by DHHS**,** or demonstrated proficiency through DHHS's approved Assessment of Prior Learning, or has successfully completed the curriculum from the Maine College of Direct Support within one (1) year of date of hire;

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

C. Has an adult protective and child protective record check;

D. Be at least 18 years of age; and

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

As of March 30, 2008, staff or subcontractors currently providing this service must obtain the DSP certification or demonstrate proficiency through DHHS's approved Assessment of Prior Learning within one (1) year (2080 hours, two thousand and

eighty) of actual employment from date of hire, or three (3) calendar years, whichever is less.

All new staff or subcontractors shall have one (1) year (2080 hours, two thousand and eighty) of actual employment from date of hire, or three (3) calendar years, whichever is less, to obtain DSP certification or demonstrate proficiency through DHHS's approved Assessment of Prior Learning. Evidence of date of hire and enrollment in the training must be documented in writing in the employee's personnel file or a file for the subcontractor. Services provided during this time are reimbursable as long as the documentation exists in the personnel file.

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

A DSP can supervise another DSP.

A DSP is legally authorized to assist with the administration of medication if the DSP is certified as a Certified Nursing Assistant-Medications (CNA-M); as a Certified Residential Medication Aide (CRMA); or otherwise has been trained to administer medications through a training program authorized, certified, or approved by DHHS.

As of March 30, 2008, DSPs who currently assist with the administration of medication must obtain the Certified Nursing Assistant-Medications (CNA-M); or a Certified Residential Medication Aide (CRMA); or otherwise be trained to administer medications through a training program authorized, certified, or approved by DHHS within one (1) calendar year.

All new DSPs who assist with the administration of medication shall have one (1) calendar year from date of hire to obtain the Certified Nursing Assistant-Medications (CNA-M); or a Certified Residential Medication Aide (CRMA); or otherwise be trained to administer medications through a training program authorized, certified, or approved by DHHS certification.

21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont)

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

A. Successfully completed an Employment Specialist Certification program as approved by DHHS. Certification must occur within six months of date of hire;

B. Supervision during the first six months of hire must be from a Certified Employment Specialist in order to provide services;

C. Work Support staff can either be certified as an Employment Specialist or complete the Approved Direct Support Curriculum along with additional modules specific to employment;

D. Graduated from high school or acquired a GED; Persons without a high school diploma or a GED and currently providing the services as of the effective date of this rule shall have three years to obtain the minimum educational requirements.

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

F. Worked for a minimum of one (1) year with a person or persons having a disability.

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

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

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

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

D. General medical practitioner;

E. Occupational therapist;

F. Physical therapist; or

G. Speech therapist.

21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont)

21.10-4 A provider must follow DHHS's rule governing emergency intervention and behavioral treatment for persons with Intellectual Disabilities (14-197 CMR Chapter 5), and training on approved behavioral interventions procedures (e.g., Mandt) if applicable and indicated as a need in the member's Personal Plan.

21.10-5 Background Check criteria-The provider must conduct background checks on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide direct support services under this Section. Background checks on persons professionally licensed by the State of Maine will

include a confirmation that the licensee is in good standing with the appropriate licensing board or entity. The provider shall not hire or retain in any capacity any person who may directly provide services to a member under this Section if that person has a record of:

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

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

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

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

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

21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont)

21.10-6 Informed Consent Policy

Providers must put in place and implement an informed consent policy approved by the Department. For the purposes of this requirement, informed consent means consent obtained in writing from a person or the person's legally authorized representative for a specific treatment, intervention or service, following disclosure of information adequate to assist the person in making the consent. Such information may include the diagnosis, the nature and purpose of the procedure(s) or service(s) for which consent is sought, all material risks and consequences of the procedure(s) or service(s), an assessment of the likelihood that the procedure(s) or service(s) will

accomplish the desired objective(s), any reasonably feasible alternatives for treatment, with the same supporting information as is required regarding the proposed procedure(s) or service(s), and the prognosis if no treatment is provided. At a minimum, a provider's informed consent policy must ensure that members served by the provider (and their guardians, where applicable) are informed of the risks and benefits of services and the right to refuse or change services or providers.

21.10-7 Reportable Events

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

21.11 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: 1-800-606-0215.

Office of Adults with Cognitive and Physical Disability Services
Department of Health and Human Services
11 State House Station
2nd Floor, Marquardt Building
Augusta, ME 04333-0011

21.12 REIMBURSEMENT

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

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

21.13 BILLING INSTRUCTIONS

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

21.14 Appendix I- Home Support and Family Centered Per Diem Criteria for increased level of support

The Standard support level is an all inclusive reimbursement for Home Support Services defined in 21.05-1. At times, a member may require increased levels of staff support due to more intensive needs. DHHS may authorize an increased level of support for the purposes of additional staff for those members who have lack of access to Community Support, those members who have not been successful in the past in Community Support, or those members who have challenging behavioral issues or high medical and safety needs. DHHS will use the following criteria to determine when this increased level of reimbursement to support the additional staff is utilized.

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

1) **Community Support**- In circumstances where the member does not utilize Community Support due to lack of access or has not been successful in the past but whose Personal Plan recommends additional supports to access community activities, the member may have increased levels of support to achieve community access. Documentation of previous failed attempts or lack of access must be provided and contained in the member's record. The Personal Plan will outline specific activities and desired outcomes of the service being provided and those activities must be separately documented in the member's record.

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

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

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

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

21.14 Appendix I- Home Support and Family Centered Per Diem Criteria for increased level of support (cont)

2) The manner in which increased support will be utilized;
3) The expected duration of the increased support. If the increased support is expected to be needed for an indefinite period of time then this expectation should be specified; and
4) The anticipated frequency of the increased support on a daily, weekly, or monthly basis.

Process of Application for the increased level of service:

The Provider must complete the Home Support Frequency tool provided by DHHS that will summarize the support needs of the member and submit the tool along with identified materials to the case manager. The Home Support Frequency tool can found at this website, http://www.maine.gov/dhhs/OACPDS/DS/budget-waiver/index.html
The case manager will be responsible for reviewing the information provided, verifying that the Personal Plan and all other information is most current.

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

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

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

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

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

A. Physician Order

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

a. The specific illness or condition to be addressed;

b. The specific procedure(s) that will be utilized;

c. The time span over which the treatment or intervention is expected to be needed. If the treatment or intervention is expected to be needed for an indefinite period of time then this expectation should be specified;

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

e. Where applicable and possible:

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

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

B. Planning Team

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

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

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

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

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

C. Provider Requirements

1. The provider must be an enrolled MaineCare provider.

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

D. Approval Process

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

2. Documents will be reviewed by a designated representative.

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

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

21.16 APPENDIX III-On Behalf of Covered Activities

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

Examples of acceptable activities include:

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

Services, activities and time that are directly related to a member that are associated with that member's Personal Plan, medical plan or behavioral plan including in-service training specific to a member's plan of support, consultations with supervisors, therapist, clinicians and or medical staff; activities relating to a member's parent, guardian or CAB representative; documentation, reports and presentations to review committees.

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

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

On Behalf of Non Covered Activities

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

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

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

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

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

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

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

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

21.17 APPENDIX IV

Limit for members who use a combination of Work Support and Community Support

When a member's personal plan includes recommendations for both Community Support and Work Support, there are limits on the maximum number of hours for each service. The limits are derived as a function of the differing rates for each service and a maximum combined expenditure limit for the total.

This Appendix includes two (2) charts to assist in determining the annual maximum number of hours for Community Support and Work Support Services.

- **Chart 1** is for members who want to first establish a number of Community Support hours in Column A, and then determine the maximum number of Work Support hours in Column B they may use.

- **Chart 2** is for members who want to first establish a number of Work Support hours in Column C, and then determine the maximum number of Community Support hours in Column D they may use.

Chart 1	
A	**B**
Annual Community Support Hours	Annual Work Support Hours
0	850
25	850
50	850
75	850
100	850
125	842
150	823
175	804
200	785
225	766
250	747
275	728
300	709
325	690
350	670
375	651
400	632
425	613
450	594
475	575
500	556
525	537

Chart 2	
C	**D**
Annual Work Support Hours	Annual Community Support Hours
0	1,125
25	1,194
50	1,162
75	1,129
100	1,096
125	1,063
150	1,031
175	998
200	965
225	933
250	900
275	867
300	835
325	802
350	769
375	736
400	704
425	671
450	638
475	606
500	573

21.17 APPENDIX IV (cont.)

Chart 1 (cont.)	
A	**B**
Annual Community Support Hours	Annual Work Support Hours
550	518
575	498
600	479
625	460
650	441
675	422
700	403
725	384
750	365
775	346
800	326
825	307
850	288
875	269
900	250
925	231
950	212
975	193
1,000	174
1,025	154
1,050	135
1,075	116

Chart 2 (cont.)	
C	**D**
Annual Work Support Hours	Annual Community Support Hours
525	540
550	508
575	475
600	442
625	409
650	377
675	344
700	311
725	279
750	246
775	213
800	181
825	148
850	115
850	115