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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The State of Maine requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title: Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

C. Waiver Number: ME.0467

D. Amendment Number:

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

01/01/18

Approved Effective Date of Waiver being Amended: 01/01/16

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The State of Maine is planning to amend the Home- and Community-based Services waiver, known in Maine as Section 29 of the MaineCare Benefits Manual. The waiver serves participants with Intellectual Disabilities and Autism Spectrum Disorder. DHHS is proposing to make changes to comply with legislative directive P.L. 2017, ch. 459, Parts A and B, which provided funding to increase reimbursement rates for Home Support, Shared Living, Community Support, Employment Specialist Services, Work Support, Career Planning, and Respite services. The increased rates are effective starting 7/1/18. Appendix J reflects the rate increase in years 3, 4, and 5. The legislation also provides that the Department ensure that caps and limitations on services are increased to reflect the rate increases. Therefore, DHHS also proposes to raise limits within this waiver, to ensure that rate increases do not result in any decrease in level of services for participants. The annual limit for participants who receive Home Support, Community support, or Shared Living will increase to $58,168.50 (Appendix C-4), and the annual limit for Respite Services will increase to $1,224.60 per year (Appendix C1/C3).

Additionally, DHHS is proposing to increase the number of participants served by this waiver. DHHS proposes to raise the unduplicated number of participants to 2635 for years 3, 4, and 5 (Appendix B-3-a). For years 3, 4, and 5, DHHS proposes to raise the number of participants served at any point in time to 2470 (Appendix B-3-b).

To comply with Federal requirements in the 21st Century CURES Act, DHHS is adding a requirement in Appendix C that
providers of Home Support-1/4 Hour and Respite services in the home must comply with Maine DHHS Electronic Visit Verification system standards and requirements. This requirement will be effective January 1, 2020.

Performance measures have been updated in Appendices A, B, C, D, G, and I. These revisions will make the performance measure in this waiver (ME.0467) consistent with those in ME.0159.

Appendix G, Participant Safeguards, has been updated to reflect changes in Maine's regulations governing Reportable Events (14-197 C.M.R. Ch. 12) and Adult Protective Services (10-149 C.M.R. Ch. 1).

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies)*:

<table>
<thead>
<tr>
<th>Component of the Approved Waiver</th>
<th>Subsection(s)</th>
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<tbody>
<tr>
<td>Waiver Application</td>
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<tr>
<td>Appendix A – Waiver Administration and Operation</td>
<td>Quality Ir</td>
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<tr>
<td>Appendix B – Participant Access and Eligibility</td>
<td>B-3-a&amp;amp,b,</td>
</tr>
<tr>
<td>Appendix C – Participant Services</td>
<td>C1/C3, C</td>
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<tr>
<td>Appendix D – Participant Centered Service Planning and Delivery</td>
<td>Quality Ir</td>
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<td>Appendix E – Participant Direction of Services</td>
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<td>Appendix F – Participant Rights</td>
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<td>Appendix G – Participant Safeguards</td>
<td>G-3-b&amp;c</td>
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<td>Appendix H</td>
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<td>Appendix I – Financial Accountability</td>
<td>I-2-a,Qua</td>
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<tr>
<td>Appendix J – Cost-Neutrality Demonstration</td>
<td>J-1,J-2</td>
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B. **Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies)*:

- [ ] Modify target group(s)
- [ ] Modify Medicaid eligibility
- [ ] Add/delete services
- [ ] Revise service specifications
- [ ] Revise provider qualifications
- [ ] Increase/decrease number of participants
- [ ] Revise cost neutrality demonstration
- [ ] Add participant-direction of services
- [ ] Other

Specify:
The amendment raises rates in Appendix J; raises the annual limit for Home Support, community Support, or Shared Living; and raises the annual limit for Respite Services. The amendment also proposes to raise the unduplicated number of participants and the number of participants served at any point in time. The amendment also adds a requirement for providers of Home Support-1/4 hour and Respite in the home to comply with Maine DHHS Electronic Visit Verification system standards and requirements. This requirement will be effective January 1, 2020. Appendix G has been updated to reflect changes in Maine's regulations governing Reportable Events and Adult Protective Services, consistent with changes approved by CMS for ME.0159.R06.02. Performance measures in Appendices A, B.C,D, G, and I have also been updated for consistency with ME.0159.
Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

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

B. Program Title (optional - this title will be used to locate this waiver in the finder):
Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

C. Type of Request: amendment

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

- 3 years  - 5 years

Original Base Waiver Number: ME.0467
Draft ID: ME.013.02.02

D. Type of Waiver (select only one):

E. Proposed Effective Date of Waiver being Amended: 01/01/16
Approved Effective Date of Waiver being Amended: 01/01/16

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

- Hospital
  Select applicable level of care
  - Hospital as defined in 42 CFR §440.10
    If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

- Nursing Facility
  Select applicable level of care
  - Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155
    If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

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

- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)
  If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

- [ ] Not applicable
- [x] Applicable

Check the applicable authority or authorities:

- ☐ Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I
- [x] Waiver(s) authorized under §1915(b) of the Act.
  
  Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:
  
  Maine Non-emergency Transportation Me.19 is concurrent with this waiver.

  Specify the §1915(b) authorities under which this program operates (check each that applies):
  
  - ☐ §1915(b)(1) (mandated enrollment to managed care)
  - ☐ §1915(b)(2) (central broker)
  - ☐ §1915(b)(3) (employ cost savings to furnish additional services)
  - [x] §1915(b)(4) (selective contracting/limit number of providers)

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

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

- ☐ A program authorized under §1915(i) of the Act.
- ☐ A program authorized under §1915(j) of the Act.
- ☐ A program authorized under §1115 of the Act.

  Specify the program:

  

H. Dual Eligibility for Medicaid and Medicare.

  Check if applicable:

  - [x] This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

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

The goal of this Waiver is to offer services to adults with intellectual disabilities or autism spectrum disorder who meet the ICF-IID level of care. Support services for are for adults who either live with their families, live on their own or a residential provider. Residential Services are being added during this waiver amendment, Shared Living or Adult Foster Care, where the participant lives in the home of the provider. The goal is that individuals will have the highest possible level of independence.

The administrative, case management and quality management components of this Waiver are the responsibility of the State of Maine Department of Health and Human Services. Case management is provided as a state plan services either by state employees or community case managers. Department of Health and Human Services (DHHS)is the umbrella agency that houses both Office of MaineCare Services(OMS) and Office of Aging and Disability Service(OADS), both report to the commissioners office. OMS and OADS have different responsibilities within the waiver. OMS has the responsibility of claims processing, policy promulgation and share waiver portal maintenance with OADS. OADS has the responsibility of program management and day to day operations of the waiver as well as shared waiver portal maintenance with OMS.

Maine’s network of service providers are responsible for personal planning and providing waiver services. The state assures that participants have a range of options throughout the state.

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (Select one):

- Yes. This waiver provides participant direction opportunities. Appendix E is required.
- No. This waiver does not provide participant direction opportunities. Appendix E is not required.

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (select one):

- Not Applicable
- No
- Yes

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (select one):

- No
- Yes

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

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

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

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in Appendix C are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in Appendix C.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in Appendix I.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in Appendix B.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in Appendix B, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per
capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in Appendix J.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in Appendix I.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in Appendix C.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
F. **FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:

The State conducted a public noticing process for the waiver renewal process.

The State followed HCBS regulations in 42 CFR § 441.301 and requested public input on this waiver amendment from October 30, 2018 through November 29, 2018. Tribal Consultation was done in writing on October 26, 2018 followed by a meeting on November 6, 2018.

On October 30, 2018, the waiver amendment was posted online. A provider list serve was done on that date to all MaineCare providers and interested parties. Comments were accepted October 30, 2018 through November 29, 2018. In addition, a public notice appeared in five (5) newspapers with the highest circulation in the state October 30, 2018.

Any interested party could go into any regional DHHS office or contact OMS or OADS for a printed copy. The waiver amendment was posted on this website at http://www.maine.gov/dhhs/oms/rules/index.shtml. A printed copy could be obtained by calling Rachel Posner at 207-624-6951 or via email at rachel.posner@maine.gov.

J. **Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

### 7. Contact Person(s)

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

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

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Hyer</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>Robert</td>
</tr>
<tr>
<td>Title:</td>
<td>Waiver Manager</td>
</tr>
<tr>
<td>Agency:</td>
<td>DHHS- The Office of Aging and Disability Services</td>
</tr>
<tr>
<td>Address:</td>
<td>11 State House Station</td>
</tr>
<tr>
<td>City:</td>
<td>Augusta</td>
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<tr>
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</tr>
<tr>
<td>Phone:</td>
<td>(207) 287-9392</td>
</tr>
<tr>
<td>Fax:</td>
<td>(207) 287-9915</td>
</tr>
<tr>
<td>E-mail:</td>
<td><a href="mailto:robert.hyer@maine.gov">robert.hyer@maine.gov</a></td>
</tr>
</tbody>
</table>

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will
continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

| Signature: | State Medicaid Director or Designee |
| Submission Date: |  |

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

| Last Name: | Nadeau |
| First Name: | Stefanie |
| Title: | Director |
| Agency: | Office of MaineCare Services |
| Address: | SHS #11 242 State Street |
| Address 2: |  |
| City: | Augusta |
| State: | Maine |
| Zip: | 04333 |
| Phone: | (207) 287-2093 Ext: | TTY |
| Fax: | (207) 287-2675 |
| E-mail: | stefanie.nadeau@maine.gov |

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

Specify the transition plan for the waiver:
Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance. Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

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

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

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

The State did not solicit comment on a waiver-specific transition plan. Two processes were used to obtain public comment on the statewide transition plan: an informal and a formal, Administrative Procedures Act (APA) compliant, process. The informal process involved the convening of a community forum on December 19, 2014. Legal notice of the forum was published in four (4) Maine newspapers on Sunday, December 14, 2014 and in a fifth newspaper on Monday, December 15, 2014. As indicated in the notice, public comment was elicited through both print and electronic formats and members of the public were told how they could obtain a copy of the statewide Transition Plan.

The Office of MaineCare Services (OMS) also invited formal public comments on the Transition Plan. On December 31, 2014, OMS provided legal notice of a public hearing and an opportunity to submit formal comments by publishing legal notice in five major newspapers and posting an announcement on the OMS' Policies and Rules webpage. The published notice provided a link to the OMS webpage for obtaining a copy of the Transition Plan and for submitting public comments.

Persons visiting the OMS webpage could download a copy of the draft Transition Plan, a graphical representation of the Transition Plan, and obtain information for viewing a copy of the Transition Plan at any of the Department’s regional offices or, obtaining a printed copy from OMS. The draft Transition Plan was posted on the Office of MaineCare Services Policies and Rules webpage December 31, 2014.

A public hearing complying with Maine’s Administrative Procedures Act (APA) was held January 16, 2015. Testimony from five members of the public was received and recorded. Formal written comments were accepted through January 31, 2015. A total of ten formal written comments were received by the January 31, 2015 deadline.

• Please include a date specific on when regulations, policies, standards, certifications and procedures will be reviewed against the HCBS Regulations to determine sufficiency. This should be done within 6 months of posting the transition plan.

Response-These reviews are in progress and changes are being made to Maine’s regulations and policies to come into compliance with the HCBS Regulations. The State anticipates that the regulations that are in compliance with the HCBS Regulations will be effective 1/1/16.

• Please provide a list of waiver specific HCBS settings types, and whether or not they meet the HCBS qualities.

Response-

Services under this waiver are provided in the following settings:

Residential Settings Non-Residential Settings
• Own Home or apartment
• Group homes
• Family-Centered Support Homes
• Shared Living
• Private Non-Medical Institutional Service Settings • Community settings
• Work settings
• Center-based community supports
• Small group work settings

The State has determined that compliance is possible in all settings in which services are provided under this waiver based on the State’s preliminary assessment. Implementation of the transition plan will entail further assessments, including a provider self-assessment survey, and a sample of on-site surveys, to determine what changes, if any, need to be made for each setting to meet the HCBS standards.

• Please indicate how settings were or will be evaluated to determine whether or not they meet the qualities. How will these findings be validated? What is the process and the sample size?

Response-The State has conducted a preliminary assessment based on an analysis of policy and key informant interviews. The State believes that all settings are in compliance or may be brought into compliance with modification based on this preliminary assessment. To confirm, the State will conduct a provider self-assessment survey. The State will conduct follow-up onsite surveys for 100% of all settings identified as presumed disqualified. For all other settings, we anticipate that the total number sampled will be five percent. The exact sampling methodology for all other settings will be guided by CMS, stakeholders, and researchers, balanced against available resources. The provider self-assessment survey and the onsite survey will be developed with input from stakeholder advisory groups.

• Please include the State’s remediation strategy for settings that do not meet the HCBS qualities.

Response-The State anticipates the all settings under this waiver can be brought into compliance with changes in policy, practice and training. Implementation of the Transition Plan will involve ensuring that policy, practice and training are in compliance. The State will also modify our verification systems to assure ongoing compliance.

• Please include a date specific by which all settings are expected to come into compliance, or be determined not to meet the qualities.

Response-The State anticipates that the provider self-assessment survey and the subsequent onsite surveys will prompt corrective action for individual settings, on a case-by-case basis. The State anticipates full implementation of revised policy and procedures and related training by June 30, 2018. The State anticipates these trainings will begin January 1, 2016 and will be ongoing at least through June 30, 2018.

• By which date will the State include a more comprehensive, detailed waiver specific transition plan?

Response-In accordance with the processing of the state-wide Transition Plan, the State will respond with a more detailed waiver specific transition plan.

• CMS is concerned that the training and education of providers on the new HCBS regulations and accompanying state policies will not take place until 2018. Please explain.

Response- The State has already conducted education and outreach on the requirements of the new HCBS rules through a number of webinars and community forums conducted in 2014. The State will continue to make these resources available through its website and will continue to conduct education and outreach as part of its ongoing communication related to implementing the transition plan, the provider self-assessment survey and the onsite survey. In addition, once the state has completed its provider self-assessment survey and onsite surveys, and used that information to develop revised policy and procedures, we anticipate that we will need to develop and implement trainings targeted to culture and practice change that are more nuanced and intensive than our other outreach and educational activities. We anticipate these trainings will take place between January 1, 2016 and June 30, 2018.

• Please include a summary of comments received and a disposition of those comments (whether they were used to update the transition plan) to be included in the HCBS Transition Plan Attachment section.

Response-
A Summary of Comments and the Department’s Response from page 47 of the State-Wide Transition Plan.
Below summarizes all informal and formal questions and written comments submitted in December and January, as well as all testimony made at the January 16, 2015 public hearing. The Department’s response indicates any changes made to the Transition Plan in response to the comments.

General Comments on Transition Plan
Comment: One commenter noted that while Maine has been in the forefront of promoting community-based services and supports for people with intellectual disability or autism there can always be improvement. This commenter embraced
change. Another commenter noted that it is laudable that the Department has acknowledged that significant change needs to happen. This commenter noted that despite numerous laws many persons accessing HCBS do not experience genuine community settings or lifestyles. This commenter noted that while many embrace the rhetoric of person-centered services, many services continue to be segregated, secluded, discriminatory and counter to the goals of individualized supports. (3, 5)

Response: The Department appreciates these commenters’ recognition of Maine’s commitment to HCBS. Like other states, Maine must ensure that the HCBS services created to replace institutional services meet the objectives of HCBS programs, the Americans with Disabilities Act and other protections and services for individuals with disabilities. The new HCBS rules were written to ensure that HCBS meet a minimum standard for ensuring autonomy, choice, access to the community, and other qualities that people without disabilities expect in their lives. While the Department still needs to gather information about current settings and practice, the Department anticipates that the new HCBS rules will lead to significant changes in current practice for at least some providers. (No change was made to the Transition Plan in response to these comments.)

Comment: Another commenter requested that the Department clarify that we have applied the HCBS standards to all of Maine’s waivers.

Response: The Department acknowledges that the new rules apply to all Maine’s waiver programs. It was not the intent of the Department to imply that any of the waivers are exempt from these requirements. This commenter assumes that a review of policy and program elements for the other waivers did not occur. This is not a correct assumption. A review did occur and technical changes were identified as being necessary as part of our preliminary assessment. (We have modified the Transition Plan to clarify that we have applied the HCBS standards to all of Maine’s waivers.)

Comment: A commenter expressed concern that the Department was trying to create an exception that does not exist. This commenter believes the Department was suggesting that the settings rules do not apply to services not provided in a provider-owned or controlled setting.

Response: The Department acknowledges that the HCBS rules apply to the settings in which HCBS services are provided. However, the HCBS rules also allow the Department to presume an individual’s own home or the home of a family member in which the individual resides is compliant with the settings standards. (No change was made to the Transition Plan in response to this comment.)

Comment: While the waiver application for Section 18 was submitted after the effective date of the rule there is no information contained within the application to suggest how Section 18 complies or how it will comply with the rule. There was no indication of what entity determined Section 18 was in compliance with the new rules. Another commenter questioned the appropriateness of assuming that new waivers meet HCBS standards (2, 9).

Response: While CMS has allowed states to develop a Transition Plan for existing waiver programs, starting with the effective date of the new HCBS rules, all new waivers must be found to be in compliance before CMS will approve them. The Brain Injury waiver was approved May 6, 2014, after the effective date of the new rules. The fact that CMS approved the waiver indicates that CMS found this waiver to be in compliance. The Department is required to operate the waiver program in compliance with this CMS-approved waiver. Section 18 is not inconsistent with the approved waiver and, in fact, incorporates language directly from the approved waiver and the new HCBS standards. (No change was made to the Transition Plan in response to this comment.)

Comment: One commenter expressed concern that Sections 18 and 20 do not address how an individual's rights will be ensured or how a setting is required to optimize initiative, autonomy and independence. (9)

Response: Because Department staff are able to play a central role in the person-centered planning process for these waiver programs, we are able to ensure that individualized services optimize individual initiative, autonomy and independence. Because these waiver programs are currently very small, Department staff are also able to provide technical assistance on how to comply as well as monitor compliance on an individualized basis. The Department plans to formalize these verification systems during the implementation phase, to ensure that, as these waiver programs increase in size, compliance is ensured on a more systematic basis. Members also have a right to an administrative hearing under the MaineCare Benefits Manual. (No change was made to the Transition Plan in response to this comment.)

Comment: One commenter expressed concern that Section 19 does not address how an individual's rights will be ensured. This commenter suggests that the Department explicitly incorporate rights into the regulations. (9)

Response: Currently, licensing regulations for adult day centers address the individual rights required under the HCBS
rules. Adult day programs are required to protect the rights of each consumer including the right to be free from interference, coercion, discrimination or reprisal for exercising rights. Each individual has the right to personal privacy for medical treatment, personal care and telephone conversations, the right to be free from physical and chemical restraint for purposes of punishment or to accommodate needs of staff, and the right to voice grievances. (See 10-144 CMR Ch. 117, §7.2.) (No change was made to the Transition Plan in response to this comment.)

Comment: One commenter expressed concern that, for the Section 18 (Brain Injury) and Section 20 (Other Related Conditions) waivers, the Department’s assessment of compliance relies largely on waiver applications, not existing rules. This commenter is concerned that waiver participants and direct staff assisting them are unlikely to be aware of standards and encourages the Department to incorporate HCBS rules into the regulations for those waiver programs. (9) Response: The Department agrees that the regulations are more accessible to members and providers and can be used to increase awareness of program standards. The Department believes these regulations do reflect the new HCBS policies. However, we plan to make technical changes to §20 (ORC) that will more clearly indicate the connection between the new HCBS standards and the language in the MaineCare Benefits Manual. (No change was made to the Transition Plan in response to this comment.)

Comment: One commenter expressed concern that the Department appears to have limited its analysis of Section 19 to Adult Day. DHHS should review all Section 19 policies to determine whether they comply with the settings rules. Standards apply to more than the physical location where services are delivered. For example, OADS should examine whether its policies encourage the provision of services in all settings that optimize autonomy and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact. Another commenter questioned the appropriateness of presuming compliance for waivers that disallow provider-owned or controlled housing. Another commenter agreed that the Department had appropriately presumed a member’s own home to be compliant and focus on adult day centers was appropriate. (1, 2, 9) Response: Currently, Section 19 offers services in an individual’s home and in adult day centers. As the commenters note, the Department has assessed compliance for adult day centers. As permitted by CMS, the Department presumes that a member’s private home meets the settings requirements under the new HCBS rules. However, doing so does not foreclose a closer examination of possible enhancements that would optimize access to the community. The Department considers the person-centered planning process an important mechanism for ensuring that individuals receiving services in their home have access to the greater community, as envisioned under the new HCBS rules. As the Department continues to strengthen its person-centered planning process, it will use the person-centered planning process as the vehicle for ensuring that individual’s living at home have the supports they need to access the community. (The Transition Plan was modified to clarify the Department’s intent relative to the person-centered planning process and access to the community for persons living at home.)

Comment: One commenter suggested it was problematic that CMS has not provided the guidance that is necessary to come into full compliance. Guidance has been coming bit by bit and after almost a year since the enactment of the rule. (3) Response: The Department is aware of the challenges of interpreting and applying the HCBS rules and will continue to look to CMS, its technical assistance providers, and CMS’ activity in other states to more fully understand how to achieve full compliance going forward. (No change was made to the Transition Plan in response to this comment.)

Comment: A commenter expressed concern about the amount of state government and private resources that will be required to fulfill the requirements of these federal rules. This commenter believes the provider self-assessment will require an enormous amount of resources. The commenter also notes that following the self-assessment process, there may be a need to redesign service offerings, amend waivers and rewrite policies. This commenter notes that CMS is not providing additional resources to assist with compliance and with all of the other change initiatives underway, this task seems daunting. (3) Response: The Department recognizes that compliance with the new rules may impose new costs on both the Department and providers. However, we do not anticipate the provider self-assessment to be an overly burdensome task for providers. The Department also cautions that it is too soon to know how significant the cost of modifying practice and settings will be. Much more information is needed about settings and provider practice before we can make an estimate. The Transition Plan proposes staggering the implementation process for the new HCBS rules to follow implementation of the SIS, so as not to overwhelm providers, members, and Department staff. (No change was made to the Transition Plan in response to this comment.)

Stakeholder Engagement in Transition Planning Process

Comment: A number of commenters expressed their disappointment about the opportunity for stakeholder involvement in the transition planning process. Commenters expressed concern that the informal comment period in December did not offer an opportunity for meaningful dialogue, especially given the short period of time between the informal release of the draft Transition Plan and the initial public forum, held in December, especially given the complexity and length of the draft Transition Plan. Commenters also expressed their belief that the draft Transition Plan would have been enhanced by stakeholder input. Some stakeholders expressed concern that only a small fraction of those people who use the services are aware of the Transition Plan or able to understand what it says. During the informal comment period, some stakeholders requested a “user friendly” version of the Transition Plan. Some found the plain language version disseminated during the formal comment period to be helpful. One commenter expressed concern that the Transition Plan was difficult to find on the Department’s website. (2, 3, 6, 9, 11)
Response: The Department acknowledges that stakeholder input is a vital ingredient for any successful policy initiative. Those who use and deliver the services can provide valuable insight into how well policy and practice align with program objectives and where improvement is needed. OADS also recognizes the importance of providing information to its members and providers about the new rules but needs to also ensure the accuracy of the information that is being provided. CMS has itself continued to issue new guidance critical to understanding how states can comply with these new requirements. As recently as December 15, 2014, CMS released the further guidance related to its “Settings Requirements Compliance Toolkit”: (1) “HCBS Final Regulations 42 C.F.R. Part 441: Questions and Answers Regarding Home and Community-Based Settings”; and (2) “Exploratory Questions to Assist States in Assessment of Non-Residential Home and Community-Based Service (HCBS) Settings.”

Because of the complexity and breadth of these new requirements, OADS has engaged in a number of different approaches, ranging from webinars to community forums to advisory groups, as described above. (See STAHELDER OUTREACH AND ENGAGEMENT starting on page 6.) While the Department acknowledges that there is always opportunity to improve stakeholder involvement in policy initiatives, we believe these outreach efforts were appropriate for this stage of analysis. As permitted by CMS, the Transition Plan sets forth only a “best estimate” of the settings that are in or out of compliance with the new rules. It also maps out a plan for active stakeholder involvement in designing the process for confirming that initial estimate. As discussed in greater detail below, this process will also involve gathering information and direct feedback from members, families and providers. (No change was made to the Transition Plan in response to this comment.)

Categorization of Settings

Comment: One commenter expressed concern that the Department had made an initial categorization of settings without benefit of input from members, and other stakeholders. (9)
Response: In compliance with CMS’ Transition Plan requirements, Maine has made a “best estimate” of how settings should be categorized. Moving forward, we will actively engage members and other stakeholders in designing the process for determining how to categorize a setting. This process will involve gathering information from members and providers about specific settings. Any decisions about how to categorize specific settings will become part of a revised Transition Plan which will be subject to formal comment from stakeholders. (No change was made to the Transition Plan in response to this comment.)

Comment: One commenter expressed agreement with what she believed to be the Department’s position that it would present evidence for any setting subject to heightened scrutiny. (3)
Response: The Department has not taken the position that, for any setting presumed to be disqualified, it will present evidence to CMS to attempt to overcome that presumption. Based on the information collected during the assessment process, the Department will determine whether there is sufficient evidence that could be submitted to overcome the presumption that the setting is disqualified. For example, we are prepared to submit evidence to CMS seeking to overcome the disqualification presumption for those settings that are co-located with a nursing facility but do not isolate members and otherwise meet HCBS standards. (The Transition Plan was modified to clarify our intent with respect to submitting evidence to CMS.)

Residential Settings

Comment: One commenter requested clarification on whether residential services reimbursed as a Medicaid State Plan Private Non-Medical Institutional (PNMI) service, rather than as a waiver service, were excluded from the Transition Plan. (4)
Response: Even though PNMI providers are reimbursed under the Medicaid State Plan, and are not a service provided under a waiver, CMS has issued guidance which suggests that waiver members must live in settings that comply with the settings requirements of the new rules, regardless of whether they are receiving waiver services in that setting. In particular, in its response to comments on the new HCBS standards, CMS said:

“...[S]ince this authority provides states the opportunity to provide individuals HCBS and not institutional services, individuals receiving 1915(i) State plan HCBS or 1915(k) CFC services must be living in settings that comport with the HCBS setting requirements as set forth in this rule regardless of whether they are receiving HCBS in that residence. This is consistent with CMS’ longstanding policy regarding 1915(c) HCBS.”

The Transition Plan sets forth a “best estimate” assessment of the number of PNMI that provide residential services to waiver participants but the residential services are reimbursed as a Medicaid State Plan service. The Department anticipates that as more information is gathered, the implications of the new HCBS standards for these PNMI will become clearer. (No change was made to the Transition Plan in response to this comment.)

Comment: A commenter noted that the Transition Plan covers state-plan funded residential settings (PNMI) serving waiver recipients but does not address Section 97 policies and practices. The Department should do this analysis and make changes to policy as necessary and work with recipients in those settings. (9)
Response: The Department believes it can adequately regulate the services provided to waiver participants through the waiver document and the regulations governing the waiver program. The regulations governing the practices of PNMI not serving waiver participants are outside the scope of this Transition Plan. (No change was made to the Transition Plan in response to this comment.)

Comment: A commenter shared her experience in accessing an appropriate service mix for her son. This commenter reported that the Department’s decision not to cover group home services for children meant that her son had to move out of...

https://wms-mmdl.cms.gov/WMS/faces/protected/35/print/PrintSelector.jsp 10/26/2018
state in order to receive the appropriate level of services. (6)

Response: The Department thanks this commenter for sharing her experience. The Department notes, however, that the Transition Plan addresses how home and community-based services are delivered but does not address the scope of covered residential services. (No change was made to the Transition Plan in response to this comment.)

Comment: A commenter expressed her belief that home and community-based residential settings should reflect the personal style and preferences of the people who live there; residents should have a key to their home and be able to lock bedrooms and bathrooms for privacy; residents should not be forced to share a room with an unknown or undesired roommate; residents should have the right to freely access and use kitchens, laundry rooms, and other social and domestic areas of the home. (5)

Response: The Department agrees that residential settings should support the member’s privacy, choice, and autonomy consistent with the standards articulated in the new HCBS rules. (No change was made to the Transition Plan in response to this comment.)

Comment: One commenter asked how residential providers will be expected to comply with an individual’s control over personal resources. This commenter sees these standards applying more significantly in cases where a representative payee is not appointed. This commenter acknowledged that the right to have a savings or checking account appears doable. The commenter wondered whether the practice of locking personal spending funds and EBT cards would be challenged. This commenter indicates that this practice is used to prevent theft when multiple staff and other residents may be coming and going. Although the individual theoretically has access to his or her funds at any time, in reality, that individual can only access those resources through the staff member holding the key. This commenter questioned how compliance with the rules will balance the individual’s right to access his or her resources at any time against the provider’s responsibility to prevent theft. (7)

Response: The Department welcomes information about the factors that must be taken into account as we move forward with implementing these new rules. The Department believes that implementation will require much more conversation with both providers and the members receiving services to ensure that members have access to their personal resources, while concerns about preventing theft are also addressed. (No change was made to the Transition Plan in response to this comment.)

Response: The Department welcomes stakeholder engagement in designing the assessment process. The Department has not made any decisions on how it will conduct onsite surveys of specific settings but would like to ensure the information collected is reliable, complete, and unbiased. (No change was made to the Transition Plan in response to this comment.)

Comment: One commenter expressed her belief that adult day centers provide the access to the community that people need personal services. .. (No change was made to the Transition Plan in response to this comment.)

Response: The Department welcomes stakeholder engagement in designing the assessment process. The Department has not made any decisions on how it will conduct onsite surveys of specific settings but would like to ensure the information collected is reliable, complete, and unbiased. (No change was made to the Transition Plan in response to this comment.)

Comment: For all waivers that provide employment supports, OADS should change its policies to ensure that no HCBS employment or work supports will be paid to programs that pay employees subminimum wage. (9)

Response: The Department recognizes that sub-minimum wage does not meet the HCBS definition of “competitive, integrated employment” and will assess all group settings for compliance as part of the verification process. Sections 21 and 29 rule requires that members receiving Work Supports on an individual basis be paid at or above minimum wage. The Department has strengthened the language in rule to require that, for individuals receiving Work Supports in group settings who receive sub-minimum wage, this service must lead to integrated Community-Based employment at or above minimum wage for that individual. In October 2014 career planning was added to Section 21 and Section 29. This service enables members to obtain, maintain, or advance competitive employment or self-employment. As part of an individual’s person-centered planning process, the person must be offered employment as the first and preferred service. The Department also actively engaged in Employment First activities recommending changes to the legislature in this area.

Comment: One commenter expressed her belief that home and community-based day and employment settings should ensure (1) Participation in activities taking place in ordinary community venues (not owned, operated or leased by HCBS providers; such as fitness facilities, parks and recreation centers, libraries, etc.; and during times open to the general public) where members include community members without disabilities (who are not paid HCBS staff) and community members who do not receive HCBS (and who are not paid HCBS staff); (2) the type and range of activities—including educational, recreational, familial, social, faith-based—as part of a meaningful day should be comparable to those in which non-disabled persons of similar age routinely engage; (3) Employment services and job placement should be individually planned and delivered; customized employment but not mobile crews and enclaves; and (4) the terms and conditions of employment—such as wages, benefits, supervision, advancement, and tenure—where employment services are provided must be comparable to those offered to non-disabled workers. (5)

Response: The Department agrees that day and employment settings should support the member’s privacy, choice, and autonomy consistent with the standards articulated in the new HCBS rules. (No change was made to the Transition Plan in response to this comment.)

Comment: One commenter expressed her opinion that “reverse integration” (bringing people without disabilities into a setting) should not be approved as an acceptable strategy for meeting the new HCBS settings regulations. The commenter
stated that this approach has not been found to be an effective means for providing opportunities to seek employment and work in competitive integrated settings, nor engage in community life.

Response: The Department welcomes this comment and recognizes that “reverse integration” may not be the best method for integrating an individual into the community in many cases. At the same time, it may be the best option available in certain contexts (for example, where an individual’s health and welfare would otherwise be compromised) that prevents even greater isolation should the person remain at home without the benefit of this service. Whether and to what degree these settings meet the new HCBS standards will need to be evaluated based on the criteria set forth in the rules. As the Department moves forward with implementing the changes required under the new HCBS rules, we will engage stakeholders in a discussion of the best strategies for integrating individuals into the community, within the context of different settings and programs. (No change was made to the Transition Plan in response to this comment.)

Modifications

Comment: A commenter expressed her interest in the state’s guidance on how to modify the application of the HCBS standards to an individual when health and safety concerns require it. This commenter used the example of modifying the application of the HCBS rule that requires providers not to restrict access to food when an individual has dietary or fluid restrictions. This commenter suggested that there is not adequate room in the person-centered plan to document these issues and that case managers are not adequately trained to facilitate these conversations. (7)

Response: The Department is committed to ensuring that the protections afforded under the HCBS rules are not undermined by inappropriate modifications to the HCBS standards. At the same time, the Department recognizes the challenges providers face when balancing the protection of individual rights against their responsibility for assuring the health and safety of those they serve. As we move forward with implementing these new rules, we will work closely with key stakeholders to develop training and educational resources designed to educate members and providers about their rights and responsibilities. We will also continue to work with case managers to ensure that they are able to adequately document modifications in the person-centered plan, facilitate conversations on modifications, and ensure ongoing compliance with review and monitoring requirements. (No change was made to the Transition Plan in response to this comment.)

Member Experience

Comment: Several commenters emphasized that when assessing a specific setting for compliance, the assessment process needs to capture the experience of waiver participants receiving services in that setting. One commenter also noted persons who have been limited to primarily isolating experiences are not likely to express dissatisfaction with their services because they will not have a point of comparison. When it comes to eliciting true member experience, this commenter emphasized that the person administering the member experience tool will be as important as the tool itself. (5, 9)

Response: The Department agrees that capturing member experience is a critical element in assuring compliance with the new rules. The Department also agrees that it will be very important to administer the member experience interview so as to capture an accurate and complete picture of patient experience. However, it is important to note that the HCBS rules do not set standards for member satisfaction with services. They have a more objective focus on the facts relating to member experience of services. For example, did the member have access to food? The ability to lock his or her door? Control over his or her personal resources? We recognize that we will still need to design and administer the member experience tool with care. However, we believe some of the concerns raised by this commenter are mitigated by the nature of the information to be gathered. (No change was made to the Transition Plan in response to this comment.)

Member Choice

Comment: One commenter noted that Maine does not provide members a choice to live alone and receive 24/7 support under Section 21. This commenter expressed her view that this is a substantial limitation on choice of residence and leaves the individual at the mercy of their roommate’s status. This commenter noted that Maine regulations instruct service providers to give notice to persons that they must leave a residence when funding stops. For some, this creates a nomadic culture of moving from place to place in an attempt to find a stable roommate. For others who are medically or behaviorally incapable of living with someone else, this requirement can prevent them from having the ability to live safely in the community. (9)

Response: The Department agrees that Section 21 does not allow new placements providing members the option to live alone and receive paid 24/7 supports. The Department recognizes that, in some cases, members will experience disruption in their lives when another member sharing the same home leaves. When these events occur the Department works with each individual to minimize any disruption the remaining member might experience, as the process of identifying another housemate or placement progresses. The Department does not believe that a person who cannot live with someone else is automatically unable to live safely in the community without 24/7 care. The Department agrees that there may be medical or behavioral factors that make living in the community unsafe without 24/7 care. Because the Transition Plan addresses settings not the scope of covered services, this issue is beyond the scope of the Transition Plan. (No change was made to the Transition Plan in response to this comment.)

Comment: One commenter raised the question of the relationship between changes in staffing ratios and the goals of individual flexibility and choice under the HCBS rules and the Transition Plan. This commenter noted that persons requiring more staff need access to the community as much as a person with a lower level of need. (6)

Response: The Department believes the changes in staffing ratios support individual flexibility and choice. A waiver participant has the option of selecting a 1:1 staffing ratio for community supports, depending on the provider’s business decision about the type of services to offer. (No change was made to the Transition Plan in response to this comment.)
Person-Centered Planning
Comment: Several commenters noted that the HCBS rules include new standards for person-centered planning (PCP). They requested the Department address the PCP standards in the Transition Plan. (8, 9)
Response: The Department agrees that person-centered planning is a key component of the new regulations and looks forward to evaluating these processes as a component of its transition planning work across the waivers. However, CMS has notified states that the process of ensuring compliance with the new PCP standards may not be included in the Transition Plan. The Department will continue to strengthen the PCP process under a coordinated but separate initiative. Our goal is to provide robust person-centered planning across all waivers while still recognizing and identifying program differences that should be preserved to meet each population’s distinct need. (The Transition Plan was modified to clarify the relationship between the HCBS settings standards and the Department’s plans for strengthening PCP across programs).
Comment: One commenter noted that while Maine has already done much to ensure compliance with the PCP requirements under the HCBS rules, this commenter believes that many of the new plans are poor quality and that case managers need more training, particularly as the Department implements the settings standards. This commenter also believes the PCP process has become less about a meaningful, vision planning process than a documentation process. (7)
Response: The Department appreciates the feedback from this commenter and will continue to provide training and technical assistance to case managers to ensure that the PCP process is truly person-centered, in compliance with the Department’s policy and the new HCBS standards. (No change was made to the Transition Plan in response to this comment.)

Stakeholder Engagement
Comment: A number of commenters emphasized the need for active stakeholder engagement during the implementation process. Commenters mentioned the importance of obtaining input from consumers, advocates, and others. Commenters suggested a number of different roles for stakeholders in the implementation process including participating on advisory groups, coordinating the assessments of settings, and developing and conducting field assessments. One commenter also encouraged the Department to engage in an active outreach and education strategy to educate consumers about the new rule, its potentially positive impact on services, and roles that they can play in shaping the transition process. Another commenter asked whether there will be a formal process for commenting on policy and practice changes made during the implementation process. (2, 6, 8, 9, 11)
Response: The Department welcomes comments about the need for active stakeholder engagement. The voices of consumers, family members, and advocates play an important role in making sure policy and program changes are responsive to the needs of those served. As one commenter said, “The deeper the understanding of the issues of those being served, the more likely a system can be created to meet those needs effectively for all involved.” We also recognize the importance of listening to providers who can help us to understand the implications of policy and practice changes and avoid unintended consequences that weaken our delivery system.

In our draft Transition Plan, we have identified the role of stakeholders in the implementation process. Based on comments, we have revised the Transition Plan to clarify our vision for how the stakeholder process will work and the roles and responsibilities of stakeholders and the Department in that process. The Department will convene four working groups who will have responsibility for advising the Department as it moves forward with implementing the Transition Team. The Department will provide support to these advisory groups to ensure that the meetings provide a meaningful opportunity for constructive engagement. The Department will consult with the advisory groups as it develops and conducts the assessment process. The Department will consult with the advisory groups as it develops or modifies existing policies and procedures and verification systems. The Department also agrees that there needs to be active outreach and education to make sure waiver participants understand the implications of these rule changes, including their rights. We expect the process of more systematically engaging stakeholders to begin this spring, in anticipation of beginning the Settings Assessment process over the summer.

Finally, substantive changes to the Transition Plan, waiver application and Department regulations will be subject to a formal comment period, consistent with the Department’s existing administrative procedures. (The Transition Plan was modified to clarify the Department’s plan for stakeholder engagement during the implementation phase.)

The Provider Self-Assessment
Comment: Several commenters made suggestions regarding the procedures for assessing settings. One commenter suggested the Department work with researchers to develop interview questions that will ensure the accuracy and reliability of the survey tool and the data collected. A commenter suggested the Department should include a small but representative stakeholder group in the actual development of the tool and to ensure the tool is reliable, valid and understandable to providers of all service types. A commenter was concerned that the tool needed to be developed with words and concepts that will not rely on the rhetorical language that can distinguish between true community integration and special proms, Special Olympics, and facility-based day programs; real community employment versus segregated work; and real homes versus living in “home-like” environments. The self-assessment must be very clear about what constitutes acceptable settings and experiences under the rule and examples must be provided to illustrate such. Some commenters suggested the Department should not rely solely on provider self-assessments. One commenter suggested that providers are likely to offer too “rosy” a picture of actual integration. (2, 5, 9, 11)
Response: We agree that the survey tool will need to be carefully designed to capture objective rather than subjective measures of compliance. Stakeholders will be actively engaged in guiding the development of the assessment tools and
The Department will work closely with stakeholders to design the assessment process to capture observable, factual data to avoid this problem. (No change was made to the Transition Plan in response to this comment.)

Response: We will conduct onsite surveys for 100% of all settings identified as presumed disqualified. For all other settings, we anticipate that the total number sampled will be five percent. The exact sampling methodology for all other settings will be guided by CMS, stakeholders, and researchers, balanced against available resources. Our proposed sample size was modeled after that used in other states. (The Transition Plan was revised to clarify the Department’s approach to the sampling methodology.)

Comment: One commenter suggested the Department focus its efforts on transitioning individuals from “presumed disqualified” settings rather than “rather than developing protocols by which institutional settings may identify themselves as Community-Based.” (2)

Response: The Department will be conducting site visits for all sites identified as “presumed disqualified” including both those identified as “presumed disqualified” during our preliminary assessment and those identified through the provider self-assessment survey. The Department will not transition persons from a “presumed disqualified” setting until it or CMS concludes that the setting has institutional qualities that cannot be remedied. (No change was made to the Transition Plan in response to this comment.)

Comment: One commenter wanted to confirm that the Department will be making site visits to waiver programs this year to initially determine their level of compliance with the new definitions of home and Community-Based services. This commenter wanted to confirm that site visits would include adult day centers. (4)

Response: The Department can confirm that it will be conducting site visits to validate the provider self-assessment survey and to more closely examine potentially disqualified sites. The timing of the site visits will be driven by CMS approval of our Transition Plan and the process of designing and implementing the site visit protocols. The timing is also likely to vary across types of settings, driven by differences in the volume of settings, the length of time involved in tool and protocol development, and stakeholder guidance and input. (No change was made to the Transition Plan in response to this comment.)

Education and Training

Comment: One commenter recommended that the Transition Plan be more fully developed to include education, mentoring, and resources to achieve provider transformation, expanded to include education for new providers and employees, people with disabilities, families, Boards of Directors, and community partners. The training should provide information on “how” and “why” change is necessary. Training should focus how to customize employment, how to build relationships with typical community members, how to make home ownership a reality for people with significant intellectual disabilities. A simple redefinition or relabeling of the status quo with no actual meaningful positive change will not benefit people with disabilities and is not the intent of this landmark CMS settings rule. (5)

Response: The Department welcomes input and suggestions on how to design the education and training needed to implement the new rules. Stakeholders will be actively involved in designing educational and training activities as we move forward with implementation. (No change was made to the Transition Plan in response to this comment.)

Comment: A commenter suggested that the Department expand its proposed case manager training to include all of the HCBS standards. This commenter suggested that the Department offer this or a similar training to waiver participants so that they know their rights under the HCBS rules and what to do if their provider is not complying. (5)

Response: The Department agrees that the quality and independence of the onsite review teams is important to this process. We do not anticipate that members or their family members will be conducting the onsite survey, although we expect that members and their families will have an active role. Capturing member experience of the services provided in a setting will be critical to confirming that the setting complies with those standards focused on member choice, autonomy and other aspects of member experience. (No change was made to the Transition Plan in response to this comment.)

Comment: A commenter encouraged the Department to have mechanisms in place to ensure that onsite review teams are knowledgeable, experienced, independent and capable of providing unbiased reviews. They recommended that the Department not presume any setting meets HCBS rules unless people with disabilities and their families and service providers adequately assess the setting. (9)

Response: The Department agrees that the use of residential agreements will be a significant change both for the unlicensed provider and for the waiver participant. The Department will conduct a training and education campaign to ensure that providers and members understand their rights and responsibilities. (The plan was modified to address member education and training.)
Comment: Several commenters had suggestions and comments on the Department’s plans for formalizing or developing systems for verifying compliance with the new rules. One commenter believes that the plan to develop and implement the verification system is extended too far into the future. This commenter also questioned whether an informal verification system could ensure that reliable and valid results over time and across monitors. This commenter questioned whether it was feasible to add the verification of participant experience to the case manager’s responsibilities, given that case managers are already overextended. This commenter requested that the details for the verification system be developed before the plan is released for formal comment. (11)
Response: We welcome the many comments on the proposed plans for developing verification systems. We appreciate the commenter’s concern that the verification systems will take some time to develop. However, implementation of the Transition Plan will require the development of tools and new procedures. It would be premature to develop systems to monitor practices and procedures that have not been developed yet. We also appreciate the commenter’s concern about adding to the case manager’s responsibilities. We recognize that the scope of responsibility for case managers is already significant but also believe that we need to leverage the professional skills and contact that case managers have with their clients as part of the verification process. We expect the role of case managers in the verification process to be an ongoing topic of discussion both internally and with our external stakeholders. The details of the verification system could not be developed prior to putting the Transition Plan out for formal comment. The proposed approach for building a verification system is subject to revision during the implementation phase. During the implementation phase, a wide range of stakeholders will be involved in designing the verification systems, including case managers. We anticipate that the optimal approach to verification will emerge through this process. (No change was made to the Transition Plan in response to this comment.)
Comment: One commenter recommended that the Department expand developmental services grievance process to include all HCBS waiver programs. This commenter indicated that because individuals receiving services are in the best position to inform the Department if the services they receive are not in compliance with the HCBS rules, the best way to capture that kind of information would be through a robust grievance process. (9)
Response: We welcome suggestions on verification systems and agree that members provide valuable insight and need to have a role in identifying areas of noncompliance. However, while a grievance process can be a useful mechanism for identifying and addressing problems, the Department does not agree that expanding the developmental services grievance process is the most effective or efficient way to formalize a verification system across waivers. We believe a more systematic approach to assessing participant experience is necessary. (No change was made to the Transition Plan in response to this comment.)
Comment: One commenter noted that the Department is planning to eliminate group residential services as a covered service under §32, the Children’s Services waiver. This commenter believes eliminating this option hurts families that may desperately need such a service, potentially creating a huge strain on family members. This commenter believes that eliminating group homes for children is inconsistent with the “flexibility” intended by the new HCBS standards. This commenter suggests that the Department consider allowing occasional “group home” exceptions. (6)
Response: The Department values the role of family caregivers and recognizes the importance of supports and services that strengthen the family caregiver role. However, that the Transition Plan focuses on ensuring that settings comply with the HCBS standards, not the scope of covered services under the waiver program. (No change was made to the Transition Plan in response to this comment.)
Comment: The commenter disagrees with the Department’s note that “implementation of the SIS is well aligned with the new HCBS rules, providing the waiver participant with greater flexibility and choice.” This commenter identifies the expansion of community-based services and the inclusion of new services such as career planning and assistive technology as positive attributes of the Department’s plan for implementing the SIS. However this commenter believes that the Department’s plan for reimbursing community and work supports does not honor the choices of many individuals not to participate in day activities for reasons related to personal preference, retirement, etc. This commenter believes that the resulting cuts to Home Supports will be so great that the proposed changes will have the effect of isolating individuals, counter to what the new HCBS standards are trying to accomplish. This commenter believes that reductions in staff resulting from the changes will mean there is only one staff on shift in a home of 3 or 4 residents, This commenter is concerned that these changes may limit each member’s independence, freedom of movement, privacy, community activities, etc. (7)
Response: The Department disagrees with this commenter’s assessment of the impact of the SIS on member independence, choice, and access to the community. (No change was made to the Transition Plan in response to this comment.)

Please note, over flow of a copy of the notice and list of commenters and changes based on comment are in section B.
The state assures that the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Here is a copy of the actual notice that went in papers and online.

Notice of Agency Hearing
AGENCY: Department of Health and Human Services, MaineCare Services
RULITITLE OR SUBJECT: Home and Community-Based Services Transition Plan

CONCISE SUMMARY: The Centers for Medicare and Medicaid Services (CMS) has implemented new rules governing Medicaid-funded Home and Community-Based Services (HCBS) authorized under §1915(c), §1915(i) and §1915(k) of the Social Security Act. The new rules set standards for person-centered planning, conflict-free case management, and the settings in which HCBS is provided. The rules became effective March 17, 2014. For the standards that apply to HCBS settings, DHHS must submit a “Transition Plan” to CMS. The Transition Plan must document compliance with the rules and develop a plan for addressing noncompliance. DHHS is required to seek public input on the draft Transition Plan which is posted at the website listed below. DHHS invites the public to comment on whether this document accurately represents the status of Maine’s HCBS programs and services and to provide input on our plan for addressing areas of noncompliance.


PUBLIC HEARING:
January 16, 2015, 9:00 am-12:00 pm
Location: Conference Room # 110
Department of Health and Human Services
19 Union Street
Augusta, ME

The Department requests that any interested party requiring special arrangements to attend the hearing contact the agency person listed below before January 10, 2015.

DEADLINE FOR COMMENTS: Comments must be received by midnight, Saturday, January 31, 2015

AGENCY CONTACT PERSON: Ginger Roberts-Scott
Children’s and Waiver Services Program Manager

AGENCY NAME: MaineCare Services
ADDRESS: 242 State Street
11 State House Station
Augusta, Maine 04333-0011

Email: Ginger.roberts-scott@maine.gov
TELEPHONE: 207-624-4048 FAX: (207) 287-1864 TTY: 711

A list of commenters and changes to the transition plan

Reference Number Name Organization, If Identified Written Informal Comments Public Testimony (January 16, 2015)
Submitted Written Formal Comments
1 Leo Delicata Legal Services for the Elderly
2 Rachel Dyer Maine Developmental Disabilities Council
3 Mary Lou Dyer Maine Association for Community Support Providers
4 Rick Erb Maine Health Care Association
5 Gail Fanjoy KFI
6 Kim Humphrey
7 Jen Jello Support Solutions
8 Pam Marshall Long Term Care Ombudsman Program
9 Katrina Ringrose Disability Rights Center
Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (select one):
   - The waiver is operated by the State Medicaid agency.
   - Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.

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

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

Specify the unit name:

(Do not complete item A-2)

2. **Summary of Changes to Transition Plan Made in Response to Comments**

In response to the comments we received, we have made several clarifications and substantive changes to the Transition Plan. These include:

- Clarifying that we have applied the HCBS standards to all of Maine’s waivers.
- Clarifying the relationship between the HCBS settings standards and the Department’s plans for strengthening the person-centered planning process and access to the community for persons living at home. Although any modification to the person-centered planning process made under this Transition Plan will only be incidental to complying with HCBS settings standards, the Department plans to continue to strengthen person centered planning across programs.
- Clarifying our intent with respect to submitting evidence to CMS for those settings presumed to be disqualified. The Department is not committed to submitting evidence for all settings presumed disqualified; only those that we believe do not isolate and can comply with the HCBS standards, with or without modification to the setting or provider practice.
- Recognize that, while only a small subset of Maine’s adult day centers serve waiver participants, which adult day centers are serving waiver participants can change from time to time. We have modified the Transition Plan to expand the provider assessment process to include all adult day centers.
- Modified the Transition Plan to more clearly articulate a stakeholder process that incorporates stakeholder input throughout the implementation phase.
- Revised the Transition Plan to incorporate the input of multiple parties in designing the sampling methodology.
- Expanded the reach of training programs to include members and others as appropriate.
- Corrections relating to data for, and the characterization of, Work Support settings.
- Updates for enrollments under §18 (Brain Injury) and §20 (ORC).
- Extended timelines for rulemaking, amending waivers, etc., to reflect more realistic timelines.

Other Changes to Transition Plan

In addition to the changes made in response to public comments, the following changes were made in response to corrections and comments of Department staff:

- The addition of a plain language explanation of the Transition Plan as well as a graphic representation of the Transition Plan.

**Summary of Changes to Transition Plan**

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**Appendix A: Waiver Administration and Operation**

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

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

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

Specify the unit name:

(Do not complete item A-2)

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

Specify the division/unit name:

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

### Appendix A: Waiver Administration and Operation

#### 2. Oversight of Performance.

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

a. The Office of Aging and Disability Services establishes waiver eligibility and enrolls participants' individual plans

*establishes relationship between the Department and waiver providers for waiver services*

*authorizes service utilization based on participant' individual plans*

b. the document used to outline roles and responsibilities related to the operation of the waiver is Chapter 101, MaineCare Benefits Manual, Section 29, Chapters II and III.

c. the Office of MaineCare Services:

*has primary responsibility for development and promulgation of state policy that governs the program and reimbursement for the waiver*

*coordinates, reviews and approves communication with CMS*

*submits required and requested submissions and reports to CMS; e.g. waiver applications, 372 reports, RAI's*

*manages provider enrollment in the MaineCare program*

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

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

### Appendix A: Waiver Administration and Operation

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

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

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

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

  The Department of Health and Human Services contracts with Molina Health Care for MMIS Services.

  The Department of Health and Human Services contracts with Kepro Health Care for prior authorization for
services.

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

Appendix A: Waiver Administration and Operation

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

- Not applicable
- Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.
  Check each that applies:
  - **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

   - The Office of MaineCare Services has a dedicated position to manage the contract with the Transportation Brokers for the Me.19 NEMT Transportation waiver.
   - The Office of MaineCare Services has a contract manager for the Molina (MMIS) contract.
   - The Office of MaineCare Services has a contract manager for the KePro contract.

Appendix A: Waiver Administration and Operation

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

   - For Transportation Services Performance Measures included in the 1915b waiver (ME.19) outline the specific methods and functions.
For the Molina (MMIS) contact there is a service level agreement that is reviewed on a regular basis and is tracked and monitored monthly.

For the KePro (prior authorization) contract, the contractor submits quarterly performance standard reports measuring performance indicators. If indicators are not met, payment is reduced according to the contract standards.

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

   i. Performance Measures

      For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:
Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
Equitable distribution of waiver openings in all geographic areas covered by the waiver
Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
Percent of waiver providers who have a current executed provider agreement.
Numerator: Total number of waiver providers with a current executed provider agreement. Denominator: Total number of waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Provider Enrollment

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
<td>100% Review</td>
</tr>
<tr>
<td>Operating Agency</td>
<td>Monthly</td>
<td>Less than 100% Review</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
<td>Representative Sample</td>
</tr>
<tr>
<td>Other Specify:</td>
<td>Annually</td>
<td>Stratified Describe Group:</td>
</tr>
<tr>
<td>Other Specify:</td>
<td>Continuously and Ongoing</td>
<td>Other Specify:</td>
</tr>
<tr>
<td>Other Specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

b. Methods for Remediation/Fixing Individual Problems
   i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
   The State Medicaid Agency operates a provider relations unit to address and solve any concerns or problems that may arise with processing claims. Providers will contact their provider relations specialist if the provider experiences any problems with claims processing. The provider relations specialist assists with claims research to identify the specific problem. All contact between the provider relations specialist and the provider is documented in the State Medicaid Agency’s MMIS.

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

<table>
<thead>
<tr>
<th>Responsible Party for data aggregation and analysis (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
<td>Weekly</td>
</tr>
<tr>
<td>Operating Agency</td>
<td>Monthly</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Other</td>
<td>Annually</td>
</tr>
<tr>
<td>Specify:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continuously and Ongoing</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>Specify:</td>
</tr>
</tbody>
</table>
c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No
- Yes

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

Appendix B: Participant Access and Eligibility

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

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

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Included</th>
<th>Target SubGroup</th>
<th>Minimum Age</th>
<th>Maximum Age</th>
<th>No Maximum Age Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged or Disabled, or Both - General</td>
<td></td>
<td>Aged</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disabled (Physical)</td>
<td></td>
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<td></td>
<td></td>
<td>Disabled (Other)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged or Disabled, or Both - Specific Recognized Subgroups</td>
<td></td>
<td>Brain Injury</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medically Fragile</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technology Dependent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intellectual Disability or Developmental Disability, or Both</td>
<td></td>
<td>Autism</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Developmental Disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intellectual Disability</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td></td>
<td>Mental Illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Serious Emotional Disturbance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Participants live with their family or on their own.
To be eligible for this waiver under "Autism" participants may also meet the following criteria:
- Rett's Disorder (299.80/F84.2)
c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (select one):

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

Specify:

Appendix B: Participant Access and Eligibility

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

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (select one). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- No Cost Limit. The State does not apply an individual cost limit. Do not complete Item B-2-b or item B-2-c.
- Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. Complete Items B-2-b and B-2-c.

The limit specified by the State is (select one)

- A level higher than 100% of the institutional average.
  Specify the percentage: 

- Other
  Specify:

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

- Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

The cost limit is not to exceed 50% of the ICF/IID cost. The basis of the limit is based upon analysis of claims data that demonstrates this is an ample amount to ensure that member have all of the services that they need.
under this waiver.
If a participant's need for assurance of health and welfare exceeds what's available under this waiver, he/she would be referred to the #0159 waiver. State plan services are also available to participants. Personal Plans are entered in to the EIS system which tracks waiver authorizations and expenditures to ensure the limit is uniformly applied to all members. Waiver participants receive a combination of waiver services and state plan services to ensure their health and safety are assured.

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

- The following dollar amount:
  Specify dollar amount: 
  
- The dollar amount (select one)
  - Is adjusted each year that the waiver is in effect by applying the following formula:
    Specify the formula:
    
  - May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
  
  - The following percentage that is less than 100% of the institutional average:
    Specify percent: 50

- Other:
  Specify:

  
**Appendix B: Participant Access and Eligibility**

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

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

The person centered planning process identifies the specific services required and the number of units of each service. In the event cost limitations result in the denial of entry to this waiver, the individual will be offered the opportunity for a Fair Hearing, in accordance with the MaineCare Eligibility Manual and the MaineCare Benefits Manual.

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

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.
Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ Other safeguard(s)

Specify:

Either one or a combination of the strategies below will be used if a participant’s needs exceed what is available within this Waiver:

• be referred for services in Maine’s #0159 waiver that can accommodate the individuals needs
• be referred for consideration of ICF-IID
• receive state funded services
• receive a combination of other MaineCare state plan services

Appendix B: Participant Access and Eligibility

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

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>2078</td>
</tr>
<tr>
<td>Year 2</td>
<td>2150</td>
</tr>
<tr>
<td>Year 3</td>
<td>2635</td>
</tr>
<tr>
<td>Year 4</td>
<td>2635</td>
</tr>
<tr>
<td>Year 5</td>
<td>2635</td>
</tr>
</tbody>
</table>

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

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

☐ The State limits the number of participants that it serves at any point in time during a waiver year.

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

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Maximum Number of Participants Served At Any Point During the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>1850</td>
</tr>
<tr>
<td>Year 2</td>
<td>2000</td>
</tr>
<tr>
<td>Year 3</td>
<td>2470</td>
</tr>
<tr>
<td>Year 4</td>
<td>2470</td>
</tr>
<tr>
<td>Year 5</td>
<td>2470</td>
</tr>
</tbody>
</table>
Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- The waiver is not subject to a phase-in or a phase-out schedule.
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. **Allocation of Waiver Capacity.**

*Select one:*

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

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

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

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 for Family Independence (OFI), and 3) the availability of a funded opening.

Individuals apply for this benefit with the assistance of the Case Manager. Based on review of the Assessment Referral Form and the member’s Personal Plan, a Qualified Intellectual Disability Professional designated by DHHS (the Waiver Manager for Developmental Services) determines the individual’s medical eligibility for services under this Section. DHHS notifies each individual or the individual’s guardian in writing of any decision regarding the individual’s medical eligibility, as well as the availability of openings under this benefit.

If there are no funded openings, the State maintains a Waiting List for this benefit. The MaineCare Benefits Manual Ch. II, Section 29 defines the Waiting List protocol. Individuals who are on the waiting list for the benefit services shall be served chronologically based on the date the Waiver Manager determines eligibility for the waiver.

When there is a funded opening available, the Waiver Manager sends a letter to the individual or the individual’s guardian. The individual or the member’s guardian has 60 days to accept or decline the benefit. The individual or the individual’s guardian submits a signed choice letter documenting the decision to receive services under this benefit. If there is no response, the individual will be removed from the waiting list.
Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **State Classification.** The State is a *(select one)*:
   - §1634 State
   - SSI Criteria State
   - 209(b) State

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - No
   - Yes

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

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

   - [ ] Low income families with children as provided in §1931 of the Act
   - [ ] SSI recipients
   - [ ] Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
   - [ ] Optional State supplement recipients
   - [ ] Optional categorically needy aged and/or disabled individuals who have income at:
     - [ ] 100% of the Federal poverty level (FPL)
     - [ ] % of FPL, which is lower than 100% of FPL.

     Specify percentage: __________

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

- Other Caretaker Relatives as specified in §435.110
- Pregnant Women as specified in §435.116
  and
- Children as specified in §435.118

**Special home and community-based waiver group under 42 CFR §435.217**

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:
  
  Select one:
  
  - 300% of the SSI Federal Benefit Rate (FBR)
  - A percentage of FBR, which is lower than 300% (42 CFR §435.236)

  Specify percentage: __________
  
  - A dollar amount which is lower than 300%.

  Specify dollar amount: __________

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:
  
  Select one:
  
  - 100% of FPL
  - % of FPL, which is lower than 100%.

  Specify percentage amount: __________

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

  Specify:
Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- The following standard included under the State plan
Select one:

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

*(select one):*

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

- A dollar amount which is less than 300%.
  
  Specify dollar amount: __________

- A percentage of the Federal poverty level
  
  Specify percentage: __________

- Other standard included under the State Plan
  
  Specify: __________

- The following dollar amount
  
  Specify dollar amount: __________ If this amount changes, this item will be revised.

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

- Other
  
  Specify: __________

---

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

- Not Applicable (see instructions)
- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The following dollar amount:
Specify dollar amount: [ ] If this amount changes, this item will be revised.

○ The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

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

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

○ The amount is determined using the following formula:

Specify:

○ Other

Specify:

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

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

Select one:

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

Specify:
Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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


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

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

- The following standard included under the State plan

Select one:

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

(select one):
300% of the SSI Federal Benefit Rate (FBR)

- A percentage of the FBR, which is less than 300%
  - Specify the percentage: 
- A dollar amount which is less than 300%.
  - Specify dollar amount: 
- A percentage of the Federal poverty level
  - Specify percentage: 
- Other standard included under the State Plan
  - Specify:
  - The following dollar amount
  - Specify dollar amount: If this amount changes, this item will be revised.
- The following formula is used to determine the needs allowance:
  - Specify:
- Other
  - Specify:
  
ii. Allowance for the spouse only (select one):
  - Not Applicable
  - The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:
  - Specify:
  
Specify the amount of the allowance (select one):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The following dollar amount:
Specify dollar amount: [ ] If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

  **Specify:**

  The state is following the rule in Section 2404 of the ACA. The WMS would not validate with the radial button Not Applicable checked off.

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

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

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

- **The amount is determined using the following formula:**

  Specify:

  - Other

    Specify:

    [ ]

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

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

Select one:

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

  Specify:

  [ ]

---

Appendix B: Participant Access and Eligibility

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

Appendix B: Participant Access and Eligibility

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

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


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

i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage: 

- The following dollar amount:

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

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

Specify formula:

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

- Allowance is the same
- Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

   i. Minimum number of services.

   The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (select one):
Directly by the Medicaid agency
By the operating agency specified in Appendix A
By an entity under contract with the Medicaid agency.

Specify the entity:

Both OADS and the case manager are responsible for performing evaluations and re-evaluations. OADS has the ultimate authority for the evaluations.

Other
Specify:

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

Qualifications:
The person conducting the assessment must meet the standard of Qualified Intellectual Disability Professional as outlined in 42 CFR 483.430(a). Specifically the person “has at least one year of experience working directly with persons with Intellectual Disability or other developmental disabilities” and “be designated as a human services professional meaning having at least a bachelor’s degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).”

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

For level of care determination the State uses the form BMS-99. The form is an assessment of a combination of medical conditions and needs, daily living skills and social adaptive skills.

A case manager assesses the level of support the member needs in each domain. The levels are independent, needs supervision, needs skills training, needs physical assistance, or total care. The domains are Activities of Daily Living (eating, dressing, toileting, bathing, grooming, mobility), Safety (avoidance of physical danger, avoidance of emotional jeopardy, engagement in healthy relationships, judgment regarding personal conduct), Household activities (cooking, laundry), Community Access (shopping, transportation, banking, recreation), Maintain Relationships (family, friends, co-workers, support staff), Health Maintenance (accessing medical care, emergency first aid, accessing mental health care, medication administration), and Communication (expressive communication, receptive communication, sign language, visual-gestural communication).

It is completed annually by case manager or other person knowledgeable of the participant and reviewed/approved by a QIDP.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (select one):

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
- A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

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

The LOC instrument used for the state plan ICF/IID service is the BMS 85, the waiver uses the BMS 99. As the level of care criteria in the state plan for ICF/IID has not changed, the BMS 85 has not been changed. The BMS 99 has not undergone any revision since 1999. The BMS 99 will be used for this Waiver and it has been...
determined that the outcomes resulting from its use are valid, reliable and fully comparable to those of the BMS 85. The BMS 99 is used for both evaluations and reevaluations. In 1999, the state sought input from the clinical division of CMS on the reliability of the instrument to yield similar results as the ICF/IID level of care instrument. CMS determined that similar results were obtained from both instruments. The instruments nor the level of care criteria have not changed since that time.

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

Evaluation: The Case manager submits the Personal Plan, “Choice Letter,” and the BMS-99 assessment form to the QIDP in the DHHS Central Office. The QIDP reviews the information for level of care determination.

Reevaluation: On an annual basis the case manager submits a current Personal Plan and (updated at a minimum annually)assessment form to a QIDP in the District Office of DHHS for reevaluation. Assessments are updated annually at a minimum but more frequently if a major life event has occurred for the member, such as moving, loss of employment or significant medical issues emerge.

The Personal Plan is the plan of care listing the waiver services the member is in need of.
The Choice letter indicates that the member is “choosing” waiver services and remaining in the community over institutionalization. The choice letter is required at the initial evaluation.
The BMS-99 is the level of care instrument indicating medical need.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (select one):

- Every three months
- Every six months
- Every twelve months
- Other schedule
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (select one):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.
  Specify the qualifications:

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

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

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

The Operating Agency and the case manager will maintain these records for a minimum period of three years. Records will be kept at the Central Office Site of DHHS in Augusta, Maine.

Appendix B: Evaluation/Reevaluation of Level of Care
Quality Improvement: Level of Care
As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Percent of initial applications with documentation that an assessment form was submitted and reviewed by QIDP for a level of care determination. Numerator: Total number of initial applications reviewed by QIDP for level of care determination. Denominator: Total number of initial applications.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Information System

<table>
<thead>
<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
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<tr>
<td>[ ] Sub-State Entity</td>
<td>[ ] Quarterly</td>
<td>[ ] Representative Sample</td>
</tr>
<tr>
<td>[ ] Other Specify:</td>
<td>✓ Annually</td>
<td>[ ] Stratified</td>
</tr>
</tbody>
</table>

Confidence Interval =

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

**Performance Measures**

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

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

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

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*
For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of level of care assessments completed by a qualified evaluator as defined in 29.02-23. Numerator: Number of LOCs completed by a qualified evaluator. Denominator: Total number of LOC assessments reviewed.

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

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Data Aggregation and Analysis:

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<td>Monthly</td>
</tr>
<tr>
<td>Sub-State Entity</td>
<td>Quarterly</td>
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</tbody>
</table>
Performance Measure:
Number and Percent of level of care determinations made by using the instrument in the approved waiver. Numerator: Number of level of care determinations made by using the approved instrument. Denominator: Total number of level of care determinations.

**Data Source** (Select one):
Other
If 'Other' is selected, specify:

**Enterprise Information System**

<table>
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<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
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<td>☐ Sub-State Entity</td>
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<tr>
<td>☐ Continuously and Ongoing</td>
<td>☐ Other</td>
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</tr>
<tr>
<td>Specify:</td>
<td>Specify:</td>
<td></td>
</tr>
</tbody>
</table>

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

b. Methods for Remediation/Fixing Individual Problems
   i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

   When the level of care is not completed in a timely manner, appropriate actions are taken through State personnel or community agency staff. For example, if the level of care has not been determined in a timely manner, the participant's eligibility date will expire and providers will not receive payment for any services delivered. If the instrument does not indicate an ICF/IID level of care, then the QIDP will not approve participant's eligibility the applicant and the case manager are notified. All participants have the right to appeal level of care determinations. If the applicant does not meet the level of care threshold it is incumbent upon the case manager and planning team to assist the applicant in obtaining alternate services for which he/she will be eligible.

ii. Remediation Data Aggregation

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

   **Responsible Party (check each that applies):**

   - State Medicaid Agency
   - Operating Agency
   - Sub-State Entity
   - Other
     - Specify:

   **Frequency of data aggregation and analysis (check each that applies):**

   - Weekly
   - Monthly
   - Quarterly
   - Annually
   - Continuously and Ongoing

   **Responsible Party for data aggregation and analysis (check each that applies):**

   - State Medicaid Agency
   - Operating Agency
   - Sub-State Entity
   - Other
     - Specify:

   **Frequency of data aggregation and analysis (check each that applies):**

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

☐ No
☐ Yes
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Prior to participation in this program, all individuals are involved in a planning process. As part of the process this waiver is discussed as a potential source of needed or recommended services. If the waiver appears to be an option, individuals are offered the choice between institutional or waiver services. Their choice is documented on a form the state identifies as a “Choice Letter”. The case manager provides the choice letter to the participant.

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

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

Appendix B: Participant Access and Eligibility

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

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

Interpreter services are available to assist anyone in need of communication assistance. These services can be viewed at http://www.maine.gov/dhhs/interpreting.html. Some services that can be accessed through this office are language interpreter services, refugee and immigration services and advocacy services.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)
a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service</th>
</tr>
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<tbody>
<tr>
<td>Statutory Service</td>
<td>Community Support</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Home Support-1/4 hour</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Respite</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Work Support- Group</td>
</tr>
<tr>
<td>Other Service</td>
<td>Adult Foster Care/Shared Living</td>
</tr>
<tr>
<td>Other Service</td>
<td>Assistive Technology</td>
</tr>
<tr>
<td>Other Service</td>
<td>Career Planning</td>
</tr>
<tr>
<td>Other Service</td>
<td>Employment Specialist Services</td>
</tr>
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<td>Other Service</td>
<td>Home Accessibility Adaptations</td>
</tr>
<tr>
<td>Other Service</td>
<td>Home Support-Remote Support</td>
</tr>
<tr>
<td>Other Service</td>
<td>Non-Medical Transportation</td>
</tr>
<tr>
<td>Other Service</td>
<td>Work Support-Individual</td>
</tr>
</tbody>
</table>

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**Appendix C: Participant Services**

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

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

**Service Type:**

- Statutory Service

**Service:**

- Day Habilitation

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

Community Support

**HCBS Taxonomy:**

- Category 1: Sub-Category 1:

- Category 2: Sub-Category 2:

- Category 3: Sub-Category 3:

- Category 4: Sub-Category 4:

**Service Definition (Scope):**

Community Support is Direct Support provided in order to increase or maintain a member’s ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that 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 may be provided as a center-based program, in the local community, an individual program or a combination of both. Community
Support is available on a daily basis for 1 or more days per week based on the individual’s needs and documented in the service plan. Community Support may be provided in the member’s residence when the individual’s physician determines that providing Community Support in another setting is medically contraindicated.

Community Support is not provided in the participant’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.

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

There is an annual limit on Home Support, Shared Living, and Community Support of $58,168.50. When participants have a need for any combination of these services, there is an annual limit in the total combined expenditure of $58,168.50.

Community Support may not be provided at the same time as Home Support, Shared Living, Career Planning, Work Support, Employment Specialist Services.

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

- [ ] Participant-directed as specified in Appendix E
- [x] Provider managed

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

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

**Provider Specifications:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>OADS approved Provider Agency</td>
</tr>
<tr>
<td>Individual</td>
<td>Independent Contractor</td>
</tr>
</tbody>
</table>

**Appendix C: Participant Services**

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

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

**Provider Category:**

- **Agency**

**Provider Type:**

- OADS approved Provider Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

- Agency employees must hold Certificate of Completion of Maine’s Direct Support Professional Curriculum, have successfully completed the corresponding Assessment of Prior Learning or a certificate from the Maine College of Direct Support.

**Other Standard (specify):**

- Provider Agency must have:
  - * Completed the enrollment process for the "Maine Integrated Health Management System" (MIHMS).
  - * Received additional approval from OADS for provision of waiver services as required in MIHMS.
Provider Agency must assure the following for individual DSP's:
* Minimum age of 18
* DSP's must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program.
* Reportable Events Training 14-197, ch 12
* Behavior Regulations Training 14-197, ch 5
* Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
* Criminal background check
* Current First Aid and CPR Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:
Upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

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

| Service Type: Statutory Service |
| Service Name: Community Support |

Provider Category:
Individual

Provider Type:
Independent Contractor

Provider Qualifications

License (specify):

Certificate (specify):
* Certificate of Completion of Maine’s Direct Support Professional Curriculum maintained by DHHS or a certificate from the Maine College of Direct Support

Other Standard (specify):
Individual must have:
* Completed the enrollment process for the "Maine Integrated Health Management System" (MIHMS)
* Received addition approval from OADS for provision of waiver services as required in MIHMS
* Minimum age of 18
* DSP's must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program.
* Reportable Events Training 14-197, ch 12
* Behavior Regulations Training 14-197, ch 5
* Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
* Criminal background check
* Current First Aid and CPR Certification

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Frequency of Verification:
Upon Enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service  
Residential Habilitation

Alternate Service Title (if any):
Home Support-1/4 hour

HCBS Taxonomy:

Category 1:  
Sub-Category 1:  

Category 2:  
Sub-Category 2:  

Category 3:  
Sub-Category 3:  

Category 4:  
Sub-Category 4:  

Service Definition (Scope):
Home Support is direct support provided to improve and maintain a member's ability to live as independently as possible in his or her home. Home Support (1/4 hour) may be provided in a family home, the participant's home or apartment, or any other living arrangement where intermittent support is needed. Home Support is direct support to a Waiver participant and includes habilitative training and/or personal assistance with ADLs and IADLs, development and personal well-being that is directly related to the participant living independently in his/her home.

This waiver does not provide a self-directed option as does other state plan personal care options, provider qualifications and supervision arrangements also differ between the different services, and training requirements are geared for DSPs under this waiver, whereas training requirements are geared for personal care assistants/personal support specialists in state plan services.

Home supports are authorized separately from community supports based on participant needs. Service plan reviews are conducted to ensure that duplication has not occurred.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Home Support may not be provided at the same time as Community Support, Shared Living, Career Planning, Work Support, or Employment Specialist Services.

There is an annual limit on Home Support, Shared Living, and Community Support of $58,168.50. When participants have a need for any combination of these services, there is an annual limit in the total combined expenditure of $58,168.50.
Service Delivery Method *(check each that applies)*:

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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<th>Provider Category</th>
<th>Provider Type Title</th>
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Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Home Support-1/4 hour

Provider Category: 
Agency

Provider Type:
OADS approved Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certificate of completion Maine's Direct Support Professional Curriculum

Other Standard *(specify):*
Provider Agency must have:
- Completed the enrollment process for the "Maine Integrated Health Management System" (MIHMS)
- Received addition approval from OADS for provision of waiver services as required in MIHMS

Effective January 1, 2020, Provider Agency must comply with Maine DHHS Electronic Visit Verification system standards and requirements.

Provider Agency must assure the following for individual DSP's:
- Minimum age of 18
- DSP's must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program.
- Reportable Events Training 14-197, ch 12
- Behavior Regulations Training 14-197, ch 5
- Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
- Criminal background check
- Current First Aid and CPR Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrollment in the MIHMS is a shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:
Upon enrollment and every three (3) years thereafter.
Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
- Statutory Service

Service:
- Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: Sub-Category 1:

Category 2: Sub-Category 2:

Category 3: Sub-Category 3:

Category 4: Sub-Category 4:

Service Definition (Scope):
Services provided to participants who are unable to care for themselves that are furnished on a short term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite may be provided in the participant's home or other location as approved by a respite agency or DHHS; ex. motel in case of emergency.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Expenditures for this service may not exceed $1,224.60 per year.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:
Appendix C: Participant Services

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

<table>
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### Service Type: Statutory Service

### Service Name: Respite

#### Provider Category:
- Individual

#### Provider Type:
- Individual

#### Provider Qualifications

**License** *(specify):*

**Certificate** *(specify):*

Certification as a Direct Support Professional. The requirements of a DSP are as below:

Direct Support Professional (DSP) is a person who has successfully completed the Direct Support Professional curriculum as adopted by DHHS, or DHHS’s approved Assessment of Prior Learning, prior to July 1, 2010 or has successfully completed the Maine College of Direct Support.

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

Effective January 1, 2020, individuals providing respite in the home must comply with Maine DHHS Electronic Visit Verification system standards and requirements.

All DSP staff must:

* Have a background check consistent with MaineCare Benefits Manual Section 29.10-4;
* Have an adult protective and child protective record check;
* Be at least eighteen (18) years of age; and
* Have graduated from high school or acquired a GED

*Reportable Events Training 14-197, ch 12
*Behavior Regulations Training 14-197, ch 5
*Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
*background check
* current First Aid and CPR Certification

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

**Frequency of Verification:**

Upon enrollment and every three (3) years thereafter.

---

**Appendix C: Participant Services**

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

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<td>OADS approved Provider Agency</td>
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</table>

Service Type: Statutory Service

Service Name: Respite

Provider Category:
- Agency

Provider Type:
OADS approved Provider Agency

Provider Qualifications

License (specify):

Certificate (specify):
A staff person providing respite must have a certificate as a Direct Support Professional (DSP) is a person who has successfully completed the Direct Support Professional curriculum as adopted by DHHS, or DHHS's approved Assessment of Prior Learning, prior to July 1, 2010 or has successfully completed the Maine College of Direct Support.

Other Standard (specify):
Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).
* Received addition approval from OADS for provision of waiver services as required in MIHMS.

Effective January 1, 2020, a Provider Agency providing respite in the home must comply with Maine DHHS Electronic Visit Verification system standards and requirements.

Provider Agency must assure the following for individual DSP's:
* Minimum age of 18
* Staff must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program
* Reportable Events Training 14-197, ch 12
* Behavior Regulations Training 14-197, ch 5
* Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
* Criminal background check
* Current First Aid and CPR Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:
Upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):
Work Support- Group

HCBS Taxonomy:

Category 1: Sub-Category 1:
Work Support is Direct Support provided to improve a participant’s ability to independently maintain employment. Work Support is provided at the participant’s place of employment; it may be provided in a participant’s home in preparation for work if it does not duplicate services already reimbursed as Home Support. Work Supports group are services and training activities that are provided in regular business, industry and community settings for groups of two to six participants. Mobile work crews, and business based workgroups (enclaves) employing small groups of workers in employment in the community are examples of the models allowed. Work Supports must be provided in a manner that promotes the integration into the workplace and interaction between participants and people without disabilities in those workplaces. The primary focus of the support job related and also encompasses adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care. This service is provided after a participant has received an assessment and services under the American with Disabilities Act, Section 504 of the Rehabilitation Act and need for on-going support has been determined and documented in the Personal Plan. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community based employment for which the participant is compensated 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 individuals without disabilities. Work Support does not include vocational services provided in a facility based work setting in specialized facilities that are not part of the general workforce. Information must be provided to the participant at least yearly that career planning and individual employment is available to them in order to make an informed decision.

Work Support does not include volunteer work. Sub-minimum wage is only allowed in this service if the employer complies with 14c of the Federal Fair Labor Standards Act and Title 26 Section MRSA 666.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual’s supported employment program.

The cost of transportation related to the provision of Work Supports is a component of the rate paid for the service.

The Ticket to Work Program (TTW) and Milestone payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided since payments are made for outcome, rather than for a Medicaid service rendered.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Work Support may not be provided at the same time as Community Support, Career Planning, Home Support, Employment Specialist Services or Shared Living.

Service Delivery Method (check each that applies):

- [ ] Participant-directed as specified in Appendix E
- [x] Provider managed
Specify whether the service may be provided by (check each that applies):

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

Provider Specifications:

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<th>Provider Category</th>
<th>Provider Type Title</th>
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<td>Individual</td>
<td>Work Support Professional</td>
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</table>

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Work Support- Group

Provider Category:

- [ ] Agency

Provider Type:

OADS Approved Supported Employment Agency

Provider Qualifications

- License (specify):
- Certificate (specify):
  Certificate of completion Maine’s Direct Support Professional Curriculum
- Other Standard (specify):
  Provider Agency must have:
  * Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS)
  * Received addition approval from OADS for provision of waiver services as required in MIHMS
  Provider Agency must assure the following for individual DSP's:
  * Minimum age of 18
  * Staff must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program.
  * Must have completed the additional employment modules in Maine College of Direct Support or the College of Employment Services Certification to provide Work Supports- group or individual
  * Reportable Events Training 14-197, ch 12
  * Behavior Regulations Training 14-197, ch 5
  * Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
  * Criminal background check
  * Criminal background check
  * Employment Specialist National (ACRE approved) Certification may be substituted for CDS and employment modules as it is a higher level of staff certification
  * Current First Aid and CPR Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:
Upon enrollment and every three years after.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service
Service Type: Statutory Service
Service Name: Work Support- Group

Provider Category:
Individual

Provider Type:
Work Support Professional

Provider Qualifications

License (specify):

Certificate (specify):
Certificate of completion Maine’s Direct Support Professional Curriculum

Other Standard (specify):
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS)
* Received addition approval from OADS for provision of waiver services as required in MIHMS.
* Minimum age of 18
* Staff must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program.
* Must have completed the additional employment modules in Maine College of Direct Support or the College of Employment Services Certification to provide Work Supports- group or individual
* Employment Specialist National (ACRE approved) Certification may be substituted for CDS and employment modules as it is a higher level of staff certification
* Reportable Events Training 14-197, ch 12
* Behavior Regulations Training 14-197, ch 5
* Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
* Criminal background check
* Current First Aid and CPR Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:
Upon Enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Adult Foster Care/Shared Living

HCBS Taxonomy:
Service Definition (Scope):
Personal care and supportive services (e.g., homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under State law) provided in a private home by a principal care provider who lives in the home. Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision. Services can be provided to participants unable to care for themselves that are furnished on a short term basis because of the absence or need for relief of those persons who normally provide care for the participant. Adult Foster Care is considered a residential habilitation service only when habilitation is included in the defined scope of the adult foster care services. Adult foster care is not considered a residential habilitation service when habilitation services are furnished in the adult foster care setting by a different provider and billed separately. A provider may not have more than two people that they care for in one home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There is an annual limit on Home Support, Shared Living, and Community Support of $58,168.50. When participants have a need for any combination of these services, there is an annual limit in the total combined expenditure of $58,168.50.

Service Delivery Method (check each that applies):

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

Specify whether the service may be provided by (check each that applies):
- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
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<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>OADS Provider Agency</td>
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</tbody>
</table>

Appendix C: Participant Services

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

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

Provider Category:
Provider Type:
OADS Provider Agency

Provider Qualifications

License (specify):

Certificate (specify):
A staff person must have a certificate as a Direct Support Professional (DSP) and have successfully completed the Direct Support Professional curriculum as adopted by DHHS, or DHHS approved Assessment of Prior Learning, prior to July 1, 2010 or has successfully completed the Maine College of Direct Support.

Other Standard (specify):
Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).
* Received addition approval from OADS for provision of waiver services as required in MIHMS.

Provider Agency must assure the following for individual DSP's:
*Minimum age of 18
* DSP's must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program.
* Reportable Events Training 14-197, ch 12.
* Behavior Regulations Training 14-197, ch 5.
* Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
* current First Aid and CPR Certification
* criminal background check
* adult and child protective background checks
* Department approved medications training

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:
Upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:
Assistive Technology

HCBS Taxonomy:
Service Definition (Scope):
Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes
(A) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
(D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
(E) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
(F) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.
(g) transmission of data required for use of the Assistive Technology Device via internet or cable utility.
Participants will exhaust State Plan services before accessing waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Assistive Technology-Assessment is subject to a combined limit of 32 units (8 hours) per year. Assistive Technology-Devices, including the selecting, fitting, customizing, adapting, applying, maintaining, repairing or replacing of assistive technology devices, is subject to a combined limit of $6,000 per year. Assistive Technology-Transmission (Utility Services) is subject to a combined limit of $50 per month.

Service Delivery Method (check each that applies):
- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):
- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<td>OADS approved Provider Agency</td>
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</table>

Appendix C: Participant Services
## Service Specifications for Service

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

### Provider Category:
- **Agency:** OADS approved Provider Agency

### Provider Type:
- **Agency:** OADS approved Provider Agency

### Provider Qualifications

#### License (specify):
- Occupational Therapist
- Speech Pathologist

#### Certificate (specify):
Direct Support Staff must be a certified Direct Support Professional (DSP) and Certification as Rehabilitation Engineering Technologist (RET) or an Assistive Technology Professional (ATP) from the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) is required to provide Assistive Technology.

#### Other Standard (specify):
Minimum requirements may include compliance with:
- Equipment must adhere to
  - Local and state codes
  - Underwriters Laboratories
  - FCC
  - NFPA Life Safety Code
  - ADA

Provider Agency must have:
- * Completed the enrollment process for the "Maine Integrated Health Management System" (MIHMS) including the Provider Agreement and additional Developmental Services Rider to said Agreement
- * Received addition approval from OADS for provision of waiver services as required in MIHMS

Provider Agency must assure the following for individual DSP's:
- *Minimum age of 18
- * DSP's must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program.
- * Reportable Events Training
- * Behavior Regulations Training
- * criminal background check
- * medication administration
- * current First Aid and CPR Certification

### Verification of Provider Qualifications

#### Entity Responsible for Verification:
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

#### Frequency of Verification:
Provider enrollment is responsible for verification of provider qualifications upon enrollment and every three (3) years thereafter.
State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

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

**Service Title:**

Career Planning

**HCBS Taxonomy:**

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</table>

**Service Definition (Scope):**

Career Planning is a person centered, comprehensive direct support provided to a participant that enables a participant to obtain, maintain or advance in competitive employment or self-employment. Career Planning assists with identifying a career direction and developing a plan for achieving competitive, integrated, individual employment or self-employment at or above the States minimum wage. Services assist in identifying skills, priorities, and capabilities determined through an individualized discovery process. It may include a referral to benefits planning, referral of assessment for use of assistive technology to increase independence in the workplace, development of experiential learning opportunities and career options consistent with the participant’s skills and interests. Career Planning may be used in preparation to gather information to be used as part of a referral to Vocational Rehabilitation.

Services provided focus on using best practices such as Discovering Personal Genius™ (DPG) and ideal conditions of employment, skills, preferences and maximizing the use of models such as resource ownership, self-employment and customized employment options. Career Planning must be time limited (up to six months), included within the Person Centered Planning process with employment related career goals, and have the long term goal of individual, competitive, integrated employment for which the participant is compensated at or above minimum wage. Career Planning services can be provided within a variety of community settings such as a Career Center, the community and local business and must be documented in the Person Centered Plan with related goals.

The cost of Transportation related to the provision of Career Planning is a component of the rate paid for the service.

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

The maximum annual allowance is 60 hours to be delivered within a six month period. No two six month periods may be provided concurrently. Career Planning may not be provided at the same time as Community Support, Home Support, Work Support, Employment Specialist Services or Shared Living.

Career Planning requires submission of the Career Plan at 3 intervals to DHHS in order to ensure that the service is provided in a manner that will result in competitive, integrated employment or self-employment at or above the States minimum wage.
Service Delivery Method *(check each that applies)*:

- [] Participant-directed as specified in Appendix E
- [x] Provider managed

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

- [] Legally Responsible Person
- [] Relative
- [] Legal Guardian

Provider Specifications:

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<th>Provider Category</th>
<th>Provider Type Title</th>
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Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Career Planning

**Provider Category:**

- [ ] Agency

**Provider Type:**

- OADS approved Provider Agency

**Provider Qualifications**

<table>
<thead>
<tr>
<th>License (specify):</th>
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</thead>
</table>

**Certificate (specify):**
Certificate of completion Maine’s Direct Support Professional Curriculum

**Other Standard (specify):**
Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).
* Received addition approval from OADS for provision of waiver services as required in MIHMS.

Provider Agency must assure the following for individual DSP's:
* Minimum age of 18
* Staff must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program and additional employment modules.
* Employment Specialist National (ACRE approved) Certification may be substituted for CDS and employment modules as it is a higher level of staff certification
* Additional 12 hours of Career Planning and Discovery provided through Maine’s Workforce Development System (www.employmentformewds.org) for either the Direct Support Professional or the Employment Specialist.
* Reportable Events Training 14-197, ch 12
* Behavior Regulations Training 14-197, ch 5
* Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
* Criminal background check
* Current First aid and CPR Certification

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.
Frequency of Verification:
Upon enrollment and every three (3) years thereafter.

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

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

Service Type:
Other Service

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

Service Title:
Employment Specialist Services

HCBS Taxonomy:

Category 1:  Sub-Category 1:

Category 2:  Sub-Category 2:

Category 3:  Sub-Category 3:

Category 4:  Sub-Category 4:

Service Definition (Scope):
Employment Services include services necessary to support an individual in maintaining Employment. Services include: (1) periodic interventions on the job site to identify an individual’s 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 an individual’s goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the individual in acclimating to a new job. (3) If Vocational Rehabilitation denies services under the Rehabilitation Act and the participant is unable to benefit from Vocational Rehabilitation then the participant may receive Employment Specialist Services for job development. Current documentation of ineligibility from Vocational Rehabilitation is required. Employment Specialist Services are provided by an Employment Specialist who may work either independently or under the auspices of a Supported Employment agency. The need for continued Employment Services must be documented in an Individual Plan as necessary to maintain employment over time.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Employment Specialist Services are provided on an intermittent basis with a maximum of 10 hours each month.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed
Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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<th>Provider Type Title</th>
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<td>Employment Specialist</td>
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<td>Agency</td>
<td>OADS Approved Supported Employment Agency</td>
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</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Specialist Services

Provider Category: Individual
Provider Type: Employment Specialist

Provider Qualifications

License (specify):

Certificate (specify):
• Certificate of completion of State of Maine’s “Maine Employment Curriculum for Employment Support Personnel”

Other Standard (specify):
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).
* Received addition approval from OADS for provision of waiver services as required in MIHMS.
* Minimum age of 18
* Staff must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program and additional employment modules.
* Employment Specialist National (ACRE approved) Certification may be substituted for CDS and employment modules as it is a higher level of staff certification
* Reportable Events Training 14-197, ch 12
* Behavior Regulations Training 14-197, ch 5
* Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
* Criminal background check
* Current First Aid and CPR Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:
Upon enrollment and every three (3) years thereafter.
Service Name: Employment Specialist Services

Provider Category:

Provider Type:
OADS Approved Supported Employment Agency

Provider Qualifications

License (specify):

Certificate (specify):
* All employees must hold a Certificate of completion of State of Maine Employment Curriculum for Employment Support Personnel

Other Standard (specify):
Provider Agency must have:
* Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).
* Received addition approval from OADS for provision of waiver services as required in MIHMS.
Provider Agency must assure the following for individual DSP's:
* Minimum age of 18
* Staff must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program and additional employment modules.
* Employment Specialist National (ACRE approved) Certification may be substituted for CDS and employment modules as it is a higher level of staff certification
* Reportable Events Training 14-197, ch 12
* Behavior Regulations Training 14-197, ch 5
* Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
* Criminal background check
* Current First Aid and CPR Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:
Upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:
Home Accessibility Adaptations

HCBS Taxonomy:

Category 1:  
Sub-Category 1:  

https://wms-mmdl.cms.gov/WMS/faces/protected/35/print/PrintSelector.jsp  10/26/2018
Service Definition

Home Accessibility Adaptations are those physical adaptations to the home, required by the participant’s service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home.

These include adaptations that are not covered under state plan services and are determined medically necessary as documented by a licensed physician and approved by DHHS The Office of Aging and Disability Services. Participants will exhaust State Plan services before accessing waiver services.

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)

The Manager of the Support Waiver must approve items not included above that have been recommended in a Personal Plan.

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

All services shall be provided in accordance with applicable State or local building codes.

Home Accessibility Adaptations may only be made to the private residence of the participant or the participant’s family.

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

$10,000 limit in 5-year period with an additional annual allowance up to $300 for repairs and replacement per year. General household repairs are not included in this service. All items in excess of $500 require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the individual’s need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit can be reimbursed under this section.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Specialized independent service provider such as: plumber, electrician, etc.</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category: Individual
Provider Type: Specialized independent service provider such as: plumber, electrician, etc.

Provider Qualifications

- License (specify): State Licensure if applicable
- Certificate (specify): Professional certification if applicable
- Other Standard (specify): any other requirements set forth by the Department or participant IF applicable
- Minimum requirements may include compliance with:
  - Local and state building codes
  - Underwriters Laboratories
  - FCC
  - NFPA Life Safety Code
  - ADA

Verification of Provider Qualifications

- Entity Responsible for Verification: DHHS the Office of Aging and Disability Services Resource Coordinator.
- Frequency of Verification: Prior to provision of service

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type: Other Service

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

Service Title: Home Support-Remote Support
HCBS Taxonomy:

Category 1: Sub-Category 1:

Category 2: Sub-Category 2:

Category 3: Sub-Category 3:

Category 4: Sub-Category 4:

Service Definition (Scope):

This service is designed to provide habilitation support and to assist the participant achieving the most integrated setting possible and increase the participant’s independence through assistive technology. This service provides real time, remote communication and support through a wide range of technological options including electronic sensors, video conferencing, environmental sensors (movement, doors, temperature, smoke, CO, etc.), video cameras, microphones and speakers, as well as health monitoring equipment. This assistive technology links each participant’s residence to the Remote Support Provider. The Remote Support Provider has staff available 24 hours per day 7 days per weeks to deliver direct 1:1 care when needed. Two levels of emergency back-up are required as identified in the Personal Plan.

The use of this service is based upon the participant’s assessed needs and the resulting Personal Plan. The Personal Plan reflects the participant’s consent and commitment to the plan elements including all assistive communication, environmental control and safety components. A thorough evaluation of all Assistive Technology will be completed prior to the finalization of the Personal Plan with the assistance of the Case Manager and use of appropriate Assistive Technology consultants. The exploration of the risks and benefits of all elements of the Personal Plan will be documented and acknowledged by the participant served. If a participant served experiences a change in support needs or status, the provider immediately adjust the direct support services to meet those needs.

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

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

Payment is not to be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5. Payment is not made, directly or indirectly, to members of the individual's immediate family, except as provided in Appendix C-2.

There are 2 types of Home Support-1. ¼ hour 2. Remote Support. Home support is Personal Care and Protective oversight and supervision. A participant may only have one of these services at a time to avoid duplication. Home Support (¼) hour is for a participant who doesn’t require 24/7 care and may be provided in the participant’s home. Home support (Remote Support) is for a participant who doesn’t require face to face care but would benefit from electronic communication to ensure health and safety. Community Support is care during the day to access the community and other resources. In order to avoid duplication, Home Support (¼ hour or Remote Support) or Community Support are not available at the same time as other Home Support (¼ hour or Remote Support) or Community Support.

There is no overlap between Assistive Technology and Home Support-Remote Support. Assistive Technology provides for the assessment, the equipment and the cost of the monthly transmission. Home Support-Remote Support provides the staff who are monitoring the participant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Home Support may not be provided at the same time as Community Support, Career Planning, Work Support, Employment Specialist Services or shared Living.

There is an annual limit on Home Support, Shared Living, and Community Support of $52,425.00. When participants have a need for any combination of these services, there is an annual limit in the total combined expenditure of $52,425.00.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>OADS approved Provider Agency</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

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

Provider Category:
- Agency

Provider Type:
- OADS approved Provider Agency

Provider Qualifications

- License (specify):
- Certificate (specify):
  Certificate of completion Maine’s Direct Support Professional Curriculum
- Other Standard (specify):
  Provider Agency must have:
  * Completed the enrollment process for the "Maine Integrated Health Management System" (MIHMS) including the Provider Agreement
  * Received addition approval from OADS for provision of waiver services as required in MIHMS to be approved to provide Home Support-Remote Support a provider must:
  * Assure that the system must be monitored by a staff person trained and oriented to the specific needs of each participant served as outlined in his or her Personal Plan.
  Provider Agency must also assure the following for individual DSP's:
  * Minimum age of 18
  * DSP's must complete the Maine College of Direct Support" program.
  * Reportable Events Training 14-197, ch 12
  * Behavior Regulations Training 14-197, ch 5
  * Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
  * Criminal background check
  * current First Aid and CPR Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by a number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & Regulatory Services, OADS.

**Frequency of Verification:**
Provider enrollment verifies provider qualifications at time of enrollment and every three years thereafter.

---

### Appendix C: Participant Services

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

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

**Service Type:**
Other Service

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

**Service Title:**
Non-Medical Transportation

**HCBS Taxonomy:**

<table>
<thead>
<tr>
<th>Category 1:</th>
<th>Sub-Category 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
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<tr>
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<table>
<thead>
<tr>
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</thead>
<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
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<th>Sub-Category 4:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Service Definition (Scope):**
Transportation service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170 (a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant’s Personal Plan.

Transportation Services are provided through a 1915(b)/1915(c) combination and arranged by transportation brokers.
Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized. Relatives and Legal guardians may only be reimbursed by the broker if they indicate that they are unable to transport at no charge or there is no other viable option and there is a recommendation by the planning team.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Service Delivery Method *(check each that applies):*

- [ ] Participant-directed as specified in Appendix E
- [✓] Provider managed

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

- [ ] Legally Responsible Person
- [✓] Relative
- [✓] Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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</thead>
<tbody>
<tr>
<td>Agency</td>
<td>broker</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

| Service Type: Other Service | Service Name: Non-MedicalTransportation |

Provider Category: 

- [ ] Agency

Provider Type: 

- [✓] broker

Provider Qualifications

- **License (specify):**

- **Certificate (specify):**

- **Other Standard (specify):**
  - Approved by MaineCare as transportation agency, Approval by DHHS as provider under this Waiver
  - MaineCare Provider agreement
  - For the individual driver, the following is also required.
  - Adequate insurance
  - Valid Driver's license
  - Age 18

Verification of Provider Qualifications

- **Entity Responsible for Verification:**
  - MaineCare Provider Enrollment Unit

- **Frequency of Verification:**
  - Upon enrollment and triennial

Appendix C: Participant Services

C-1/C-3: Service Specification

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

**Service Type:**

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

**Service Title:**

Work Support-Individual

**HCBS Taxonomy:**

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<th>Category 1:</th>
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<tbody>
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</table>

<table>
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<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 4:</th>
<th>Sub-Category 4:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Service Definition (Scope):**

Work Support is Direct Support provided to improve a participant’s ability to independently maintain employment. Work support-individual is provided at the participant’s place of employment; it may be provided in a participant’s home in preparation for work if it does not duplicate services already reimbursed as Home Support. Supports to participants that who because of their disabilities need intensive ongoing support to maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which the individual is compensated 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 individuals without disabilities. This service is provided after a participant has received an assessment and services under the American with Disabilities Act, Section 504 of the Rehabilitation Act and need for on-going support has been determined and documented in the Personal Plan. Self-employment requiring individual work supports may include home-based self-employment – and can provide ongoing identification of the supports that are necessary in order for the participant to operate the business. Support may be used for Customized employment for participants with severe disabilities – to include long term support to successfully maintain a job due to the ongoing nature of the participant’s support needs, changes in life situation, or evolving and changing job responsibilities. The primary focus of the support is job related and also encompasses adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual’s supported employment program.

The cost of transportation related to the provision of Work Support is a component of the rate paid for the service.
The Ticket to Work Program (TTW) and Milestone payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided since payments are made for outcome, rather than for a Medicaid service rendered.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Work Support may not be provided at the same time as Community Support, Career Planning, Home Support, Employment Specialist Services or Shared Living.

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

- [ ] Participant-directed as specified in Appendix E
- [x] Provider managed

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

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

**Provider Specifications:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>OADS Approved Supported Employment Agency</td>
</tr>
<tr>
<td>Individual</td>
<td>Work Support Professional</td>
</tr>
</tbody>
</table>

**Appendix C: Participant Services**

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

**Service Type: Other Service**
**Service Name: Work Support-Individual**

**Provider Category:**

- Agency

**Provider Type:**

- OADS Approved Supported Employment Agency

**Provider Qualifications**

- **License** (specify):

**Certificate** (specify):
- All employees must hold a Certificate of completion Maine’s Direct Support Professional Curriculum or a certificate from the Maine College of Direct Support

**Other Standard** (specify):
- Provider Agency must have:
  - * Completed the enrollment process for the "Maine Integrated Health Management System" (MIHMS)
  - * Received additional approval from OADS for provision of waiver services as required in MIMHS.
- Provider Agency must assure the following for individual DSP's:
  - *Minimum age of 18
  - * Staff must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program.
  - * Must have completed the additional employment modules in Maine College of Direct Support or the College of Employment Services Certification to provide Work Supports- group or individual
  - * Employment Specialist National (ACRE approved) Certification may be substituted for CDS and employment modules as it is a higher level of staff certification
  - *Reportable Events Training 14-197, ch 12
  - *Behavior Regulations Training 14-197, ch 5
  - *Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
Verification of Provider Qualifications

Entity Responsible for Verification:
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:
Upon enrollment and every three (3) years thereafter.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Work Support-Individual

Provider Category:

Provider Type:
Work Support Professional

Provider Qualifications

License (specify):

Certificate (specify):
- Certificate of completion Maine’s Direct Support Professional Curriculum or a certificate from the Maine College of Direct Support

Other Standard (specify):
- Completed the enrollment process for the "Maine Integrated Health Management Solution" (MIHMS).
- Received addition approval from OADS for provision of waiver services as required in MIHMS.
- Minimum age of 18
- Staff must successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program and additional employment modules.
- Employment Specialist National (ACRE approved) Certification may be substituted for CDS and employment modules as it is a higher level of staff certification
- Must have completed the additional employment modules in Maine College of Direct Support or the College of Employment Services Certification to provide Work Supports- group or individual
- Reportable Events Training 14-197, ch 12
- Behavior Regulations Training 14-197, ch 5
- Rights of Persons with Intellectual Disabilities or Autism Training Title 34-B §5605
- Criminal background check
- In addition to the above requirements, the selected provider must meet all requirements set forth by the individual in the Personal Plan. This may require professional certification such as med training or lifting.
- Current First Aid and CPR Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrollment in the MIHMS is shared responsibility and application and other information and materials are shared and reviewed by number of entities within DHHS. Final verification is by Office of MaineCare Provider Enrollment but this action represents review by staff from some or all of the following areas: Program Integrity, finance/rate-setting, licensing & regulatory services, OADS.

Frequency of Verification:
Upon enrollment and every three (3) years thereafter.
Appendix C: Participant Services

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

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (select one):

- **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  *Check each that applies:*
  - As a waiver service defined in Appendix C-3. **Do not complete item C-1-c.**
  - As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). **Complete item C-1-c.**
  - As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). **Complete item C-1-c.**
  - As an administrative activity. **Complete item C-1-c.**

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management services are provided as a State Plan Service and provided as follows:
1. State of Maine: Case Managers employed by the Office of Aging and Disability Services within DHHS
2. DHHS approved community case management agencies.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- **No.** Criminal history and/or background investigations are not required.
- **Yes.** Criminal history and/or background investigations are required.

  Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a) Any position that provides direct service e.g., direct support professionals, employment specialist. As per MaineCare policy, it is the responsibility of the employing provider to conduct background checks.
b) State Bureau of Investigation (State only), Maine Department of Motor Vehicle (State Only) for criminal history.
c) Providers are required to meet these requirements which are stipulated in the MaineCare policy that governs this waiver. The State requires that providers attest to all sections of policy that they are billing under and sign the provider agreement. Retattement is required every three years. As a component of its investigatory process the state Program Integrity Unit may check provider records for compliance. The State operated Adult Protective Services system maintains a list of any employee that has had a substantiated allegation of abuse, neglect or exploitation. Providers are required to check this system to determine whether a potential employee is on the list or not. In addition, at the time of any reportable event, adult protective services performs a background check on the suspected offender.

The providers conduct the background checks/investigations for their employees or subcontractors.
b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ☐ No. The State does not conduct abuse registry screening.
- ☑ Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

**C-2: General Service Specifications (2 of 3)**

c. **Services in Facilities Subject to §1616(e) of the Social Security Act. Select one:**

- ☐ No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.
- ☑ Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

<table>
<thead>
<tr>
<th>Facility Type</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted Housing Level I</td>
<td></td>
</tr>
</tbody>
</table>

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Larger facilities are not used, homes are for 1 to 2 individuals.

Appendix C: Participant Services

**C-2: Facility Specifications**

Facility Type:

Assisted Housing Level I

Waiver Service(s) Provided in Facility:

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Provided in Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Accessibility Adaptations</td>
<td>☐</td>
</tr>
<tr>
<td>Assistive Technology</td>
<td>☐</td>
</tr>
<tr>
<td>Employment Specialist Services</td>
<td>☐</td>
</tr>
</tbody>
</table>
Facility Capacity Limit:

1-2

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (check each that applies):

<table>
<thead>
<tr>
<th>Scope of State Facility Standards</th>
<th>Topic Addressed</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>Physical environment</td>
<td>✓</td>
</tr>
<tr>
<td>Sanitation</td>
<td>✓</td>
</tr>
<tr>
<td>Safety</td>
<td>✓</td>
</tr>
<tr>
<td>Staff : resident ratios</td>
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<tr>
<td>Staff training and qualifications</td>
<td>✓</td>
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<tr>
<td>Staff supervision</td>
<td>✓</td>
</tr>
<tr>
<td>Resident rights</td>
<td>✓</td>
</tr>
<tr>
<td>Medication administration</td>
<td>✓</td>
</tr>
<tr>
<td>Use of restrictive interventions</td>
<td>✓</td>
</tr>
<tr>
<td>Incident reporting</td>
<td>✓</td>
</tr>
<tr>
<td>Provision of or arrangement for necessary health services</td>
<td>✓</td>
</tr>
</tbody>
</table>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

---

**Appendix C: Participant Services**

**C-2: General Service Specifications (3 of 3)**

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible
individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. Select one:

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of extraordinary care by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.

Select one:

- Self-directed
- Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. Select one:

- The State does not make payment to relatives/legal guardians for furnishing waiver services.
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.

The state contracts out Transportation Services to a broker through a 1915(b) waiver and at times will reimburse relatives or legal guardians for Transportation Services if they indicate that they are unable to transport at no charge, if there is no other viable option or there is a recommendation by the planning team. The state allows relatives to provide Respite Services, they must meet qualifications.

Relative/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Select one:

- Other policy.

Specify:
f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any person or entity showing interest in various MaineCare programs may enroll as a provider so long as all necessary qualifications are met. The State has on-going open enrollment and State staff available to assist with the qualifications and enrollment process.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measures

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

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

Performance Measure:
Percent of approved providers (by type) who initially and continually meet required licensure/certification requirements. Numerator: Total number of provider applications (by type) for which approved providers have a current license/certificate. Denominator: Total number of provider applications (by type).

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

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**Performance Measure:**
Percent of qualified employed direct Support Professionals (DSPs) servicing waiver participants who have a background check prior to the provision of waiver services. Numerator: Total number of DSPs who had a background check prior to provision of waiver services. Denominator: Total number of DSPs employed less than two years.

**Data Source** (Select one):
- Record reviews, off-site
- If 'Other' is selected, specify:
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### Performance Measure:
Percent of qualified employed direct Support Professionals (DSPs) servicing waiver participants who have a background check every two years. Numerator: Total number of DSPs who had a background check every two years. Denominator: Total number of DSPs employed more than two years.

**Data Source (Select one):**
- Record reviews, off-site

If ‘Other’ is selected, specify:

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Other Specify: | |
b. **Sub-Assurance**: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

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

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

**Performance Measure:**
Percent of providers by type that meet waiver requirements: Numerator: Total number of providers by type that meet the requirement Denominator: Total number of providers by type.

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

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c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

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

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

Performance Measure:
Percent of Direct Support Professionals (DSPs) who have completed Department sponsored training in Reportable Events and Adult Protective Services, Regulations Governing Behavioral Support, Rights and Basic Protections within six (6) months of hire. Numerator: Total number of DSPs completing the training within 6 months. Denominator: Total number of DSPs required to complete initial training.

Data Source (Select one):
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Performance Measure:
Percent of DSPs who have completed Department sponsored training in Reportable Events & Adult Protective Services, Regulations Governing Behavioral Support, Rights & Basic Protections every 36 mo. after initial DSP certification. Numerator: Total # of DSPs completing the training every 36 mo. after initial DSP certification. Denominator: Total # of DSPs required to complete ongoing training.

Data Source (Select one):
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Performance Measure:
Percent of newly employed Direct Support Professionals (DSPs) who complete the five (5) required modules before working with a participant. Numerator: Total number of newly employed DSPs completing the five (5) modules. Denominator: Total number of newly employed DSPs.

Data Source (Select one):
Record reviews, off-site
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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems
   i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. Absence of appropriate licensure/certification and attestation to Medicaid policy will disqualify the agency from enrollment into the Medicaid program. An agency that has not re-enrolled or verified licensure/certification, when appropriate, will no longer be able to bill for MaineCare services. Any services provided without this verification will be subject to financial recoupment. If the Medicaid Agency discovers that an individual DSP has not completed training within the 6 month time frame, this individual would not be able to provide direct support services and these services would not be billable.

If OADS Quality Management notices irregularities or problems when reviewing aggregated data, the unit will bring issues forward for systemic review. Written documentation and notification of such concerns will be sent to the appropriate provider and/or Departmental management team to be remedied.

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

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   \[Other\]

   Specify:
   Licensure, certification, or training is verified upon enrollment and when any license, certification or training is up for renewal.

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

- No
- Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (select one).

- Not applicable - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (check each that applies)

- Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

- (a) There is an annual limit on Home Support, Shared Living, and Community Support of $58,168.50. When participants have a need for any combination of these services, there is an annual limit in the total combined expenditure of $58,168.50.
- (b) Utilization data show that the average use of Community Support is 759 hours per year. If utilization and unmet needs data indicate a need for changing the combined limit over the waiver period, and the financial situation allows, DHHS will consider making changes via amendment.
- (c) With the two particular services affected by this limit, it is expected to be exceedingly rare for there to be significant health and safety considerations. The case manager and planning team will work with the participant to make adjustments as necessary if there are such considerations. Adjustments could include, referral to a State plan service(s), referral to State-funded programs, or increase use of natural/informal supports.
- (e) Any limit(s) on services needed by a participant is discussed at the planning meeting and the plan is written accordingly.

- Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.
Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*

Other Type of Limit. The State employs another type of limit. *Describe the limit and furnish the information specified above.*

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCBS Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCBS Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCBS Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

Residential Settings Non-Residential Settings
- Own Home or apartment
- Group homes
- Family-Centered Support Homes
- Shared Living
- Private Non-Medical Institutional Service Settings
- Community settings
- Work settings
- Center-based community supports
- Small group work settings

The State has determined that compliance is possible in all settings in which services are provided under this waiver based on the State’s preliminary assessment. Implementation of the transition plan will entail further assessments, including a provider self-assessment survey, and a sample of on-site surveys, to determine what changes, if any, need to be made for each setting to meet the HCBS standards.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Personal Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (select each that applies):
Registered nurse, licensed to practice in the State
Licensed practical or vocational nurse, acting within the scope of practice under State law
Licensed physician (M.D. or D.O)
Case Manager (qualifications specified in Appendix C-1/C-3)
Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Intellectual Disabilities Case Manager

DESCRIPTION: Performs professional social work for eligible adults with developmental disabilities, physical disabilities, co-occurring diagnoses such as mental health issues and brain injury. Extensive travel is required in order for Caseworkers to coordinate the provision of services including medical, housing, employment, direct supports, day services, and the promotion of community inclusion. Caseworkers participate in care planning which includes plan writing and extensive documentation. This position provides a wide range of casework services to people living within their communities and/or persons in facilities. There is significant work with a varying number of individuals assigned as public or private guardians, as well as financial decision making responsibilities. This position occasionally requires unplanned overtime.

REPRESENTATIVE TASKS: Advocates for and coordinates provision of services including medical, housing, employment, day services, and community inclusion.
. Assesses participant living arrangements and support systems.
. Visits participants regularly for ongoing assessment of needs and safety.

Social Worker

Specify qualifications:

State Employee

MINIMUM REQUIREMENTS

In order to qualify, you must have a Bachelor’s Degree from an accredited educational institution in Social Work/Social Welfare; OR a Bachelor’s Degree in a related social service/social welfare/social work area which includes at least 12 courses in behavioral science, social science, or social work; AND must have or be eligible for conditional or full licensure as a Licensed Social Worker (LSW) as determined by the Maine State Board of Social Worker Licensure.

NECESSARY SPECIAL REQUIREMENT: Applicants must have or be eligible for conditional or full licensure at the Licensed Social Worker (LSW) level as issued by the Maine State Board of Social Worker Licensure. An LSW requires an earned BA/BS in social work/social welfare. An LSW-Conditional requires an earned BA/BS in a field related to social work/social welfare.

*Chapter 10 of the Maine State Board of Social Worker Licensure regulations defines a field related to social work or social welfare as including but not limited to: “behavioral science, social and behavioral sciences, childhood development, education and human development, mental health and human services, psychology, psychology/educational psychology, rehabilitation services, and sociology.” The board will consider degrees in other areas on an individual basis. For additional information on degree requirements, contact the Maine Board of Social Work Licensure at (207) 624-8603.

Other

Specify the individuals and their qualifications:

Community Case management Workers-BA/BS in social work/social welfare.

Appendix D: Participant-Centered Planning and Service Delivery
b. Service Plan Development Safeguards. Select one:

/entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
/entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Plan development and service planning includes the case manager, participant, guardian, other individuals in the planning team. Information reviewed includes the planning tools, review of reportable events and identification of current and needed services).

(b) The participant/guardian has the ability to choose who will be invited to the meeting and involved in the planning process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The case manager is responsible for the service plan but it is developed in conjunction with the participant, and guardian (if applicable). Service plans are required to be developed at least annually and as part of the initial eligibility process.

(b) The assessment addresses participant expressed needs, participant preferences and goals related to his/her service plan, as well as any medical treatments/services the participant is receiving or may need.

(c) The case manager describes all services available to the participant.

(d) Once the plan is written it is sent to the participant and/or guardian for review and signature. The case manager then reviews the plan to assure that all goals, needs and preferences have been addressed for the participant.

(e) The service plan includes other services, outside of waiver services. All services and supports are reviewed and monitored by the case manager.

(f) As part of the planning process, specific individuals are identified to monitor health care needs, delivery of habilitative services, and all are overseen by the case manager.

(g) The plan is updated at least annually. For any change in need, any member of the team, including the participant can request a meeting to amend the plan during the course of the planning year.
Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The crisis teams are contacted by any team member, participants, families, case managers or providers. During the planning process potential crises are identified and plans developed for risk assessment and future mitigation. If a participant has a history of or potential of requiring crisis intervention a crisis team member is invited to the planning meeting to mitigate future risk.

The planning team addresses potential risks as part of the plan. A more comprehensive preventative back-up plan may be developed if crisis services are involved. DHHS also has a complement of District crisis teams that are able to respond to emergency situations on a 24/7 basis. During a crisis there is a crisis hot line number to request immediate intervention. If intervention by this team occurs three times or more within a two-week period it will trigger an Individual Support team meeting that is wholly focused on the crisis situations and a back-up plan will be developed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Choice of providers for waiver participants is assured by two complimentary processes. The Office of Aging and Disability Services maintains a provider directory on its website. Listings are voluntary and must be initiated by the provider and the Office facilitates the posting.

This allows participants, families and other to search for providers within specific geographic areas and by service.

The other approach to offering choice is known as the "vendor call" process. Once a participant's team has made a service recommendation, the need is made known to all potential providers within any specified area. A brief de-personalized description of the person's needed services and any individualized specifications are sent to all providers via list serve. Providers that express interest and have capacity to potentially support the individual, respond affirmatively to the case manager and contact information is provided to the participant, family and/or case manager for follow up.

Additionally, the Disability Rights Maine has developed an interview guide for families to assist them in picking a provider that best suits their needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Office of Aging and Disability Services, which operates this waiver, is part of the single state Medicaid agency. OADS reviews all service plans and has ultimate authority of service plan approval.
h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (check each that applies):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

### Appendix D: Participant-Centered Planning and Service Delivery

#### D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

A. Case managers are responsible for the monitoring and assurance of the implementation of the service plan. This includes monitoring of the health, welfare and safety of the participant. The district QM staff also provide an oversight function.

B. There are regular reviews of each plan that are completed by the case manager. The focus of the reviews is on the needs and goals identified in the plan. The case manager supports the participant in obtaining and maintaining all waiver services and other non-waiver services identified in the plan.

The case manager makes frequent checks with the participant and his/her guardian to discuss if the back up plan is working and makes modifications as needed until the full need is met/provider is identified. Case managers use multiple assessment tools such as the home visit tool and reportable events system to assure the participant's health and welfare. Upon identification of a service need, the case manager assists the participant in a vendor search to solicit interested, qualified providers. Through the on-going case management process, case managers and other members of the participant's service team address and coordinate a participant's access to non-waiver services in the service plan including health services. The State maintains the assessment information, case management contacts, monthly notes, participant medical information, to be aggregated at any point in time. If a problem is identified in relation to the participant, the case manager will assess the acuity and respond accordingly.

C. Case managers make at least monthly contact with participants. At that time they review the recommendations and progress to achieving the goals included in the plan.

b. **Monitoring Safeguards. Select one:**

- Entities and/or individuals that have responsibility to monitor service plan implementation and
participant health and welfare may not provide other direct waiver services to the participant.

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:

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Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:
   a. Sub-assurance: Service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

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

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

Performance Measure:
Percent of participant service plans that address health and safety risks.
Numerator: Number of participant service plans that address health and safety risks. Denominator: Total number of participant service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Enterprise Information System (EIS)

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Performance Measure:
Percent of all participant service plans that address participant's goals as indicated in the initial and/or annual assessment. Numerator: Total number participant service plans that address participants' goals. Denominator: Total number of plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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Performance Measure:
Percent of interim plans developed to address unmet needs. Numerator: Total number of interim plans developed to address unmet needs. Denominator: Total participant service plans with an unmet need(s).

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

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b. **Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

**Performance Measures**

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

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


c. **Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s needs.**

**Performance Measures**

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

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

**Performance Measure:**

Percent of participant service plans that were updated on or before the participant's annual review date. **Numerator:** Total number of all participant service plans that were updated on or before the participant's annual review date. **Denominator:** Total number of participant service plans reviewed.

**Data Source** (Select one):

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### Performance Measure:
Percent of participant service plans that were revised due to change in needs of the participant. Numerator: Number of participant service plans that were revised due to changing needs of the participant. Denominator: Total number of participant service plans reviewed that required a revision due to changing needs of the participant.

### Data Source (Select one):
- Other
  - If 'Other' is selected, specify:
  - Enterprise Information System (EIS)
d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.
Performance Measures

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

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

Performance Measure:
Percent of participants receiving the type of services described in their person-centered plan. Numerator: Total number of all participants with a paid claim for service type as described in their person-centered plan. Denominator: Total number of participant person-centered plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Claims data

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<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
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### Performance Measure:
Percent of participants receiving the scope and amount of services as described in their person-centered plan. Numerator: Total number of participants receiving the scope and amount of services described in their person-centered plan. Denominator: Total number of participant person-centered plans reviewed.

**Data Source** (Select one):
- Other
  - If 'Other' is selected, specify:
  - Medicaid Claims data

**Responsible Party for data collection/generation**
(check each that applies):
- State Medicaid Agency
- Operating Agency
- Sub-State Entity
- Other
  - Specify:

**Frequency of data collection/generation**
(check each that applies):
- Weekly
- Monthly
- Quarterly
- Annually

**Sampling Approach**
(check each that applies):
- 100% Review
- Less than 100% Review
- Representative Sample
  - Confidence Interval = 95%
- Stratified
  - Describe Group:

**Continuously and Ongoing**
- Other
  - Specify:
Data Aggregation and Analysis:

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Performance Measure:
Percent of participants who receive services in duration and frequency in accordance with their person-centered plan. Numerator: Total number of participants who received the services in duration and frequency in accordance with their person-centered plan. Denominator: Total number of person-centered plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Claims data

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e. **Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.**

**Performance Measures**

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

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

**Performance Measure:**
Percent of participants with annual documentation in the service plan that freedom of choice was given among waiver services and providers. Numerator:
Number of participants with documented freedom of choice among waiver services
and providers. Denominator: Total number of service plans reviewed.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Enterprise Information System**

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

Transportation is provided through a brokerage system in Maine, via a 1915b waiver. The transportation broker collects extensive data on performance measures for reporting on the 1915b waiver. The data will be provided to the 1915c waiver administrators for inclusion in the quality review process on an annual basis. Office of MaineCare Services and the program offices responsible for 1915c waiver administration will work together to discover, identify and remediate any problems as they arise.

b. Methods for Remediation/Fixing Individual Problems
i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

It is the responsibility of the case manager to assure that the Personal plan meets the identified needs of the participant. In addition, the case manager is responsible to monitor implementation of the Personal plan and update and modify as needed, based on the needs of the participant. If a problem is identified by the participant and/or guardian, the case manager is contacted and assesses the acuity of the problem. A personal plan meeting will be held if it is determined necessary. The case manager documents all communication regarding the problem and identified solutions in the participant's member record.

In regards to performance measure 3 Sub-assurance A – the State plans to review unmet needs to identify any additional resources and resource development needs.

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

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specify: every 6 months

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

[ ] No
[ ] Yes
Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.
- No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.
Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.
Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The following is copied from: Chapter 1, MaineCare Benefits Manual, General Administrative Policies and Procedures. Notices requesting fair hearings are kept in the Medicaid Agency's Health Care Management Unit.

1.22 MEMBER APPEALS

1.22-1 Right to Administrative Hearing,

In accordance with 42 CFR §431.220 the Department must grant an opportunity for a hearing to:

A. Any member who requests it because his or her claim for services is denied or not acted upon with reasonable promptness; and
B. Any member who requests it because he or she believes the agency has erroneously terminated, reduced, or suspended MaineCare medical eligibility or covered services.

1.22-2 Notice of Intent to Deny, Terminate, Reduce or Suspend MaineCare Eligibility or Covered Services

A. Notice must be mailed or delivered in person to the member when there has been a denial, termination, suspension or reduction of eligibility for MaineCare or covered services or when there has been a determination by a skilled nursing facility or nursing facility to transfer or discharge residents, as set forth below.

Specific information that must be included in these notices include:

1. A statement of the intended action.
2. An explanation of the reasons for the action, as well as a specific citation to the underlying State or Federal regulations that support the action.
3. A statement that the member has a right to a hearing.
4. An explanation of exactly how to obtain a hearing.
5. A statement that a member may be represented by legal counsel, relatives, friends or a spokesperson and a list of selected legal service providers available to assist the member in arranging for legal counsel.
6. The name and telephone number of the person who should be contacted, should the member have questions regarding the notice.
7. An explanation of the circumstances under which medical eligibility for MaineCare or covered services are continued if a hearing is requested.

B. Advance notice must be mailed or delivered in person to a member at least ten (10) calendar days before an action to deny, terminate, suspend, or reduce services becomes effective, except as required by licensing of other State mandates. A member is presumed to have been provided a notice if there is evidence of when the notice was placed in the mail system or delivered in person.

The advance notice requirement applies unless:

1. the Department has facts indicating that the action should be taken because of probable fraud, and the facts have been verified if possible, in which case advance notice of five (5) calendar days is required;
2. the Department has factual information confirming the death of a member;
3. the agency receives a clear written statement, signed by the member, that the member no longer wishes services; or gives information that requires termination or reduction of services and indicates that the member understands that this termination or reduction is the result of giving that information.
4. the member has been admitted to an institution where he or she is ineligible for further services;
5. the member’s whereabouts are unknown, and the post office returns agency mail directed to him or her indicating no forwarding address;
6. the member has been accepted for services by another local jurisdiction, State or territory; or
7. a change in the level of medical care is prescribed by the member’s physician or primary care provider where authorized.

C. Continuation of MaineCare eligibility or services during the appeal process applies as follows:

1. In accordance with 42 CFR § 431.230 and when advanced notice is required by this Section, MaineCare services currently being provided will not be terminated, reduced, or suspended until an administrative hearing decision is rendered provided that the member requests an administrative hearing before the date of action. This applies unless it is determined at the hearing that the sole issue is one of Federal or State law or policy, and the Department promptly informs the member in writing that services are to be terminated, reduced or suspended while awaiting the hearing decision.
2. The date of action means the intended date on which a termination, reduction or suspension becomes effective.
3. For Order of Reference decisions, as defined in the Administrative Hearings Regulations the Department will take action to terminate, reduce or suspend services five (5) business days from the date of the final decision signed by the
1.22-3 Procedure to Request an Administrative Hearing

A member may request an administrative hearing if he or she is aggrieved by any Departmental action that may deny, terminate, reduce, or suspend services provided by MaineCare. The Department may respond to a series of individual requests for a hearing by conducting a single group hearing. Members must follow the procedures described in this Section when requesting an administrative hearing.

A. An administrative hearing may be requested by a member or his/her authorized representative.

B. Unless otherwise specified in this Chapter, a request for an administrative hearing must be received within sixty (60) calendar days of the date of written notification to the member of the action the member wishes to appeal.

C. Unless otherwise specified in this Manual, the request must be made by the member or his or her representative, in writing or verbally, to MaineCare Member Services at P.O. Box 709, Augusta, ME 04332 for a hearing with the Office of Administrative Hearings, Department of Human Services. For the purposes of determining when a hearing was requested, the date of the hearing request shall be the date on which the request for a hearing is received by MaineCare Member Services. The date a verbal request for an administrative hearing is made is considered the date of request for the hearing. MaineCare Member Services may also request that a verbal request for an administrative hearing be followed up in writing, but may not delay or deny a request on the basis that a written follow-up has not been received. MaineCare Member Services shall send a fax or copy of all hearing requests to the Assistant Director of the Office of MaineCare Services, and to the Office of Administrative Hearings, within twenty-four (24) hours of receiving the request.

D. The hearing will be held in conformity with the Maine Administrative Procedures Act, 5 M.R.S.A. §8001 et. seq. and the Department's Administrative Hearings Regulations.

E. The hearing will be conducted at a time, date and place convenient to the parties and at the discretion of the Office of Administrative Hearings , and at least twenty (20) calendar days preliminary notice will be given. In scheduling a hearing, there may be instances where the hearing officer shall schedule the hearing at a location near the member or by telephone or interactive television system.

F. The Department and the member may be represented by others, including legal counsel and may have witnesses appear on his or her behalf.

G. The hearing will be conducted by an impartial official.

H. The hearing officer on his or her own motion or at the request of either Department representatives or the member may request or subpoena persons to appear where that person can be expected to present testimony or documents relating to the issues at the hearing. The cost of the subpoena shall be borne by the Department.

I. When a medical assessment as defined in 42 CFR § 431.240 (3) (b) by a medical authority other than the one involved in the decision under question is requested by the hearing officer or the member, and considered necessary by the hearing officer, it will be obtained at the Department's expense, and forwarded to the member or the member's representative and hearing officer allowing both parties to comment.

J. When the member or the Department or an authorized agent of the Department requests a delay, the hearing officer may reschedule the hearing, after notice to both parties.

K. The decisions, rendered by the hearing authority, in the name of the Maine Department of Human Services, will be binding upon the Department, unless the Commissioner directs the hearing officer to make a proposed decision reserving final decision making authorization to him or herself.

L. Any person who is dissatisfied with the hearing authority's decision has the right to judicial review under Maine Rules of Civil Procedure, Rule 80C.

1.22-4 Dismissal of Administrative Hearing Requests

A. If any of the following circumstances exist, the Office of Administrative Hearings may dismiss the request for an administrative hearing. This dismissal is the final agency action on the matter.
1. The member withdraws the request for a hearing.
2. The member, without good cause, abandons the hearing by failing to appear.
3. The sole issue being appealed is one of Federal or State law requiring an automatic change adversely affecting some or all members. The procedure to follow when requesting a change in State policy is described in Section 1.06-4 (D) of this Manual.

B. Where an applicant's or member’s request for an administrative hearing is dismissed pursuant to this Section, the Office of Administrative Hearings shall notify the member of his/her right to appeal that decision in Superior Court.

1.22-5 Corrective Action

The Department must promptly make corrective payments when appropriate, retroactive to the date an incorrect action was taken by the Department if:

A. The hearing decision is favorable to the applicant or member; or
B. The agency decides in the applicant's or member’s favor before the hearing.

FOR MORE INFORMATION
WRITE OR CALL
Maine Department of Health and Human Services
Office of Administrative Hearings
221 State Street
11 State House Station
Augusta, ME 04333-0011
TEL: (207)287-3610
FAX: (207)287-8448
TTY: 711 (Hearing Impaired)

Appendix F: Participant-Rights
Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. Select one:

- No. This Appendix does not apply
- Yes. The State operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

- OADS operates the dispute resolution process.
- Mediation is handled as a component of the grievance process.
- If mediation or grievance is not resolving the issue a fair hearing is always an option.

Appendix F: Participant-Rights
Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. Select one:

- No. This Appendix does not apply
Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Office of Aging and Disability Services, has a grievance process that is specific to those individuals for whom it has statutory obligations to serve.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) The nature of grievances/complaints addressed by the system are related to violation of rights, or withholding services that a participant felt he/she was entitled to. Participants are informed that making a grievance or complaint is not a prerequisite or substitute to a fair hearing. The link to the State rule is as follows:

Examples: case manager not assisting in following up on planning team recommendation, participant feels s/he needs respite to due difficulty with a staff person in the home and the case manager says to "stick it out", participant wants something very specific included in the plan and the facilitator refuses to add it.

(b) In short, the grievance process involves three (3) levels. Level I allows the participant/family to attempt resolution with the case manager. If not resolved within eight (8) days it moves on to Level II. At Level II the concern moves to the District Program Administrator for negotiation/resolution. If the decision is unacceptable at this Level II the issue moves to a formal Administrative Fair Hearing. The participant has ten (10) workdays to make the request for an Administrative Hearing and the Team Leader forwards the request within five (5) days to the OADS Central Office. Within the next three (3) days it is sent on to the Hearings Unit and a hearing will be scheduled within fifteen (15) days.

(c) see information at the link above

In addition to the grievance process above, when participants are denied a service or receives a reduction in services they are notified of their rights to request a fair hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. Select one:

- Yes. The State operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)
- No. This Appendix does not apply (do not complete Items b through e)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As set forth at 14-197 C.M.R. Ch. 12, Section 2(2)(A), the State requires that providers report any incidents (known
as “Reportable Events”) that meet the following criteria:

i. Death, including but not limited to an unexpected death not attributed to a current medical diagnosis or chronic condition and a natural or expected death caused by a long-term illness, diagnosed chronic medical condition, or age;

ii. A Suicide Attempt;

iii. A Suicide Threat made by an Individual Receiving Services, which indicates a present intention to end his or her life and a plan to end his or her life;

iv. Emergency Department visit;

v. Planned or unplanned Hospital admission, including observation status;

vi. Medication Error that leads to a health or safety concern of a serious and immediate nature due to any of the following:
   (a) Refusal to take a prescribed medication;
   (b) Taking medication in an incorrect dosage, form, or route of administration;
   (c) Taking medication on an incorrect schedule;
   (d) Taking medication, which was not prescribed;
   (e) An allergic reaction to a medication; or
   (f) Incorrect procedure followed for assisting an Individual Receiving Services with self-medication.

vii. Medical treatment outside of a Hospital setting provided by Emergency Medical Services beyond first aid;

viii. Serious Injury, defined as an injury where an Individual Receiving Services requires treatment beyond first aid;

ix. Lost or missing Individual Receiving Services;

x. A Physical Plant disaster including, fire, natural disaster, or other incident causing displacement due to the condition of the Physical Plant

xi. Law Enforcement Intervention involving any of the following:
   (a) An Individual Receiving Services is charged with a crime or is the subject of a police investigation;
   (b) An Individual Receiving Services is a victim of a crime and law enforcement has been contacted regarding the crime; or
   (c) Law enforcement personnel have been contacted as a result of planned strategy or unplanned crisis situation.

xii. Transportation accident involving any of the following:
   (a) An Individual Receiving Services is a pedestrian or cyclist involved in a traffic accident;
   (b) An Individual Receiving Services is a passenger in a motorized vehicle or on a watercraft involved in an accident; or
   (c) An Individual Receiving Services is involved in any accident involving a motorized vehicle.

xiii. Physical assault or altercation involving any of the following:
   (a) An Individual Receiving Services initiates a physical altercation with another individual(s) (including staff, another Individual Receiving Services, or any other member of the community);
   (b) An Individual Receiving Services is physically assaulted by another Individual Receiving Services.

xiv. Use of an Emergency Restraint (not as part of an approved behavior plan pursuant to 14-197 C.M.R. ch. 5) on an Individual Receiving Services;

xv. Rights Violation involving any action or inaction that deprives an Individual Receiving Services with an intellectual disability or autism of any of the rights or basic protections described in 34-B M.R.S. § 5605;

xvi. Individual Receiving Services is in a dangerous situation posing an imminent risk of harm to self or others that is not included in any of the categories listed in Section 2(2)(A)(1)-(15).

Regarding the individuals and/or entities that are required to report, a Required Reporter is “any individual involved in the support of an Individual Receiving Services, including but not limited to Mandated Reporters.” (14-197 C.M.R. Ch. 12, Section 1(25). A Provider is “an agency licensed, funded, or regulated in whole or in part by the Department that provides support services to an Individual(s) Receiving Services.” (14-197 C.M.R. Ch. 12, Section 1(21).

Regarding the timelines for reporting, all incidents must be reported as soon as possible, within one business day of the incident (14-197 C.M.R. Ch. 12, Section 2(3).

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Case managers provide information to participants concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives) can notify appropriate authorities. One can also obtain information through Adult Protective Services or the statewide Crisis hotline. Training is available through the
d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Office of Aging and Disability Services receives reports of Reportable Events. Our Reportable Event Database is the Enterprise Information System (EIS), a secure HIPAA-compliant application built on an Oracle database platform. Providers are trained in the entry and use of the EIS, and they can enter reports directly into the system. If a Provider does not have timely access to EIS, they must submit a Reportable Event via fax to the Office of Aging and Disability Services.

Regarding the methods used to evaluate reports, Incident Data Specialists receive and inspect Reportable Events for completeness. All Reportable Events are sent the Case Manager. Reportable Events that allege Rights Violations are also sent to Disability Rights Maine. Disability Rights Maine follows up on these Reportable Events as set forth at 14-197 C.M.R. Ch. 12, Section 3:

5. **Additional Follow-Up on Reportable Events Involving Rights Violations**

A. The Protection and Advocacy Agency shall have access within the Reportable Event Database to Reportable Events that involve one or more alleged Rights Violations.

B. The Protection and Advocacy Agency may investigate any Reportable Event that involves one or more alleged Rights Violations.

C. Providers must cooperate fully with the Protection and Advocacy Agency during any investigation of a Reportable Event involving one or more Rights Violations.

D. Requirements within this Rule related to Provider Reportable Event Internal Review, Remediation, and Follow-Up Reports are not impacted by whether the Protection and Advocacy Agency investigates a Reportable Event involving one or more alleged Rights Violations. Provider requirements following a Reportable Event involving one or more alleged Rights Violations are governed by Section 3.

The State has expectations for both Providers and Case Managers regarding the processes and timeframes for responding to Reportable Events, as set forth at 14-97 C.M.R. Ch. 12, Section 3:

1. **Provider Reportable Event Internal Review and Remediation**

   A. When a Provider becomes aware that a Reportable Event has been reported involving an Individual Receiving Services under the Provider’s care (whether through the Reportable Event Database or otherwise), the Provider shall conduct an Internal Review into the circumstances surrounding the Reportable Event.

   i. The Internal Review may involve, but is not limited to, the following:

      1. Communication with the Individual Receiving Services, if appropriate;
      2. Communication with any witnesses to the Reportable Event, if appropriate;
      3. Survey of the area where the Reportable Event occurred, if appropriate.

   B. The Provider and the Individual Receiving Services’ Case Manager or Care Coordinator shall communicate as part of the Internal Review process and work cooperatively to determine the cause of the Reportable Event and to identify potential Remediation Action Steps.

   C. Following the Internal Review, the Provider shall determine what, if any, Remediation Action Steps would decrease the likelihood that such an incident will reoccur.

   D. Reporting Reportable Event and conducting Internal Review and remediation of Reportable Event does not preclude Providers from conducting reviews and identifying Remediation Action Steps related to other events, incidents, or observations that are not identified within the categories of Reportable Event listed in Section 2(2)(A) (1)-(16).

2. **Provider Reportable Event Follow-Up**

   A. Provider Follow-Up Report

   i. Following the Provider Internal Review, the Provider shall submit a Follow-Up Report to the Department through the Reportable Event Database outlining the following:
1. The date and time of the Reportable Event and, if the Reportable Event is reported in the Reportable Event Database more than one business day from the time of the Reportable Event, an explanation for the delay in reporting;

2. A summary of the circumstances that resulted in the Reportable Event;
3. An outline of any Remediation Action Steps that were taken following the Reportable Event to decrease the likelihood that the same or a similar incident will reoccur, including the date(s) of implementation and the party or parties responsible for implementing each Remediation Action Step;
4. An outline of any future Remediation Action Steps that will be taken to decrease the likelihood that such an incident will reoccur, including the planned dates of implementation, if applicable, and the party or parties responsible for implementing each Remediation Action Step;
5. If no Remediation Action Steps have been or will be taken in response to the incident, an explanation as to why Remediation Action Steps are not necessary.

ii. The Provider Follow-Up Report on a Reportable Event shall be submitted into the Reportable Event Database no later than thirty (30) calendar days from the date of the Reportable Event.

3. Case Manager and Care Coordinator Reportable Event Follow-Up

A. The Case Manager or Care Coordinator shall review the Reportable Event Database to determine whether Provider Reportable Event Follow-Up has taken place and ensure that Remediation Action Steps are reflected in the person-centered plan of the Individual Receiving Services, as necessary.

B. The Case Manager or Care Coordinator shall consult with the Individual Receiving Services on the Remediation Action Steps taken or to be taken by the Provider in a manner that demonstrates inclusion and informed consent of the Individual Receiving Services and his or her legal guardian as appropriate

4. Additional Follow-Up on Reportable Event that involve the Death of an Individual Receiving Services
A. Mortality Review Form
i. Following any Reportable Event that involves the death of an Individual Receiving Services, the Individual Receiving Services’ Case Manager or Care Coordinator shall complete the Mortality Review Form within the Reportable Event Database.
ii. The Mortality Review Form shall be submitted into the Reportable Event Database no later than ten (10) business days from the date of the Reportable Event involving the death of an Individual Receiving Services.
iii. In the event that the Case Manager or Care Coordinator is not available at the time of death, a supervisor of the Case Manager or Care Coordinator shall complete the Mortality Review Form within the required timeframe.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Office of Aging and Disability Services is responsible for overseeing the reporting and response to Reportable Events. For deaths, oversight is conducted as set forth at 14-197 C.M.R. Ch. 12, Section 4(B):

B. Mortality Review Committee
i. The Mortality Review Committee will conduct trend analysis based on completed Mortality Review Form aggregate data.
ii. The Mortality Review Committee will meet quarterly to review any identifiable patterns and trends related to the deaths of Individuals Receiving Services.
iii. The Mortality Review Committee will produce an annual report to the Commissioner that outlines trend analysis findings and makes recommendations to improve care for Individuals Receiving Services.
Additional information regarding frequency and type of oversight for all types of Reportable Events can be found at 14-197 C.M.R. Ch. 12, Section 3:

6. Department and Provider Aggregate Reportable Event Review
A. Providers shall conduct trend analysis of Reportable Event data on an ongoing basis, at least quarterly, in order to identify areas where services may be improved to ensure the health and safety of Individuals Receiving Services.
B. The Department will meet quarterly with every Provider required to report Reportable Event in accordance with this Rule to discuss Reportable Event data collected during the previous quarter, including, but not limited to:
   i. The total number of Reportable Event involving Individuals Receiving Services under the Provider’s care during the quarter;
   ii. Any identified trends and patterns associated with Reportable Events;
Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

(1 of 3)

a. Use of Restraints. (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

- The State does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

- The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

  i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department’s “Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine” are found in 14-197 CMR Chapter 5. The most recent version of the Regulations went into effect in April of 2016. The Department put forth these Regulations in order to implement Maine law regarding the Rights of Persons with Intellectual Disabilities or Autism, which are primarily found in 34-B Maine Revised Statutes §5601- §5610.

The Department defines Restraint and its variations as follows:

“5.02-43 Restraint: means a mechanism or action that limits or controls a Person’s voluntary movement against his or her will. Restraint deprives a Person of the use of all or part of the Person’s body, or maintains a Person in an area through physical presence, physical limitation or Coercion. Restraint includes Blocking, as well as the Coercive movement of a Person to a place where the Person does not wish to go. Restraint also includes any inaction that limits or controls a Person’s voluntary movement, such as refusing to give support to meet a Person’s mobility needs. Some Restraints are Prohibited Practices.”

“5.02-7 Blocking: means a momentary deflection of a Person’s movement, without holding, when that movement would otherwise be destructive or harmful. Blocking is considered a Restraint.”

“5.02-10 Chemical Restraint: means the use of a prescribed medicine when the primary purpose of the medication is a response to behavior rather than a physical condition; and the prescribed medication is a drug or dosage that would not otherwise be administered to the Person as part of a regular medication regimen; and the prescribed medicine impairs the Person’s ability to engage in or accomplish the Person’s usual activities of daily living (as compared to the Person’s usual performance when the medicine is not administered) by causing disorientation, confusion, or an impairment of physical or mental functioning. Medications that help a Person sleep during the Person’s regular sleeping hours are not considered Chemical Restraints.”

“5.02-16 Escort: means physical assistance to support a Person to stand or walk when the person who is providing the support follows the lead of the Person being supported. The use of physical force, the threat
of the use of physical force, or the use of any coercive action to move or compel a Person to move is not an Escort. It is a Restraint.”

“5.02-23 Mechanical Restraint: means an apparatus employed to restrain a Person, or the act of using an apparatus to address Challenging Behavior. A Mechanical Restraint is any item worn by or placed on the Person to limit behavior or movement and which cannot be removed by the Person. Mechanical Restraints include, but are not limited to, devices such as mittens, straps, arm splints and helmets. They do not include positioning or adaptive devices when used prescriptively in accordance with 34-B M.R.S. §5605 (“Rights and Basic Protections of a Person with Intellectual Disabilities or Autism”).”

“5.02-50 Specialized Restraint: is an individualized Restraint approved by the Department to meet a Person’s specific needs that cannot be met through a nationally recognized or certified behavior management program.”

Safeguards for Restraint:

The Planning Team must develop a Behavior Management Plan in consultation with a qualified professional. There are obligatory planning, documentation, and approval requirements before the Behavior Management Plan can be implemented. Restraint is authorized only when there is documentation that less intrusive attempts to address the behavior have been unsuccessful. Restraint cannot be used to change behavior or for the convenience of staff. It may only be used to keep a Person or the community safe. When Restraint is used, it must be kept to a minimum in terms of frequency, duration, and degree of physical intrusion. There are specific requirements when Restraint is part of a Behavior Management Plan, as set forth in 5.05-4:

“A. When a Behavior Management Plan includes Restraint, the Planning Team must ensure that it specifies strategies for continuous monitoring and assessment of:
1. The Person’s physical condition, breathing, circulation or pain;
2. Criteria for attempting release and reengaging the Restraint if necessary;
3. Indicators that identify when the restriction of Rights or the use of Restraint should cease; and
4. How the Person should be supported to resume normal activities.

B. When a Behavior Management Plan includes Restraint, the Planning Team must ensure that a Psychological Assessment has been conducted in the past six months and is considered in the design of the Behavior Management Plan. If Restraint use continues to be recommended in the Behavior Management Plan, the Psychological Assessment must be updated at least every three years.

The Psychological Assessment must include, but is not limited to:
1. Review, consideration and clarification of current and historic diagnoses; and
2. A conceptualization of the Challenging Behavior and recommendations regarding the necessity and anticipated impact of:
   a. Positive Supports;
   b. Environmental modifications;
   c. Restrictions of rights; and
   d. The use of restraint.

C. When a Behavior Management Plan includes Restraint, the Planning Team must ensure completion of a Physician’s Evaluation, in which a physician (as described in 02-373 CMR Ch. 1) or a physician assistant (as described in 02-373 CMR Ch. 2) evaluates the Person no more than thirty (30) days prior to the implementation of the Behavior Management Plan and yearly thereafter. Whenever a significant change in physical or medical condition occurs, a new evaluation must be conducted. In order for a Behavior Management Plan including restraint to be implemented, the Physician’s Evaluation must state in writing that:

1. The proposed Plan is safe, given the Person’s physical and emotional condition; and
2. The behavior cannot be better treated medically.

D. When a Behavior Management Plan includes a Specialized Restraint, the Planning Team must take into account the particular medical condition of the Person, the Person’s history of physical or sexual trauma, or other relevant factors that necessitate the use of a Specialized Restraint. In addition to all other required elements the Behavior Management Plan must include: identification of the need; and a description of the Specialized Restraint.”
The Department acknowledges that emergencies and unforeseen circumstances will occur in which a Person’s Challenging Behavior presents an Imminent Risk to the safety of the Person or community. The criteria for response to these circumstances are outlined at 5.08:

“A. If necessary to protect the Person or the community from Imminent Risk, Emergency Interventions, including Specialized Restraints, otherwise permitted in this regulation may be used on an Emergency basis.

B. When Emergency Intervention is utilized; the least restrictive technique necessary to make the situation safe must be used.

C. Any Emergency Intervention must be terminated as soon as the need for protection is over; no further restriction may be imposed.

D. Emergency Intervention may include temporary removal of personal property to protect the Person or the community from Imminent Risk of injury. The property must be returned as soon as it is safe to do so as required by “Rights and Basic Protections of a Person with Intellectual Disabilities or Autism - 6. Personal property” (34-B M.R.S. §5605.6).

E. Whenever Emergency Intervention is used, it must be reported under Departmental rule 14-197 Chapter 12, §6.03 (“Regulations Governing Reportable Events, Adult Protective Investigations and Substantiation Hearings Regarding Persons with Intellectual Disabilities or Autism – Reportable Events and Protective Responsibilities”).

F. Prohibited practices, as outlined in Section 5.06 of this regulation, must not be used on an Emergency basis.”

If Emergency Intervention occurs repeatedly, the Department requires several additional safeguards, as found at 5.08-3, which mandate that an Individual Support Team (IST) meeting occur:

“If an Emergency Restraint is used on a Person more than three (3) times in a two-week period, or six (6) times in any 365-day period, or is used in a recurring pattern; or other Emergency Intervention (Specialized Restraint or removal of personal property) is used three (3) times in a 365-day period then the Planning Team must ensure a Functional Assessment is developed or updated and the Positive Support Plan reviewed for effectiveness. In addition:

A. An IST must be convened.

B. If the Planning Team determines a Behavior Management Plan is warranted, an appropriate Plan must be developed and submitted for approval pursuant to this regulation.

C. When a Behavior Management Plan is identified as a need and is not developed within sixty days, the Planning Team must identify it as an unmet need.

If the Planning Team does not develop a Behavior Management Plan, the Planning Team must submit to the Review Team for approval a justification explaining why a Behavior Management Plan is not necessary. The Review Team may require that a Behavior Management Plan be developed to address recurring Challenging Behavior.”

Practices prohibited by the Department include several that relate to Restraint, which can be found at 5.06:

• “Certain Physical Restraints (Restraints involving excessive force, punching, hitting, head hold; Prone Restraint, in which the Person is held face down; Restraints that have the Person lying on the ground or in a bed with a worker on top of the Person, on the back or chest, or straddling or sitting on the torso; Restraints that restrict breathing or inhibit the digestive system; Restraints that hyper-extend a joint; Restraints that put pressure on chest; Restraints that rely on pain for control; Restraints that rely on a takedown technique (in which the Person is not supported, allowing for free fall to the floor) or force the Person to his or her knees or hands and knees; Restraint that involves physical contact covering the face; Any Restraint face first against a wall, railing or post; A Restraint or physical intervention which puts the Person off balance not part of a physical restraint program approved by the Department.)”

• “Certain Mechanical Restraints (Totally Enclosed Crib; Camisole or straightjacket; Restraint Chairs; Harnesses; Bed netting; Swaddling, from which the Person cannot remove him or herself; Swaddling
from which the Person can remove him or herself but to which the Person or the Person’s guardian communicates an objection; Prone Mechanical Restraint in which the person is held face down.”
- “Routine use of Emergency Intervention (When an IST is required under §5.08 and a justification to address the Challenging Behavior without a Behavior Management Plan has not been approved by the Review Team.)”

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department is responsible for overseeing the use of restraints. All Behavior Management Plans that include Restraint are classified as either Level 4 or Level 5. There are several different points of review that occur, as outlined at 5.07:

“A. There are three different review tiers for Positive Support Plans and Behavior Management Plans, based on the level of restriction proposed. Planning Teams are responsible for obtaining the designated level of approval prior to implementation of any plan.
1. The Planning Team, the Person or Guardian, and Case Manager must review and approve all plans before they are implemented or sent for further review.
2. A Review Team is responsible for review and disposition of all Behavior Management Plans at Level 3 or above.
3. The Statewide Review Panel is responsible for review of all Behavior Management Plans at Level 5, prior to review by the Commissioner or designee.

B. Review Teams must be maintained as governed by a memorandum of understanding between the Department, the Protection and Advocacy Agency and the Maine Developmental Services Oversight and Advisory Board. Each team shall be composed of:
1. A representative from the Department;
2. A representative from the Protection and Advocacy Agency; and
3. A representative designated by the Maine Developmental Services Oversight and Advisory Board; and

C. A Statewide Review Panel shall be designated and governed by a memorandum of understanding between the Department, the Protection and Advocacy Agency and the Maine Developmental Services Oversight and Advisory Board.

5.07-2 Review Procedures

A. Review Requirements

1. Positive Support Plans at Levels 1 and 2 may be implemented with Planning Team, including Case Manager approval.

2. Each proposed plan must be reviewed at the appropriate level corresponding to the most intrusive proposed restriction of Rights or the use of Restraint before it can be implemented.

3. At each level of review, the requirements for the preceding level of review must have been met and approval obtained.

4. Any member of the Planning Team may request review or involvement by an Advocate. The Advocate must be notified when a Planning Team is considering a Behavior Management Plan at Level 3 or above.

5. Plans requiring approval at Level 3 and above must have the approval and signature of the Case Manager and Case Management Supervisor.

B. Review Team Practices

Behavior Management Plans at Level 3 and above require consideration by the Review Team. The voting members of the Review Team are the representatives from the Department and the Maine Developmental Services Oversight and Advisory Board. The Protection and Advocacy representative is a participating
non-voting member of the Review Team. The Review Team’s role is to ensure compliance with and raise concerns related to, the applicable statutes and regulations.

1. The approval of the Behavior Management Plan at Level 3 and above requires both voting members to vote in favor of the Behavior Management Plan or the Behavior Management Plan with conditions.

2. The Review Team may require additional information prior to approval of any plan.

3. The voting members of the Review Team have the discretion to determine duration of Behavior Management Plan approval to a maximum of one year. If less than one year, the duration of Behavior Management Plan approval must be indicated in writing.

4. The voting members of the Review Team may elect to approve part of a plan, or provide time-limited or conditional approval based on written conditions to be met as defined by the voting members of the Review Team.

5. If either voting member of the Review Team does not approve all or part of a Behavior Management Plan, the voting members of the Review Team must specify the reasons for disapproval in writing.

6. The Case Manager or Case Management Supervisor must participate in the review process.

7. After initial approval of a Behavior Management Plan, the Review Team may refer cases for continued monitoring to the Planning Team, the Case Manager and the case management supervisor. The Review Team must review for approval each Behavior Management Plan at least once a year.

8. The Review Team may, at its discretion, refer any Behavior Management Plan for review by the Statewide Review Panel. The Review Team should consider a referral in cases where resources are an issue in meeting the Person’s support needs without the use of Behavior Management.

9. No Behavior Management Plan component requiring approval at Level 3 or above shall be implemented without appropriate approval as provided by these regulations.

10. Each Review Team must establish a process for review and disposition of Behavior Management Plans requested for emergencies. The Review Team may grant written provisional approval of all or part of an emergency Behavior Management Plan. Provisional approval must be agreed upon by the representative of the Department and Maine Developmental Services Oversight and Advisory Board and must not exceed sixty (60) days. After sixty (60) days the Planning Team must meet all regular requirements for review and disposition of the Behavior Management Plan.

C. Exceptions

Behavior Management Plans requiring approval at Level 5 are rare exceptions and must meet a higher standard of review and approval. Level 5 Behavior Management Plans must have been approved by the Review Team and reviewed by the Statewide Review Panel before being submitted to the Commissioner for disposition.

1. Prior to submitting a Behavior Management Plan for initial approval at Level 5, the Planning Team is required to seek a second opinion from a licensed psychologist or psychiatrist. At the discretion of the Review Team a second opinion may be requested before any annual review.

a. That clinician shall meet with the Person and the Person’s support staff and confer with the Person’s family if they are involved, and the Guardian, if there is one, and Correspondent, if one has been appointed.

b. The clinician must provide a written opinion of the potential risks and benefits of the proposed program.

c. If the clinician providing the second opinion concurs in the need for the program, the Statewide Review Panel will review the plan and make recommendations to the Commissioner.
2. If the Commissioner approves the Behavior Management Plan, the Review Team will assume responsibility for monitoring the Behavior Management Plan.

3. Level 5 Behavior Management Plans must comply with the foregoing review and approval requirements.

5.07-3 Data Collection and Monitoring

A. The Department shall be responsible for collecting and tracking data regarding Behavior Management Plans in each region as directed within the memorandum of understanding governing the statewide Review Teams.

B. The Statewide Review Panel will be responsible for monitoring for quality and consistency.

1. The Statewide Review Panel will examine all new Behavior Management Plans at Level 4 for quality assurance purposes, including concerns regarding the review process, inconsistencies or quality of Behavior Management Plans.

2. The Statewide Review Panel may request data regarding Behavior Management Plans. The team may also request a random sample of Behavior Management Plans for a quality review.

3. The Statewide Review Panel shall review and advise the Department regarding interventions that may put consumers at risk and assure that applicable policies, regulations and laws are being followed.

4. The Statewide Review Panel will provide an annual report to the Commissioner regarding all active and approved Level 5 Behavior Plans.”

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

(2 of 3)

b. Use of Restrictive Interventions. (Select one):

- The State does not permit or prohibits the use of restrictive interventions

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- The use of restrictive interventions is permitted during the course of the delivery of waiver services

  Complete Items G-2-b-i and G-2-b-ii.

  i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

  The State does not permit the utilization of aversive methods to modify behavior. The State defines Aversive as follows: “5.02-3 Aversive: means an intervention or action intended to modify behavior that could cause harm or damage to a Person, or could arouse fear or distress in that Person, even when the intervention or action appears to be pleasant or neutral to others. This is a Prohibited Practice.” Restrictions upon participant rights are authorized only when there is documentation that less intrusive attempts to address the Challenging Behavior have been unsuccessful. Restriction of rights may only be used for keeping the Person or community safe from harm, not to change behavior or for staff convenience. Rights restrictions must be kept to a minimum in terms of frequency, duration, and degree
of physical intrusion. Restricting Basic Rights (inhumane treatment or restricting the right to vote, work, or hold a religious belief) is a Prohibited Practice. Restriction of Activities or Contact with Family or Significant Others is a Prohibited Practice (will not be approved and must not be implemented at any level of intervention). As set forth in 5.06, “Regularly scheduled social activities (such as specified in the Personal Plan) cannot be restricted as part of Behavior Modification or Behavior Management. This includes denial of communication or visitation with family members or significant others for the purpose behavior modification or behavior management.” The State has several safeguards in place regarding allowable restrictions upon participant movement and restrictions upon participant access to other individuals, locations, or activities: “5.02-20 In-Home Stabilization: means a limited period of time for which a Person whose Challenging Behavior has placed that Person or the community in Imminent Risk of harm may be denied access to the community for safety and assessment.” When In-Home Stabilization will be utilized, the Planning Team must develop an In-Home Stabilization Plan. “In-Home Stabilization must be used only to ensure the safety of the Person or the community and must be the result of an assessment that the Person’s Challenging Behavior may continue to pose an Imminent Risk to the Person or the community. In-Home Stabilization must be tied directly to safety and not be used as a teaching or Behavior Modification technique” (5.05-3(D)). Further information can be found in Appendix Three, In-Home Stabilization: “The Functional Assessment of the Person must address the Challenging Behavior and the justification for the use of In-Home Stabilization. The justification must include the history of the Challenging Behavior and the types of problems it poses and how the In-Home Stabilization addresses those problems.

A. The proposed use of In-Home Stabilization must be described in an In-Home Stabilization Plan which includes:
   1. A clear description of the specific Challenging Behavior that initiates a period of In-Home Stabilization.
   2. Criteria that will be used for assessment of discontinuing the In-Home Stabilization.
   3. Criteria that will be used for assessment of continuing the In-Home Stabilization.
   4. The identity of who will conduct the assessment of risk and a description of when those assessments will occur.
   5. A description of how staff will support the Person to transition to regular activities after the period of In-Home Stabilization.

B. The proposed use of In-Home Stabilization for a period not to exceed one hour is a Level 2 intervention. A Level 2 In-Home Stabilization Plan must be derived from the Functional Assessment and incorporated into the Positive Support Plan. A plan for In-Home Stabilization of one hour or less must have the approval of the Planning Team and the Case Manager prior to implementation.

C. The proposed use of In-Home Stabilization for a period greater than one hour, but not to exceed 24 hours, is a Level 3 intervention. The use of a Level 2 In-Home Stabilizations three times or more during any two week period of time requires review and approval as a Level 3 Plan. A Level 3 In-Home Stabilization Plan must be incorporated into the Behavior Management Plan, and is subject to all requirements for Behavior Management Planning, review and approval prior to implementation.

D. In-Home Stabilization at Level 2 or Level 3 must not be applied cumulatively. Once the criteria for safety have been met, or the identified time period has expired, In-Home Stabilization must end and the Person must be supported to transition to regular activities, or be supported to seek emergency medical attention.

E. When the Planning Team identifies a need for In-Home Stabilization beyond 24 hours, the Planning Team must submit an In-Home Stabilization Plan for a Level 4 intervention. The Level 4 In-Home Stabilization Plan must be justified by the Functional Assessment and documentation of prior interventions. The Level 4 In-Home Stabilization Plan must be incorporated into a Behavior Management Plan proposed for review at Level 4. A Level 4 In-Home Stabilization Plan must include, but is not limited to:

1. All information required in the In-Home Stabilization Plan in Part (A), above.
2. A safety assessment describing the criteria to be used at the end of the 24-hour period to determine if there is a need for continued In-Home Stabilization.
3. A plan for in-person safety assessment of the Person by the qualified professional overseeing the plan.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and
overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DHHS has the responsibility to monitor and oversee the use of restrictive interventions. 5.05-5 provides additional detail regarding how oversight is conducted and its frequency:

“Monitoring the Behavior Management Plan
The Planning Team and the responsible qualified professional (as defined at 5.03-3(A)) must continue to monitor implementation of an approved Behavior Management Plan and make modifications as necessary. Their roles are:
A. The qualified professional must oversee implementation and must monitor and document progress at least on a monthly basis. Documentation must include a description of the current and baseline measurements of the frequency, duration, intensity and/or severity of each Challenging Behavior, the interventions used and the result. Documentation must also include recommendations about continuation or modification of Plan elements. The qualified professional must meet and observe the individual at least twice annually.

B. At a minimum, one representative from each agency responsible for the implementation of the approved Plan must be present during these monthly clinical reviews with the qualified professional. Their role is to provide documentation and discussion regarding the effectiveness of the approved Plan and to provide other pertinent input regarding less restrictive alternatives.

C. The individual’s guardian and assigned Case Manager must also be provided the option to participate in the monthly clinical reviews with the qualified professional.

D. The Planning Team, with in consultation with the qualified professional must review, monitor and document the effectiveness of the Plan at least quarterly.
E. Any increase of restrictive measures must be approved by the Planning Team and the Review Team prior to implementation.
F. All modifications of the Behavior Management Plan which include a reduction of restrictive measures must be approved by the Planning Team prior to implementation, and the revised Behavior Management Plan must be sent to the Review Team within thirty (30) days.
G. When a Person has a Behavior Management Plan, the Case Manager must conduct an in-person review of the implementation of the Plan at least quarterly. When the Person does not have a Case Manager, the Q.I.D.P. must monitor the Behavior Management Plan.
1. For the purpose of this review, the Case Manager shall be granted unrestricted access to direct support professionals and the Person’s record; and
2. The Review Team may, at its discretion; request increased monitoring by the Case Manager.”

DHHS has the responsibility to detect the unauthorized use of seclusion. DHHS defines seclusion as follows:

“5.02-47 Seclusion: means the solitary involuntary confinement of a Person for any period of time in a room or a specific area from which egress is denied by a locking mechanism, barrier or other imposed physical limitation. This is a Prohibited Practice. “ Any use of a prohibited intervention must be reported as required in Departmental rule 14-197 Chapter 12, §6.03 (C) (“Regulations Governing Reportable Events, Adult Protective Investigations and Substantiation Hearings Regarding Persons with Intellectual Disability or Autism - Reportable Events and Protective Responsibilities”).

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions
(3 of 3)

c. Use of Seclusion. (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

The State does not permit or prohibits the use of seclusion

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- No. This Appendix is not applicable (do not complete the remaining items)
- Yes. This Appendix applies (complete the remaining items)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Providers who hold license(s) and certification(s) have ongoing responsibility for monitoring participant medication regimens. The methods for conducting and monitoring depend on the level of license and certification. OADS has developed a medication administration course for Shared Living Providers that support one or two individuals. The Department requires that other Direct Support Professionals who administer medications hold a Certified Residential Medication Administration (CRMA) certificate.

Maine State law (34-B M.R.S. Section 5605(8)(D) provides that periodically, but no less frequently than every 6 months, the drug regimen of each person with an intellectual disability or autism must be reviewed by a physician or other appropriate monitoring body, consistent with appropriate standards of medical practice.

Many provider agencies employ or contract with nurse consultants who monitor medication administration within their agencies. All providers must monitor the health and safety of their participants, including those that self-administer medications. The Department requires provider agencies to have policies requiring that participant guardians/families are notified and authorize all medication changes.

The State utilizes the Reportable Events System to receive information relative to inappropriate medication management. Potentially harmful practices are identified by provider or Department...
Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. Select one:

- Not applicable. (do not complete the remaining items)
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. (complete the remaining items)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Anyone assisting in the administration of medication in a licensed residence must complete a Certified Residential Medication Assistant (CRMA) training and be re-certified every two years. This training is monitored by the DHHS, Division of Licensing and Regulatory Services, and includes training and certification of Registered Nurse instructors. This training includes the nurse trainer observing the trainee administering medication.

Providers who operate unlicensed Adult Foster Care/Shared living homes must have completed the abbreviated medication administration course designed specifically for such homes. This requirement is included in the State MaineCare policy (MaineCare Benefits Manual Sec. 29) that governs this waiver.

Staff who work in DHHS licensed facilities must meet the training and certification standards for Certified Residential Medication Aide (CRMA). This requirement is included in State licensing regulations and also State MaineCare policy (Sec. 21 of MaineCare Benefits Manual) that governs this waiver.

Waiver rules require the same training for Community Support, Work Support and Home Support. In Adult Foster Care/Shared Living, unlicensed persons assisting with medication administration must complete a medication course taught by a Registered Nurse and must be re-certified every two years. This training includes the nurse trainer observing the trainee administering medication. Many provider agencies employ or contract for nurse consultants who monitor medication administration within their agencies.

iii. Medication Error Reporting. Select one of the following:

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  Department of Health and Human Services, Office of Aging and Disability Services is responsible for oversight and receiving error reports.

  (b) Specify the types of medication errors that providers are required to record:
As set forth at 14-197 C.M.R. Ch. 12, Section 2(A)(vi), providers are required to record and report as a Reportable Event any medication Error that leads to a health or safety concern of a serious and immediate nature due to any of the following:
(a) Refusal to take a prescribed medication;
(b) Taking medication in an incorrect dosage, form, or route of administration;
(c) Taking medication on an incorrect schedule;
(d) Taking medication which was not prescribed;
(e) An allergic reaction to a medication; or
(f) Incorrect procedure followed for assisting an Individual Receiving Services with self-medication.

(c) Specify the types of medication errors that providers must report to the State:

Same as above.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Monitoring is done either through the reportable event system or through the participant's case manager's review of the Medication Administration Record when using the home visit tool. Reports generated from the reportable events system are aggregated by the provider and reviewed at quarterly lead team meetings.

Appendix G: Participant Safeguards
Quality Improvement: Health and Welfare

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

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:
   a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

   Performance Measures

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

   For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.
Performance Measure:
Percent of participants/legal guardians who annually receive information &
education about how to report abuse, neglect, exploitation & other critical
incidents. Num: total # of participants or legal guardians who annually receive
information & education about how to report abuse, neglect, exploitation & other
critical incidents annually. Denom: total # of waiver participants or legal
guardians.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Information System

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Performance Measure:
Percent of abuse, neglect & exploitation reported through the Adult Protective Services system within one business day. Numerator: total # of incidents of abuse, neglect & exploitation reported within one business day through the Adult Protective Services system. Denominator: Total # of incidents of abuse, neglect & exploitation reported through the Adult Protective System.

**Data Source** (Select one):

Other
If 'Other' is selected, specify:

**Adult Protective System**

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### Performance Measure:
Percent of reports of abuse, neglect & exploitation that were investigated by APS within established timeframes in state rule & policy. Numerator: Total number of abuse, neglect & exploitation reports that are investigated within established timeframes in state rule & policy. Denominator: Total number of incidents of a abuse, neglect & exploitation investigated by APS.

### Data Source (Select one):
- Other
  If 'Other' is selected, specify:

### Adult Protective System

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Performance Measure:
Percent of deaths reviewed by APS. Numerator: Total number of deaths reviewed by APS. Denominator: Total number of deaths reported to APS.

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
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Performance Measure:
Percent of substantiated abuse, neglect, exploitation and unexplained death incidents where required/recommended follow-up was completed. Numerator: Total number of substantiated abuse, neglect, exploitation and unexplained death incidents where recommended follow-up was completed. Denominator: Total number of substantiated abuse, neglect, exploitation and unexplained death incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Protective System

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b. **Sub-assurance**: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

**Performance Measures**

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

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

**Performance Measure:**
Percent of provider follow-up reports submitted within 30 calendar days from the date of the incident. Numerator: Total number of provider incident follow-up reports submitted within 30 calendar days from the date of the incident. Denominator: Total number of incidents requiring a follow-up report.

**Data Source** (Select one):
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If 'Other' is selected, specify:

**Critical Incident Management System (EIS)**

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- Other Specify:

### Performance Measure:

Percent of critical incident trends that resulted in a systemic intervention being completed. Numerator: Number of systemic interventions implemented based on critical incident trends. Denominator: Number of critical incident trends identified for systemic interventions.

### Data Source (Select one):
- Record reviews, off-site
  - If 'Other' is selected, specify:
    - Critical Incident Management System (EIS)/Off-site review

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[Application for 1915(c) HCBS Waiver: Draft ME.013.02.02 - Jan 01, 2018](https://wms-mmdl.cms.gov/WMS/faces/protected/35/print/PrintSelector.jsp)
c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

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

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

Performance Measure:
Percent of unauthorized restraints reviewed with the provider. Numerator: Total number emergency restraints reviewed with provider. Denominator: Total number of emergency restraints.

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
### Critical Incident Management System (EIS)

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Performance Measure:
The percent of Planning Team meetings held in response to 3 incidents of a restraint occurring within a two week period. Numerator: Total number of meetings held. Denominator: Total number of individuals with 3 critical incidents occurring in a two week period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Management System (EIS)

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Performance Measure:
Percent of participants whose behavior plan does not include any instances of the use of seclusion. Numerator: Total number of participants whose behavior plan does not include any instances of the use of seclusion. Denominator: Total number of behavior plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enterprise Information System (EIS)

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Other
Specify:
d. **Sub-assurance:** The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

**Performance Measures**

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

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

**Performance Measure:**

Percent of all participants receiving a physical health exam by their primary care provider on an annual basis. Numerator: Total number of all participants who annually receive a physical health exam. Denominator: Total number of waiver participants.

**Data Source** (Select one):

- **Other**
  - If ‘Other’ is selected, specify:
  - **Medicaid Claims data**

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

Maine participates in the National Core Indicators (NCI) Adult Consumer Survey, which is a face-to-face survey with adults with intellectual/developmental disabilities. The survey is used to assess outcomes of...
b. Methods for Remediation/Fixing Individual Problems
i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. OADS Adult Protective Unit reviews each reported event. Resolution can often mean explanation or clarification dependent upon the nature of the individual concern/problem. If an explanation or clarification is not applicable, the case manager would assist the participant with resolving any immediate issues and develop plans for longer term resolution. In instance where a report is not within required timeframes there is follow-up with the agency or reporting entity.

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

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

- No
- Yes

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.
Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence-based discovery activities that will be conducted for each of the six major waiver assurances;
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent roles/responsibilities of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously assess the effectiveness of the OIS and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

**Appendix H: Quality Improvement Strategy (2 of 2)**

**H-1: Systems Improvement**

a. **System Improvements**

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The primary goals for the Quality Improvement Strategy (QIS) are to administer and evaluate a quality improvement system that ensures participants have choice from a variety of waiver services and available waiver providers to address individual needs including health, safety and welfare at a total cost of services that does not exceed the maximum dollar amount allocated to their level of care and does not exceed the limits of allowable and authorized amounts, allows for the provision of appropriate quality services to eligible...
participants as possible, within available resources; identifies opportunities for improvement and ensures action, when indicated; and ensures that the State meets each of its statutorily required assurances to CMS.

The State has several approaches to collecting data from multiple sources that is then analyzed and used for systems improvement. Within the OADS offices, the Enterprise Information System (EIS) remains the primary source of data for waiver services and serves as the electronic data keeping system. In addition, the State also uses its MMIS to retrieve data. The State also has a reporting capability to bring together data from EIS and expenditure data from MMIS to aggregate the following information:

- Cost comparisons
- Predicting future utilization
- Maintaining cost and budget neutrality
- Evaluating service utilization

The waiver program is managed based on the data that is collected, as stated above. This assists with maintaining financial integrity within the program.

Service utilization, expenditures and other data not only informs OADS and these stakeholders, it also informs the state legislature and a broader constituent group. Data is aggregated annually or more frequently including on an ad-hoc basis. When circumstances warrant, the State uses this information to suggest program re-design to the Legislature and stakeholder groups for consideration.

With regard to the QIS spanning other waivers, Enterprise Information System (EIS) is also used for Maine's other waiver for Adults with Intellectual Disabilities and Autistic Disorder (0159). The information collected for both waivers is stratified.

### ii. System Improvement Activities

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### b. System Design Changes

#### i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

OADS uses data to determine the level of success a service is achieving in improving the health and well-being of participants: to assist and monitor quality; to inform and guide reimbursement decision; and to assess the conditions of provider participation across MaineCare services.

OADS has specific areas of focuses in monitoring of the system. They include participants’ health, safety and welfare, individual choice and quality service delivery. The management team regularly reviews data reports...
on each of the areas. In addition, the OADS Quality Management Team, operating independently, conducts data quality reviews. The results of the data are shared with families, participants, Developmental Disabilities Counsel, MaineCare Advisory Committee, Disabilities Rights Maine and other stakeholder groups.

Quality and Data Management

Health, Safety and Welfare
Standards:
• At least annually, Personal Plans (PCP) are reviewed to assure they address assessed needs; adequately address health and safety risks; identify unmet needs; and have a corresponding interim plan as needed.
• Participants receive appropriate level of preventive health care on an annual basis
• Critical incident reports, reviews and investigations adhere to expected timeframes
• At least annually, information and education specific to identify and report abuse, neglect and exploitation is provided to participants and guardians
• A proposed Behavior Management Plan is reviewed by a qualified professional to assure all possible steps to protect the health, safety, and rights of the member have been taken

Monitoring Activities: PCP Reviews, Reportable Events and Adult Protective Services Investigations Reports, Unmet Need Reports, 90 Reviews, and Ongoing Management Reports, Case Management Manual

Data Source: EIS, MAPSIS, Grievance and Appeals site visits and utilization reviews

Choice of Integrated Community Based Services
Standards
• Settings where waiver services are provided are reviewed for compliance with HBC standards
• Participants receiving Work Support-Individual services will have worked a total number of hours of paid employment during the quarter that is greater than the total number of Work Support-Individual support hours
• Participants use integrated community services and participate in everyday community activities
• Participants have choice from a variety of waiver services and available waiver providers to address individual needs

Monitoring Activities: Site Reviews, Provider Self-Assessment Survey, PCP Reviews,

Data Source: EIS, Provider Sites, Provider Self-Assessment Survey, NCI Survey

Quality Service
Standards:
• Level of Care (LOC) assessments are completed at least annually by qualified staff
• Providers enrolling initially to provide waiver service have appropriate licensure/certification and training for service provision
• Providers maintain appropriate licensure/certification and training for specified waiver service provision
• Provision of services to eligible recipients as possible, within available resources
• Personal Plans implemented include services that meet the participants assessed need.

Monitoring Activities: LOC Assessments, Enrollment and Personnel Records, PCP Reviews, reviews and approvals, 90 Reviews, Waiver Enrollment and Ongoing Management Reports

Data Source: EIS, CDS, Waiver Waitlist and Enrollment Reports, site visits and utilization reviews Grievance and Appeals.

Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

OADS engages with other Offices within the State and contracted entities to review, assess and make recommendations for quality improvements. A Quality Management team works independently within OADS to evaluate quality and propose quality improvement strategies. The assessment, review and recommendations for quality improvements in this system are conducted regularly. These internal and external independent entities reviewing OADS outcome data and improvement processes enhance objective input.

The State's plan is to consolidate this waivers (ME00467) quality report and ME0159 quality report during the next reporting period. For ME0159 the evidence letter will be sent 7/1/18 and the State is requesting that the evidence letter for ME0467 be sent at the same time instead of 1/1/19 so that the two reports can be combined and submitted at the same time. The populations are the same and the services are similar. ME 0159 will be amended at a later date to include this information as well.
Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a- The State of Maine does not require independent audits specific to this waiver.

b- Maine’s published rate system does not require an expense based audit. A "service review" is conducted that consists of review of approved units of service, employee payroll records and documentation in participants’ files to ensure that services were actually provided. The DHHS Resource Coordinators will review a sample of routine cases and will also review the majority of those cases that significantly exceed the utilization and cost. In any case where irregularities are identified, a referral will be made to the DHHS Program Integrity Unit. This process is included in Section 29, Chapter III of the MaineCare Benefits Manual.

c- Maine State Department of Audit will perform the Single Audit as defined in the Single Audit Act (31 U.S.C 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146).

Chapter I of the MaineCare Benefits Manual authorizes audits for Services. The Non-emergency Transportation Waiver 1915b (Me.19) is covered by these same audit requirements.

Appendix I: Financial Accountability

**Quality Improvement: Financial Accountability**

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

a. **Methods for Discovery: Financial Accountability Assurance:**

   *The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.* (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

   i. **Sub-Assurances:**

      a. **Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

         (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
Number and Percent of claims coded and paid for in accordance with the reimbursement methodology. Numerator: Number of claims coded in accordance with the reimbursement methodology. Denominator: Total number of claims paid.

**Data Source** (Select one):
- Financial records (including expenditures)

If ‘Other’ is selected, specify:

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b. **Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

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

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

**Performance Measure:**
Number and Percent of rates consistent with approved rate methodology.
Numerator: Number of rates consistent with approved rate methodology.
Denominator: Total number of rates.

**Data Source** (Select one):
Record reviews, on-site

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

The current MMIS system limits all services provided under the waiver to what is permitted by the policy for each classification group. Claims are denied if improper rates are billed or units of service are billed in excess of the limits outlined in policy.

b. Methods for Remediation/Fixing Individual Problems

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

If concerns are raised by a provider regarding claims, the provider contacts the provider relations specialist through the Medicaid agency. If additional policy issues are identified, OADS requests data from OMS to verify the information. OADS and OMS work together to develop a plan for making changes in policy, provider's billing process and/or the MMIS system.

If the State Medicaid Agency were to identify a problem with claims, they would be evaluated further by having a discussion with the agency submitting the claim. The provider would then need to correct the claim. If there was any indication that the provider knowingly submitted inaccurate claims, or appeared fraudulent in any way, the State's program integrity unit would be contacted. Program Integrity would pull provider records, claims information, member records etc...to determine if there are errors between the service delivered, what's authorized, and how it is billed. Depending on the errors or discrepancies detected, program integrity could seek recoupment, terminate the provider agreement, or even refer the provider to the Health Care Crimes unit of the State's Attorney General's Office.
### ii. Remediation Data Aggregation

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

<table>
<thead>
<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ State Medicaid Agency</td>
<td>☐ Weekly</td>
</tr>
<tr>
<td>☐ Operating Agency</td>
<td>☐ Monthly</td>
</tr>
<tr>
<td>☐ Sub-State Entity</td>
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<td>☐ Continuously and Ongoing</td>
<td></td>
</tr>
<tr>
<td>☒ Other</td>
<td></td>
</tr>
<tr>
<td>Specify:</td>
<td></td>
</tr>
</tbody>
</table>

**c. Timelines**

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

- **No**
- **Yes**

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

---

### Appendix I: Financial Accountability

#### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The rates for ME.0467 are subject to review and amendment by the State legislature. For example, rate and cap increases effective July 1, 2018 resulted from the Maine Legislature’s passage of P.L. 2017, Ch. 459, Parts A and B. The legislation requires the Department to amend its rules for reimbursement for Section 29(ME.0467) to increase rates for specific procedure codes. The legislation directs the Department to increase the rates for specific procedure codes in equal proportion to the funding provided for that purpose. The legislation also requires the rate increases to be effective July 1, 2018. The legislation also provides that the Department ensure that caps and limitations on services "are increased to reflect increases in reimbursements that result from this Part." Therefore, in addition to rate increases, the Department proposes to increase affected service limits in this waiver to ensure that rate increases do not result in decreased level of services for participants.

The rates for the majority of the waiver services are included in the MaineCare Benefits Manual, Section 29, Chapter III. Those that are not specified in the policy are based on actual costs. Home Support, Shared Living, Community Support, Work Support, and Employment Specialist Services: The rates for these services are published in state rule and were determined by a combination of factors:
b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver billings flow directly from service providers to the State’s claims processing system. The current claims system is the Maine Integrated Health Management Solution (MIHMS) and is fully functional regarding claims processing.

The Broker shall receive a monthly capitated per-member–per-month (PMPM) payment for each member whose eligibility for the current month has been confirmed by the Department regardless of the members NEMT service use. This is a full risk contract outside of the MMIS system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

* Analysis of claims data for five year period
* Analysis of costs associated with costs of each service
* Provider Survey
* Analysis comparing comparable positions within Maine and across a selection of other states

The rates are prospective, fee-for-service rates. Rates are published and the public is allowed time to comment. Community Support is paid at a standardized rate per 1/4 hour unit and the rate is based on an overall program staff: participant ratio of 1:4.

Career Planning is paid at a standardized rate per hour unit. Remote Support-Interactive Support uses the same rate as the direct care service of $6.27 since the care is one to one. Remote Support-monitor only $ of 1.62 is approximately equivalent to a group rate of 3.75. This is the average group size that would occur during monitoring only.

Work Support is an individualized service and is paid at a standard 1/4 hour unit rate. Prior to publication, these rates go through the State Medicaid Agency, Finance Division, Commissioner's office for oversight and approval. All rates are proposed in rule and open to public comment.

Specialized Medical Equipment and Supplies, Home Accessibility Adaptations: These goods and/or services are reimbursed at “cost” as long as there is prior approval from DHHS. DHHS requires at least two estimates for Home Accessibility Adaptations being requested and approves the most cost effective estimate.

Assistive Technology-The assessment is based on the rate in the state plan, although the providers differ slightly with the ones serving the participants in this waiver must have experience with Intellectual Disabilities. The transmission is the cost of the monthly fee for the cable or internet. Any equipment or installation costs come under the Assistive Technology device.

This information is gathered by OADS and presented to the Rate Setting Division within DHHS. Rate Setting analyzes the data and formulates the final rate. This rate goes through the State's rule-making process, whereby it is reviewed by the Medicaid Agency, and other DHHS offices. Notification of the rate is made public in several newspapers and providers are also notified electronically. The Department holds a public hearing and/or comment period after publishing notice of the change. All comments are reviewed, summarized and responded to by the Department. Sometimes changes are made as a result of comments.

The most recent rate study was done July 2017 by Burns & Associates, a rate-setting consulting firm contracted to the Maine Department of Health and Human Services, working in collaboration with the Department’s rate-setting unit. Rates are regularly reviewed for economy, efficiency, and quality of care through regular, ongoing collaboration by the Office of Aging and Disability Services, the Office of MaineCare Services, and DHHS’s rate-setting unit.

Transportation Services- The state of Maine has moved from a fee-for-service reimbursement model to a full risk capitation model for MaineCare’ NEMT services. The rates were calculated and were consistent with CMS requirements that the capitation rates be actuarially sound and appropriate for the population covered for the program and conform to capital standards of Practice and promulgated by the actuarial standards board by Deloitte Consulting LLP. The data base variables (by region) included paid amount, number of rides, rides per thousand, average cost per ride, miles, miles per ride, cost per ride, and base per member per month.

Shared Living/Adult Foster Care is the same rate as Maine's comprehensive waiver ME0159.

Transportation Services - The state of Maine has moved from a fee-for-service reimbursement model to a full risk capitation model for MaineCare’ NEMT services. The rates were calculated and were consistent with CMS requirements that the capitation rates be actuarially sound and appropriate for the population covered for the program and conform to capital standards of Practice and promulgated by the actuarial standards board by Deloitte Consulting LLP. The data base variables (by region) included paid amount, number of rides, rides per thousand, average cost per ride, miles, miles per ride, cost per ride, and base per member per month.

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Shared Living/Adult Foster Care is the same rate as Maine's comprehensive waiver ME0159.
Select at least one:

☐ Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant’s approved service plan; and, (c) the services were provided:

(a) The claims system has an internal capacity to determine whether people are eligible as of the date of service as part of processing claim. Claims are not paid to a provider if an individual has not yet been determined eligible, or eligibility for services has lapsed.

(b) When service is recommended in the participant’s plan, authorization is given to the provider in advance of provision of services and authorization is electronically transferred to the claims system.

(c) Provider must document provision of services in the participant’s record.

For Transportation Services- The Broker shall have internal controls, policies and procedures in place designed to prevent, detect and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR parts 455 and 456. The Broker will submit encounter claims data.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS (select one):**
Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

a. Transportation is reimbursed through a 1915b Me.19 Maine Non-emergency Transportation Waiver capitated system with contracted brokers outside the MMIS system. b. The process for making the payments is through contracted services, the entity that processes these payments is the Department of Administration and Finance. c. The Broker shall have internal controls, policies and procedures in place designed to prevent, detect and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR parts 455 and 456. The Broker submits encounter claims data. A review of the encounter data for each transportation broker is completed regularly. Transportation Service reimbursement is capitated and paid to the broker through the monthly invoice submitted to the Department by the Broker. The monthly invoice is paid through the State’s accounting system and subject to the internal controls established by the Office of the State Controller. An audit trail of payments is based on the Maine Medicaid chart of accounts. A detailed explanation of transportation services is described in greater detail in the transportation waiver. The appropriation and unit / Object codes for entry onto line 19A of the CMS64 report are as follows:

Appropriation: 0147-
Unit for waivered services: 3618
Object codes: 6772; 6778; and 6786;
Cash draws for the federal portion of the Payment Management System are completed regularly through the Batch Interface claims processing system; and accounted for through the accounting appropriation 0147 for Medicaid. The unit for waivered services is 3618 using object codes 6772 ; 6778; and 6786. d. The basis of the draw is through the Maine Medicaid chart of accounts. The appropriation and unit / Object codes for entry onto line 19A of the CMS64 report are as follows (and previously noted):

Appropriation: 0147-
Unit for waivered services: 3618
Object codes: 6772; 6778; and 6786;
Cash draws for the federal portion of the Payment Management System are completed regularly through the Batch Interface claims processing system; and accounted for through the accounting appropriation 0147 for Medicaid. The unit for waivered services is 3618 using object codes 6772 ; 6778; and 6786.

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)
b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements *(select at least one)*:

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

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For Transportation Services - The limited fiscal agent is selected through an rfp process. The waiver services that the fiscal agent will make payment for are Transportation Services. The fiscal agent pays through a capitated system. Chapter I of the MaineCare Benefits Manual authorizes audits for Services. The Non-emergency Transportation Waiver 1915b (Me.19) is covered by these same audit requirements. The Broker shall have internal controls, policies and procedures in place designed to prevent, detect and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR parts 455 and 456. The Broker will submit encounter claims data. The broker for transportation is one of 3 contracted entities for the 8 regions depending upon the region in the state. Region 3 is served by Penquis Community Action Program, Region 8 is served by Logisticare Solutions, LLC, and Regions 1,2,4,5,6, and 7 are served by Coordinated Transportation Solutions, Inc.

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c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one*:

- No. The State does not make supplemental or enhanced payments for waiver services.
- Yes. The State makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.
Appendix I: Financial Accountability
I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. Specify whether State or local government providers receive payment for the provision of waiver services.

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability
I-3: Payment (5 of 7)
e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report.

Select one:

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

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability
I-3: Payment (6 of 7)
f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability
I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. Select one:

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b)
the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. Select at least one:

- Appropriation of State Tax Revenues to the State Medicaid agency
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

- Not Applicable. There are no local government level sources of funds utilized as the non-federal share.
- Applicable
  
  Check each that applies:
  - Appropriation of Local Government Revenues.
Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

### Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

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### Appendix I: Financial Accountability

#### I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs
- The following source(s) are used
  
  **Check each that applies:**
  
  - Health care-related taxes or fees
  - Provider-related donations
  - Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

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### Appendix I: Financial Accountability

#### I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** Select one:

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The rate structure for services delivered in residential settings is based solely on the cost of delivering the service and does not include room and board costs. Cost of room and board is paid for separately by a combination of participant...
Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.

- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.
  i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible
- Coinsurance
- Co-Payment
- Other charge

Specify:
Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.
   
   ii. Participants Subject to Co-pay Charges for Waiver Services.
   
   Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.
   
   iii. Amount of Co-Pay Charges for Waiver Services.
   
   Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.
   
   iv. Cumulative Maximum Charges.
   
   Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:
   
   ☐ No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
   
   ☐ Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.
   
   Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in
Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: ICF/IID**

<table>
<thead>
<tr>
<th>Year</th>
<th>Factor D</th>
<th>Factor D'</th>
<th>Total: D+D'</th>
<th>Factor G</th>
<th>Factor G'</th>
<th>Total: G+G'</th>
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<td>198925.00</td>
<td>8126.00</td>
<td>207051.00</td>
<td>169546.68</td>
</tr>
</tbody>
</table>

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (1 of 9)**

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Total Unduplicated Number of Participants (from Item B-3-a)</th>
<th>Distribution of Unduplicated Participants by Level of Care (if applicable)</th>
</tr>
</thead>
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<tr>
<td></td>
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<td>Level of Care:</td>
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<tr>
<td></td>
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<td>2078</td>
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<tr>
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<tr>
<td>Year 3</td>
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<td>2635</td>
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<td>Year 4</td>
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<tr>
<td>Year 5</td>
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<td>2635</td>
</tr>
</tbody>
</table>

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (2 of 9)**

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average LOS equals 320 days. This number equals the amount taken directly from the most recent 372 Waiver reporting that was submitted, which is for FY 2016 (01/01/2016 - 12/31/2016).

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (3 of 9)**

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for
these estimates is as follows:

The D Calculation was based on utilization of services based on FY 2018 actual utilization which includes new services within the waiver as well as estimates from case managers of future utilization for new services (service components which were recently added to the waiver). Community support and home support services were reviewed for SFY 2018 and used as a bases for future utilization. Home Accessibility Modifications and Respite showed utilization increases in Waiver Year 2018. Recent historical utilization was used as a predictor of future utilization during the renewal period. Utilization from FY 2019 was distributed to the new waiver member group of 2,150 and 2635 members. Rates for the renewal were updated and represent the most current rate increases. Utilization for the renewal period were assigned to the services and the member usage was multiplied by the expected units of service as well as by the unit rate. This calculation gave us the total cost for the program for the renewal years.

Adult Foster Care/Shared Living determinations were based on FY 2018 utilization. In addition to the noted rate studies and changes, legislative increases effective 7/1/2017 to 6/30/2018 occurred. Increased funding effective 7/1/2018 to 6/30/2019 due to LDs 924 & 925 allowed for increased rates as well as enrollments.

As indicated in Appendix C of the submitted amendment, ME.0467 defines this service as follows:

Shared Living/Adult Foster Care; Community Support, and Home Support. Personal care and supportive services (e.g., homemaker, chore, attendant care, companion, medication oversight (to the extent permitted under State law) provided in a private home by a principal care provider who lives in the home. Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal care and protective oversight and supervision. Services can be provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Adult Foster Care is considered a residential habilitation service only when habilitation is included in the defined scope of the adult foster care services. Adult foster care is not considered a residential habilitation service when habilitation services are furnished in the adult foster care setting by a different provider and billed separately. A provider may not have more than two people that they care for in one home.

In the Department’s experience with ME.0159, the rate has been found to be sufficient to maintain this service for this population. Based on FY 2018 utilization, the rate is sufficient for the ME.0467 waiver. The Adult Foster Care/Shared Living service and procedure code have been in effect for nearly 5 years. Maine will continue to assess the economy, efficiency, and adequacy of rates on an ongoing basis. But thus far, the new service at the $156.00 per diem rate is improving access for the waiver population. Maine still intends to engage in a rate study in the near future to determine any necessary adjustments that may need to be made to this rate (i.e. for Adult Foster Care/Shared Living).

**ii. Factor D’ Derivation.** The estimates of Factor D’ for each waiver year are included in Item J-1. The basis of these estimates is as follows:

For Year 1 of the renewal period, the amount (13,730) was taken directly from the most recent 372 Waiver report that was submitted, which is for FY 2016 (01/01/2016 - 12/31/2016). Starting with the year 3 renewal period, and ending with the year 5 renewal period. A 2% projected increase was used based on projected budget increases for the 5 year time period.

**iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G changes reflect utilization from the most recently completed FY 2016 372 Report. Projections were based on a 0% budget increase for years 3 through 5 for Factor G.

**iv. Factor G’ Derivation.** The estimates of Factor G’ for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G’ changes reflect utilization from the most recently completed FY 2016 372 Report. Projections were based on a 0% budget increase for years 3 through 5 for Factor G.
Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

<table>
<thead>
<tr>
<th>Waiver Services</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Support</td>
<td></td>
<td></td>
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<tr>
<td>Home Support-1/4 hour</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respite</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work Support- Group</td>
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</tr>
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<td>Assistive Technology</td>
<td></td>
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</tr>
<tr>
<td>Career Planning</td>
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</tr>
<tr>
<td>Employment Specialist Services</td>
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<td>Home Accessibility Adaptations</td>
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<td>Home Support-Remote Support</td>
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<tr>
<td>Non-MedicalTransport</td>
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<tr>
<td>Work Support-Individual</td>
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</tr>
</tbody>
</table>

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. **Estimate of Factor D.**

   ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

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<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/ Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
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<td>Community Support</td>
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<td></td>
<td></td>
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<td></td>
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<td>per 1/4 hour</td>
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</tr>
<tr>
<td>Factor D (Divide total by number of participants)</td>
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</tbody>
</table>
Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Capitation</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Support Total:</td>
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</tr>
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<td>2329.00</td>
<td>5.93</td>
<td>13838591.94</td>
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<td>per 1/4 hour</td>
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<td>7.04</td>
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<td>11.00</td>
<td>100.11</td>
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<td>7708.47</td>
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</tr>
<tr>
<td>Respite Services-1/4 Hour</td>
<td>per 1/4 hour</td>
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<td>1.00</td>
<td>3.31</td>
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<tr>
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d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

### Waiver Year: Year 3

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</tr>
<tr>
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</tbody>
</table>
d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

### Waiver Year: Year 4

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<th>Avg. Cost/Unit</th>
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<th>Total Cost</th>
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<td>2372</td>
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<td>6.53</td>
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<td>per 1/4 hour</td>
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<td>per diem</td>
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<td>per 1/4 hour</td>
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<td>12406.24</td>
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<td>2.82</td>
<td>146.64</td>
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<td>2.12</td>
<td>674.16</td>
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<td>per 1/4 hour</td>
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<td>1.69</td>
<td>486.72</td>
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</tr>
<tr>
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<td>1.00</td>
<td>1.41</td>
<td>1.41</td>
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d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component average length of stay on the waiver.

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<th>Avg. Cost/Unit</th>
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<tr>
<td>Two person placement</td>
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<td>Assistive Technology-Device</td>
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Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)
Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

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<td>Work Support- Group-Five Participants</td>
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<td>Work Support- Group-Six Participants</td>
<td>per diem</td>
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<td>Adult Foster Care/Shared Living Total:</td>
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<td>Adult Foster Care-One person placement</td>
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<td>Adult Foster Care-Two person placement</td>
<td>per month</td>
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<td>Assistive Technology-Assessment</td>
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<td>Career Planning Total:</td>
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<td>26.00</td>
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<td>Home Accessibility Adaptations Total:</td>
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### Support Total:

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<tr>
<th>Service Type</th>
<th>Units</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Interactive Support</td>
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<td>1.00</td>
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<tr>
<td>Monitor only</td>
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<td>1.00</td>
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**Total:** 9.38

### Non-Medical Transportation Total:

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<td>Non-Medical Transportation - PMPM</td>
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**Total:** 9,599,515.80

### Work Support - Individual Total:

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<tr>
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<tbody>
<tr>
<td>Work Support - Individual</td>
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**Total:** 17,102,73.60

**Grand Total:** 65,072,169.06

**Total: Services included in capitation:** 1.63

**Total: Services not included in capitation:** 65,072,167.43

**Total Estimated Unduplicated Participants:** 2,635

**Factor D (Divide total by number of participants):** 2,469.32

**Services included in capitation:** 0.00

**Services not included in capitation:** 2,469.32

**Average Length of Stay on the Waiver:** 341