DATE: November 12, 2013

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services


The Department made changes to the rule to comply with the concurrent operation of a 1915(b) Non-Emergency Transportation Waiver. The changes to Section 32 included referencing the regional, risk-based, Pre-Paid Ambulatory Health Plan (PAHP) Brokerages operating under a 1915(b) waiver (see 42 U.S.C. §1396n) approved by the Centers for Medicare and Medicaid Services (CMS). Under risk-based contractual agreements, the Department contracted with Broker(s) to establish, manage, authorize, coordinate and reimburse the provision of Non-Emergency Transportation (NET) services for eligible MaineCare members. The Broker(s) are responsible for establishing a network of NET drivers to deliver NET transportation services to eligible members within assigned regions.

The Department has also made a number of other changes:

1. The Department made changes to the definitions of “seclusion” and “restraint” to conform to the definitions employed in the Department of Education’s regulations (5-71 C.M.R. ch. 33). The Department of Health and Human Services was directed by the Legislature’s Committee on Health and Human Services to amend Chapter II to mirror the definitions of seclusion and restraint in the Department of Education’s regulations.

2. The Department replaced the term “aggression” throughout the rule with “self-injurious behavior and/or aggression.”

3. The Department added language that clarified, for purposes of initial and continuing eligibility, that the annual cost of a member’s services under Section 32 may not exceed the statewide average annual cost of care for an individual in either (a) an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or (b) an Inpatient Psychiatric Facility for individuals age 21 and under, depending upon the level of care at which the individual qualified for the waiver. This is not a new limit; the Department made the changes to clarify that these limits are not fixed numbers, but instead change each year based upon the prior year’s statewide average annual cost of care for the respective facility type.

5. The Department clarified the requirements for providers of Section 32 services. These changes included clarification of the circumstances under which Behavioral Health Professionals may assist with administration of medication, requirements for Respite Service providers, and a requirement that providers put in place a Department-approved informed consent policy.

6. Performance Measures were adopted in Section 32.11. The primary goal of Performance Measurement is to use data to determine the level of success a service is achieving in improving the health and wellbeing of members. Performance Goals and Performance Measures have been established to monitor quality, inform and guide reimbursement decisions and conditions of provider participation across MaineCare services. This focus on Performance Measurement is anticipated to enhance the overall quality of services provided and raise the level of public accountability for both the Department and MaineCare providers.

Additionally, changes to the final rule were made based on the recommendation of the Attorney General’s office.

1. 32.02-1, “means” was inserted into the definition.
2. 32.03-2(B), there was an incorrect citation; 34-B MRSA § 6001 has been changed to 5001.
3. In 32.05-1, a comma was added after the reference to the MaineCare Benefits Manual and a reference to (14 472 CMR 1) was inserted.
4. In 32.05-1(C), a typographical error “has an change” was changed to “has any change.”
5. In 32.05-1(F), a hyphen was inserted in DHHS-sponsored.
6. In 32.05-1(N), the reference to SAMHSA’s system of care principles was modified to refer to an appendix added containing a copy of the principles and called APPENDIX I-Federal Substance Abuse and Mental Health Services Administration’s (SAMHSA) System of Care Principles.

A public hearing was held on August 26, 2013. There were no attendees. The comment deadline was September 5, 2013.

Rules and related rulemaking documents may be reviewed at, and printed from, the MaineCare Services website at [http://www.maine.gov/dhhs/oms/rules/index.shtml](http://www.maine.gov/dhhs/oms/rules/index.shtml) For a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

A copy of the public comments and Departmental responses may be viewed at, and printed from, the MaineCare Services website or obtained by calling (207) 287-9368 or TTY: 711.

If you have any questions regarding the policy, please contact Provider Services at 1-866-690-5585 or TTY: 711.
Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, Office of MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapter 101, Chapter II, Section 32, Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders.

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The Department made changes to the rule to comply with the concurrent operation of a 1915(b) Non-Emergency Transportation Waiver. The changes to Section 32 included referencing the regional, risk-based, Pre-Paid Ambulatory Health Plan (PAHP) Brokerages operating under a 1915(b) waiver (see 42 U.S.C. §1396n) approved by the Centers for Medicare and Medicaid Services (CMS). Under risk-based contractual agreements, the Department contracted with Broker(s) to establish, manage, authorize, coordinate and reimburse the provision of Non-Emergency Transportation (NET) services for eligible MaineCare members. The Broker(s) are responsible for establishing a network of NET drivers to deliver NET transportation services to eligible members within assigned region.

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6. In 32.05-1(N), the reference to SAMHSA’s system of care principles was modified to refer to an appendix added containing a copy of the principles and called APPENDIX I- Federal Substance Abuse and Mental Health Services Administration’s (SAMHSA) System of Care Principles.

The Department does not anticipate that this rule change will impose any additional cost on municipalities or counties or have any adverse impact on small businesses.


EFFECTIVE DATE: November 17, 2013

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APPENDICES

Appendix #1 Federal Substance Abuse and Mental Health Services Administration’s (SAMHSA) System of Care Principles
32.01 INTRODUCTION

MaineCare members who are at least five (5) years of age and under seventeen (17) years and who have Intellectual Disabilities or Pervasive Developmental Disorders are eligible for this Home and Community Waiver Benefit. Once admitted into the program, a member may remain in it until his or her 21st birthday, assuming that the member continues to meet other conditions of eligibility.

The intent of this service is to provide members the opportunity to remain in their own homes or in other homes in the community, avoiding or delaying institutional care. Home and Community Waiver benefits supplement, but do not replace, the natural support of family and community relationships. These benefits complement, but do not duplicate, the services that are available to members through other sections of the MaineCare Benefits Manual. MaineCare members can receive Home and Community Waiver benefits under only one Home and Community waiver at a time.

The Home and Community Waiver Benefit is offered in a community-based setting as an alternative for members who qualify for the level of care provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or a Psychiatric Hospital.

Eligibility for this benefit is based on meeting criteria identified in 32.03-1 and 32.03-2 and priority status and the availability of a funded opening for which the individual qualifies, as detailed in subsections 32.03-3, 32.03-4 and 32.03-5. When no funded openings are available, an otherwise eligible individual may be placed on a waiting list, and will be selected to fill a new funded opening in priority order, as described in subsections 32.03-6 and 32.03-7. An individual’s eligibility for this benefit must be redetermined on an annual basis.

32.02 DEFINITIONS

32.02-1 Authorized Agent means an organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.

32.02-2 Agency Home Support means a facility that routinely employs direct care staff to provide direct support services in an agency operated facility.

32.02-3 Behavioral Interventions are actions such as redirection or blocking necessary to maintain safety. Redirection consists of directing a member to a task where the undesirable behavior is not observed when there is a behavior that would otherwise be destructive, harmful or dangerous to self or others. Blocking is a momentary deflection of a member’s movement, when that movement would otherwise be destructive, harmful or dangerous to self or others. These interventions are less severe than Restraints or Seclusion. Behavioral Interventions must be consistent with the current Behavior Regulations Governing Emergency Interventions and Behavioral Treatment for People with Intellectual Disabilities and/or Autism applicable to children, upon DHHS’s adoption of such regulations.
32.02 DEFINITIONS (Cont)

32.02-4 Comprehensive Assessment is a thorough evaluation intended to identify strengths and needs of the member and family. The Comprehensive Assessment provides the basis of the Waiver Service Plan. The comprehensive assessment process determines the intensity and frequency of medically necessary services and includes use of tools as may be approved or required by DHHS.

32.02-5 Crisis/Safety Plan is a plan that addresses the safety of the member and others surrounding a member experiencing a crisis. The Plan must be current, individualized and updated regularly to reflect the changing needs and circumstances of the member.

32.02-6 Department of Health and Human Services (DHHS) is the state agency that manages the Office of MaineCare Services (OMS), and the Office of Child and Family Services (OCFS).

32.02-7 Discharge Plan is a document that describes the circumstances of completion of the member’s treatment.

32.02-8 Discharge/Closing Summary is a document that describes treatment and other support services that the member received from admission through discharge from treatment under this program.

32.02-9 Family, unless otherwise defined in this Section, means the primary caregiver(s) in a member’s daily life, and may include a biological or adoptive parent, foster parent, legal guardian or designee, sibling, stepparent, stepbrother or stepsister, brother-in-law, sister-in-law, grandparent, spouse of grandparent of grandchild, a person who provides kinship care, or any person sharing a common residence as part of a single family unit.

32.02-10 Family Home Support means services provided to the member in the family environment with the family and the member sharing a home that is not owned by a provider agency.

32.02-11 Intellectual Disability means a diagnosis of mental retardation as defined in Section 317-319 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 34-B MRSA § 5001. The terms “mental retardation” and “intellectual disability” are used interchangeably in these regulations. Use of the term “intellectual disability” in no way alters the criteria for eligibility set forth in §32.03-2.

32.02-12 Mechanical Restraint is any item worn by or placed on the member to limit behavior or movement and which cannot be removed by the member.
32.02 DEFINITIONS (Cont)

32.02-13 Member is a person who is eligible for MaineCare.

32.02-14 Natural Supports include the relatives, friends, neighbors, and community resources that a family goes to for support. They may participate in the treatment team, but their services will not be paid for by MaineCare.

32.02-15 Office of Child and Family Services (OCFS) is the DHHS service office responsible for administration and oversight of this Home and Community Waiver benefit. OCFS or its Authorized Agent is responsible for authorizing services and approving service providers.

32.02-16 Parent or Guardian is the biological or adoptive parent, or the legal guardian of the member. He or she must be a participant in the Support Team, but MaineCare will not pay the parent or guardian for participation. The member's parent or guardian must sign the Waiver Service Plan.

32.02-17 Pervasive Developmental Disorder (PDD) is a diagnosis that includes Autistic Disorder. Pervasive Developmental Disorder—not otherwise specified, Asperger's Syndrome, Rett's Disorder and Childhood Disintegrative Disorder, as described in Section 299.0-299.80 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of autism codified in 34-B MRSA § 6002 and accompanying rules.

32.02-18 Physical Restraint is an intervention that restricts a member's freedom of movement or normal access to his or her body, and includes physically moving a member who has not moved voluntarily. Physical restraint does not include: physical escort, physical prompt, physical contact when the purpose of the intervention is to comfort a member and the member voluntarily accepts the contact, momentarily deflecting the movement of a member when the member's movement would be destructive, harmful or dangerous to the member or to others, the use of seat belts, safety belts or similar passenger restraint, when used as intended during the transportation of a child in a motor vehicle, the use of a medically prescribed harness, when used as intended, or a brief period of physical contact necessary to break up a fight.

32.02-19 Prior Authorization is the formal process of approval by DHHS or its Authorized Agent of Waiver Services before they are delivered.

32.02-20 Restraint is either a Mechanical Restraint as described in 32.02-12 or a Physical Restraint as described in 32.02-18.

32.02-21 Seclusion is the involuntary confinement of a member alone in a room or clearly defined area from which the member is physically prevented from leaving. Seclusion is not timeout.
32.02 DEFINITIONS (Cont)

32.02-22 Support Team is the group of people responsible for developing and reviewing a member's Waiver Service Plan. The team must include the parent or legal guardian of a minor child. The team may include the member, to the extent possible, and also include the member's family, case manager, waiver service provider, any other pertinent professionals, and those who provide natural supports.

32.02-23 Utilization Review is a formal assessment of the medical necessity, efficacy and appropriateness of services in the Waiver Service Plan on a prospective, concurrent or retrospective basis.

32.02-24 Waiver Service Plan is the plan of care developed by the Support Team. The Waiver Service Plan is based on a comprehensive assessment of the member. The Waiver Service Plan includes measurable goals and objectives, timelines and Crisis/Safety and Discharge Plans, where appropriate.

32.03 DETERMINATION OF ELIGIBILITY

Eligibility for this benefit is based on the following three sets of criteria: 32.03-1 General Eligibility Criteria, 32.03-2 Specific Eligibility Criteria for Services and 32.03-3 Priority.

32.03-1 General Eligibility Criteria

To be eligible for these services, members must be at least five (5) years of age and under seventeen (17) years and meet the criteria in section 32.03-4 and all of the following criteria:

A. Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual (MEM).

B. All Home and Community Waiver benefit services provided must be reviewed and be authorized at least annually by the DHHS or its Authorized Agent.

C. Once admitted to the Home and Community Waiver benefit, a member may continue to receive waiver services until the member turns twenty-one (21), assuming that the member continues to meet all other criteria for eligibility.

D. Individuals must meet the medical eligibility criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) as set forth under the MaineCare Benefits Manual, Chapter II, Section 50 or the medical eligibility criteria for admission to a Psychiatric Hospital as set forth under the MaineCare Benefits Manual, Chapter II, Section 46.
32.03 DETERMINATION OF ELIGIBILITY (Cont)

E. The estimated cost of the member’s waiver services cannot exceed the cost limits specified in § 32.06 of this rule.

32.03-2 Specific Eligibility Criteria for Services

To be eligible for these services, members must meet the criteria in section 32.03-3 and must have:

A. Intellectual Disabilities:

An Axis II diagnosis of Mental Retardation as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association) (DSM) that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 34-B MRSA § 5001.

OR

B. Pervasive Developmental Disorders (PDD):

An Axis I diagnosis which falls within the category of Pervasive Developmental Disorders (PDD) which include Autistic Disorder, Asperger’s Syndrome, Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS), Rett’s Disorder, and or Childhood Disintegrative Disorder, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association) (DSM) that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 34-B MRSA § 5001.

AND

A documented assessment of functional impairment measured as two (2) standard deviations below the mean on the composite score of the Vineland Adaptive Behavior Scale or the Adaptive Behavioral Assessment Scales (ABAS). Other comparable functional assessment tools that are proven to be reliable and valid, and that are approved by DHHS, may also be used.

32.03-3 Priority

When a member is found to be eligible under Sections 32.03-1 and 32.03-2 for these services, the priority for a funded opening shall be established in accordance with a weighted assessment of the following criteria as documented in the member’s medical record:
Frequency and severity of self-injurious behavior and/or aggression to others within the past two months or for the two months prior to an admission to a treatment facility if the child is currently in a facility;

Number of environments in which self-injurious behavior and/or aggression to others occurs within the past two months or for the two months prior to an admission to a treatment facility if the child is currently in a facility;

Seriousness of injury resulting from self-injurious behavior and/or aggression to others within the past two months or for the two months prior to an admission to a treatment facility if the child is currently in a facility;

Frequency and length of Restraint and/or Seclusion within the past two months or for the two months prior to an admission to a treatment facility if the child is currently in a facility;

Frequency of Behavioral Interventions within the past two months or for the two months prior to an admission to a treatment facility if the child is currently in a facility;

Level of supervision to maintain safety within the past two months or for the two months prior to an admission to a treatment facility if the child is currently in a facility;

Frequency and length of stays in hospitals, Intermediate Care Facilities for Individuals with Intellectual Disability (ICFID) or residential treatment facilities within the past twelve (12) months;

Presence of symptoms in the past two (2) months, or for the two months prior to an admission to a treatment facility if the child is currently in a facility, of medical and or behavioral needs so severe that the level of available home and community supports are not sufficient to maintain the member safely or there would be significant risk of harm to self or others if a lower level of care were attempted;

Current presence in a hospital, Intermediate Care Facility or Residential Treatment Facility due to severe behavioral needs or medical need, or both;

Frequency and severity of self-injurious behavior or aggression to others causing or having the potential to cause injury to self or others within the past two months or for the two months prior to an admission to a treatment facility if the child is currently in a facility; and

Frequency and severity of self-injurious behavior or aggression to others causing or having the potential to cause property destruction or injury to animals within the past two (2) months or for the two months prior to an admission to a treatment facility if
32.03 DETERMINATION OF ELIGIBILITY (Cont)

the child is currently in a facility.

32.03-4 Reserved Capacity

Effective 11/17/13

The DHHS or its Authorized Agent reserves a portion of the funded openings of the waiver for specified purposes subject to CMS review and approval in order to address the needs of members with health and safety concerns.

Eligible members will be considered for reserved capacity if they meet the increased level of support criteria as detailed in 32.10.

The number of reserved capacity funded openings associated with 32.03-4 is an average based on DHHS data from recent years.

32.03-5 Wait List

Effective 11/17/13

DHHS or its Authorized Agent will maintain a wait list of eligible MaineCare members who cannot get waiver services because a funded opening is not available. Members who are on the wait list for the benefit services shall be served in accordance with the priorities identified above in Section 32.03-3.

32.03-6 Choosing Whom to Serve Within the Same Priority

Effective 11/17/13

If the number of openings is insufficient to serve all members on the waiting list who have been determined eligible, at the time that any opening is determined to be available, to be within the same priority group, DHHS or its Authorized Agent shall first determine whether each member continues to meet the financial and medical eligibility criteria to be served through this benefit. For those who continue to meet such criteria, DHHS or its Authorized Agent will request updated documentation and will redetermine current services and DHHS or its Authorized Agent shall determine which members to serve. The determination will be based on a comparison of the members' known needs, the availability of capable service providers who can adequately meet those needs, and the comparative degree of risk of harm that each member will likely experience in the absence of the provision of the benefit.

32.03-7 Redetermination of Eligibility

Effective 11/17/13

The family must submit a Redetermination of Eligibility form and accompanying documentation to DHHS or its Authorized Agent twelve (12) months from the date of initial approval, and every twelve (12) months thereafter. Late submission of a Redetermination of Eligibility form may result in termination or delays of reimbursement to the provider for services or termination of services. If the updated Redetermination of Eligibility form is received after the due date, reimbursement for
32.03 DETERMINATION OF ELIGIBILITY (Cont)

Services will resume upon receipt of the form. Whenever significant changes occur that alters eligibility, the family must submit an updated Redetermination of Eligibility form to DHHS or its Authorized Agent within ten (10) days of the change.

32.03-8 Approved Opening

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

If the member is found to be medically and financially eligible, DHHS must send the member or guardian written notice that the member has the choice of receiving institutional care or services under this Section. In order to receive services under this section, the member or guardian must submit to DHHS a signed choice letter documenting the member’s choice to receive services under this section.

32.04 COVERED SERVICES

A covered service is a medically necessary service provided to a member for which payment may be made under the MaineCare Program. The following services are covered under this program when provided to an eligible member by approved staff.

Covered Services in this section are:

32.04-1 Home Support Services are medically necessary support services designed to improve or preserve functional abilities that have been negatively affected by the member’s intellectual disabilities or pervasive developmental disorders. These services are focused on behavior modification and management, social development, and acquisition and retention of developmentally appropriate skills.

Home Support is direct support to a member and is primarily habilitative training and/or personal assistance to support developmental stability or growth, and to promote personal well-being. This habilitative service focuses on community inclusion, personal development, and support in areas of daily living skills. Home Support is intended to be flexible, responsive and provided to members consistent with his or her Waiver Service Plan. Comprehensive Assessment and Waiver Service Plan development are components of Home Support. Home Support Services are provided in the member’s home or an agency owned home.

Home Support activities include the following:

Personal assistance is assistance provided to a member in performing tasks the member would typically perform if the member did not have his or her disability.
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ESTABLISHED: 7/1/11
EFFECTIVE: 11/17/13

32.04 COVERED SERVICES (Cont)

Personal assistance may include performance of guiding, directing, or overseeing the performance of self-care and self-management of activities.

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

Self-management includes assistance with managing safe and responsible behavior; exercising judgment with respect to the member’s health and well-being; communication, including conveying information, interpreting information, and advocating in the member’s interests; managing money including paying bills, making choices on how to spend money, keeping receipts, and expending funds with the permission of a member’s representative payee. Self-management also includes teaching coping skills, giving emotional support, and guidance to other resources the member may need to access.

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

Activities that support personal well-being include directly or indirectly intervening to promote the health and well-being of the member. This may include identifying risks such as risk of abuse, participating in a member’s risk assessment, identifying and reporting to an immediate supervisor changes in health status and behavior; anticipating or preventing unsafe or destructive behavior; and safely intervening against undesirable behavior according to an intervention plan. It may also be necessary to seek emergency medical or safety assistance when needed and comply with incident reporting requirements.

32.04-2 Respite Services are services furnished on a short-term basis due to the absence of or need for relief of those persons who normally provide care. Respite services are provided to members unable to care for themselves. Respite care can be given in the member’s home, respite provider’s home or other location as approved by DHHS.
32.04 COVERED SERVICES (Cont)

The setting must be identified on the Waiver Service Plan and approved by the parent or guardian. This service is available to members residing in their own homes or family member’s homes, but not to members residing in homes owned or operated by an agency or provider.

32.04-3 **Home Accessibility Adaptations** are all physical alterations to a member’s home or the member’s family home that are necessary to ensure the health, welfare, and safety of the member. The need for Home Accessibility Adaptations must be documented in the member’s Waiver Service Plan. Home Accessibility Adaptations allow the member to function with greater independence in the home, and prevent the member being forced into a more restrictive environment or institutionalization.

Reimbursement for Home Accessibility Adaptations under this section is available only for home accessibility adaptations that are not covered under other sections of the MaineCare Benefits Manual. Reimbursement is available only for adaptations that are medically necessary as documented by a licensed physician or other appropriate professional such as an Occupational Therapist, Physical Therapist or Speech Therapist and approved by DHHS.

Only items in excess of five hundred dollars ($500) require documentation from a physician or other appropriate professional that the purchase is appropriate and medically necessary to meet the member’s need.

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;
- Non-breakable windows, e.g. Lexan, for health & safety purposes;
- Specialized flooring (to improve mobility and sanitation).

MaineCare will not pay for those adaptations or improvements to the home that are of general utility, and that are not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are also excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). In-floor radiant heating will not be paid for under this program. General household repairs are not included in this benefit.
All adaptations must comply with applicable local, State or Federal building codes.

MaineCare will pay for home accessibility adaptations only to a home owned by the member or member's family; payment is not available for adaptations to homes owned or operated by a provider or agency. Home Accessibility Adaptation benefits are subject to the limitations in § 32.06.

32.04-4 Consultation Services are services provided to persons responsible for developing or carrying out a member's Waiver Service Plan. Consultation Services are advisory in nature and are provided by licensed or certified professionals in their areas of expertise. Brief, goal oriented consultation services are used to assist parents, service providers, and the Support Team to provide for the needs of the member.

Consultation Services include:

A. Professional evaluations and assessments of the member's present and potential level of psychological, physical, speech, occupational, recreational and social functioning, direct interviews with the member and others involved in the Waiver Service Plan; review and analysis of previous reports and evaluations; review of current treatment modalities and the particular applications to the individual member; advice to the support team.

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

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

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

E. Providing information and assistance to the member and Support Team.

MaineCare will pay for consultation services only in the following specialties: Occupational Therapy, Physical Therapy, Speech Therapy, Recreational Therapy, Psychiatry, Behavioral Services and Psychological services.

32.04-5 Communication Aids are devices or services necessary to assist a member with hearing, speech or vision impairments to effectively communicate with service providers.
32.04 COVERED SERVICES (Cont)

providers, family, friends, and other community members. MaineCare will also pay the cost of repairing and maintaining these Communication Aids.

Communication Aids include:

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

B. Speech amplifiers, aids and assistive devices if not otherwise covered for reimbursement under other sections of the MaineCare Benefits Manual.

32.04-6 Transportation Services are provided under the MaineCare Benefits Manual, Section 113 (Non-Emergency Transportation Services) offered in order to enable members to gain access to waiver and other community services, activities and resources, as specified by the Waiver Service Plan.

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

32.05 POLICIES AND PROCEDURES

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32.05-1 Provider Agency Requirements

All providers of services under this Section must be enrolled and approved as MaineCare providers by MaineCare Services (OMS). In addition to meeting the general requirements for MaineCare enrolled providers, providers of services under this program must be approved by OCFS and must meet all applicable provider requirements of this Section. Providers are also subject to all requirements of the MaineCare Benefits Manual (MBM), Chapter I, General Administrative Policies and Procedures, and the Rights of Recipients of Mental Health Services Who Are Children in Need of Treatment (14 472 CMR 1).

A. Referral requirements for Children’s Home and Community Waiver Providers Provider requirements include, but are not be limited to the following:
1. Providers will only accept referrals that come from DHHS.
2. Providers will not solicit referrals.
3. Providers will report to DHHS, upon request, the ability and capacity to provide services to children under Section 32.
4. Providers will complete the intake, assessment, planning process and begin service delivery at the earliest possible date.
5. Providers will notify DHHS in the event of any delays in completion of the intake, assessment or start of service delivery.
6. Providers will assist the member, guardian and or parent in contacting DHHS and take all reasonable steps to facilitate a timely referral and exchange of
Effective 11/1/13

B. The Provider will develop and implement policies and procedures for covering shifts in the event of planned or unplanned staff absence.

C. Agency Home Support must have at least one staff provider of Home Support Services physically present for all hours in which a member is present. The Provider must ensure that staff are able to respond if the member has any change in his or her daily schedule.

D. The Provider will ensure that policies and procedures are in place to prevent abuse, neglect or injury to the member or staff. The Provider will ensure that the staff is properly trained in restraints. The Provider will investigate any situations where there has been an injury and adjust agency policy, practice, and training accordingly. Staff will be trained in identifying and reporting child abuse and neglect as mandated reporters.

E. The Provider will consult and coordinate with other service providers in order to accommodate the member’s physical health needs. Providers will only provide services within the scope of their certification or licensure.

F. The Provider will fully cooperate with DHHS regarding the provision or collecting and reporting of data on Section 32 Services. The Provider will follow all policies, procedures and protocols developed by DHHS, including without limitation, procedures and protocols for tracking and reporting grievances and rights violations, and critical incidents as defined by DHHS. The Provider will develop the capacity to electronically transmit identified uniform data elements in accordance with specifications established by DHHS. The Provider will participate in DHHS-sponsored Provider meetings at the local, state and the regional/district level from which funds are contracted, and work cooperatively with DHHS.

G. The Provider will maintain current documentation in Provider employee records verifying training in approved behavioral interventions, including but not limited to a copy of Behavioral Health Professional Certification.

H. Providers will put in place and implement an informed consent policy approved by DHHS. For the purposes of this requirement, informed consent means consent obtained in writing from a person or the person’s legally authorized representative for a specific treatment, intervention or service, following disclosure of information adequate to assist the person in making the consent.

Such information may include the diagnosis, the nature and purpose of the procedure(s) or service(s) for which consent is sought, all material risks and
consequences of the procedure(s) or service(s), an assessment of the likelihood that the procedure(s) or service(s) will accomplish the desired objective(s), any reasonably feasible alternatives for treatment, with the same supporting information as is required regarding the proposed procedure(s) or service(s), and the prognosis if no treatment is provided. At a minimum, a provider’s informed consent policy will ensure that members served by the provider (and their guardians, where applicable) are informed of the risks and benefits of services and the right to refuse or change services or providers.

I. The Provider will not deny services to any person solely on the basis of the member having experienced trauma, having a known mental illness or a known substance use/abuse disorder, or because that member takes prescribed psychoactive medications or participates in medication assisted treatment of their substance use.

J. The Provider will not deny a referral or services to any member if the services are described in the Waiver Service Plan and authorized by DHHS or its Authorized Agent, except where provision of the service by the provider would be clinically contraindicated.

K. The Provider will, except where clinically or legally contraindicated or for the purposes of clinical supervision, include the member, parents and/or guardians in any Service or Treatment Planning and any other discussions about the care of the member to the greatest extent possible and will document such encounters, including attempts to secure the presence of such person(s). At a minimum, the Provider will seek and record caregiver and family feedback during treatment, at discharge and post discharge.

L. The Provider will communicate with the prescriber of any psychoactive medications and document the reason for the prescription, dosage, frequency, any potential side effects, and any other relevant information related to the medication at least every three months or sooner, if clinically indicated, consistent with a signed release from the parent or guardian.

M. The Provider will prepare and maintain a Continuous Quality Improvement Plan. The Plan shall be based upon outcome measures provided by DHHS, and shall define how the Provider will monitor progress towards those goals, improve performance in the delivery of waiver services, and correct deficiencies in performance, including a description of how the Provider will collect data necessary to establish performance measurement. Written documentation of measurable progress from the Provider’s Continuous Quality Improvement Plan shall be submitted to DHHS in a quarterly report of performance. The Provider
32.05 POLICIES AND PROCEDURES (Cont)

will review quarterly performance results with the DHHS or its Authorized Agent and make adjustments for its Continuous Quality Improvement Plan as required by DHHS.

N. Providers will comply with the Federal Substance Abuse and Mental Health Services Administration’s (SAMHSA) System of Care Principles of 1. Family Driven, 2. Youth Guided, and 3. Culturally and Linguistically Competent care as set forth in Appendix I. For the purposes of this rule, references to youth in Appendix I apply to members at least five (5) years of age and under seventeen (17) years of age. Additional information about System of Care can be found on the Office of Child and Family Services website at http://maine.gov/dhhs/cofs/cbhs/index.shtml.

32.05-2 Comprehensive Assessment

A. A supervisor or staff with qualifications comparable to a supervisor (as set forth in 32.05(4)) must complete a comprehensive assessment within thirty (30) days of the member’s referral to the provider agency. A report of the Comprehensive Assessment must be included in the member’s record. The comprehensive assessment must include a direct encounter with the member, if appropriate, and with the parents or guardians. The comprehensive assessment must be updated annually, or more frequently, as needed, to verify the advancement of functional abilities.

B. The comprehensive assessment must be in writing and contain the following:

1. The member's identifying information, including the reason for referral,
2. Medical information, including medications, dental and vision,
3. Developmental history, educational history, vocational history, (if appropriate), and current status,
4. History and current status of other services,
5. The current status, including the member's strengths and needs, in the following areas:
   a. Functional life skills including activities of daily living and, if 14 or older, independent living skills,
   b. Behavioral functioning,
32.05 POLICIES AND PROCEDURES (Cont)

c. Social functioning,

d. Family information that may impact treatment, including stressors,

e. Child care information,

f. Natural supports and community resources,

g. Other significant information that may affect treatment including, but not limited to, member or family history of mental health or developmental issues,

h. Involvement with substance abuse, and

i. History of involvement with trauma, such as physical or sexual violence or personal loss.

C. The assessment must be summarized, signed, credentialed and dated by the person performing the assessment, the parent or guardian and the member, if appropriate. The assessment must include the source and date of the diagnosis from the 5 axes of the current version of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).

D. If any of the information required above is not included in the assessment, the assessment must state what is missing and the reason the information cannot be obtained.

32.05-3 Waiver Service Plan

If the member or guardian chooses services under this Section, the request for services must be submitted to DHHS or its Authorized Agent in the form of a Waiver Service Plan. As part of the planning process, the member’s needs are identified and documented in the Waiver Service Plan. Except for out-of-home agency services, other services shall be provided to the member no later than ninety (90) days following the completed Waiver Service Plan. For out-of-home agency services, such services shall be provided no later than six (6) months from the date of the completed Waiver Service Plan. The time periods set forth in this section are subject to the funded opening and waiting list provisions in this Section.

Medically necessary services and units of services must be identified in the Waiver Service Plan and receive Prior Authorization by DHHS or its Authorized Agent. If there is a need for an increase in the amount of Covered Services, the member or guardian must submit a revised Waiver Service Plan including information justifying the need for the increase which must be authorized by DHHS or its Authorized
32.05 POLICIES AND PROCEDURES (Cont)

Agent. Utilization Review will be conducted by DHHS or its Authorized Agent at least annually.

A. The Support Team must develop a Waiver Service Plan within thirty (30) days of acceptance of referral by the waiver service provider agency. The Waiver Service Plan is based on the comprehensive assessment and must be appropriate to the developmental level of the member.

B. The Waiver Service Plan must contain the following:

1. The member’s diagnosis (es) and reason for receiving the waiver service.

2. Clear, identifiable, realistic and measurable long-term goals with target dates for achieving the goals and objectives that allow for measurement of progress.

3. Clear, identifiable, realistic and measurable short-term goals with target dates for achieving the goals and objectives that allow for measurement of progress.

4. Specific support services to be provided with methods, frequency and duration of services and designation of who will provide each service.


The plan must:

a. Identify the precursors or circumstances of behaviors preceding a potential crisis;

b. Identify the strategies and techniques that may be utilized to stabilize the situation;

c. Identify the individuals responsible for and their role in the implementation of the Crisis/Safety Plan including any individuals whom the member (or parents or guardian, as appropriate) identifies as significant to the member’s stability and well-being.

6. Discharge Plan

The plan must be in writing and must:
32.05 POLICIES AND PROCEDURES (Cont)

a. Identify discharge criteria that are related to goals and objectives described in the Waiver Service Plan;

b. Identify the individuals responsible for implementing the Discharge Plan; and

c. Be reviewed annually, or more frequently, as necessary, as part of the required review of the Waiver Service Plan.

7. Special accommodations needed to address barriers to provide the service.

C. Signature and Review

1. The parent or guardian and the member, if applicable, and the waiver provider's supervisor must sign, date and credential the Waiver Service Plan.

2. The Waiver Service Plan must be reviewed every 90 days or whenever a significant change occurs in the member's needs.

3. The initial 90-day period commences when the service plan is signed.

4. If indicated, the member's needs may be reassessed and the Waiver Service Plan may be reviewed and amended more frequently than every ninety (90) days. Team meetings will be required when risk of placement disruption becomes apparent to avert disruption.

5. Changes and reviews to the Waiver Service Plan are considered to be in effect as of the date they are signed by the parent or guardian, the member, if applicable and the waiver provider's supervisor.

6. The provider will supply the member, or parent or guardian, as appropriate, and DHHS or its Authorized Agent with a copy of the initial and reviewed Waiver Service Plan within seven (7) days of signing the Waiver Service Plan.

7. The provider will ensure that services are provided in the type, amount, frequency, scope and duration as described in the Waiver Service Plan and authorized by DHHS or its Authorized Agent.

D. Progress Notes
32.05 POLICIES AND PROCEDURES (Cont)

1. Providers must maintain written daily progress notes for all waiver services, in chronological order.

2. All entries must describe the waiver service provided and include the signature and credentials of the person providing the service, the date on which the service was provided, the duration of the service and the progress the member is making toward attaining the goals or outcomes identified in the Waiver Service Plan.

3. For in-home services, the provider must ask the member, or an adult responsible for the member, to sign a document noting the date, time of arrival, and time of departure of the provider. The documentation must be kept in the member’s file.

E. Discharge/Closing Summary:

The Summary must:

1. Document the reason for discharge;

2. Include a summary of the member’s progress, or lack thereof, in reaching the goals set forth in the Waiver Service Plan and any after care or support services recommended at the time of discharge; and

3. Be completed within fifteen (15) days of discharge, and be placed in the member’s record.

32.05-4 Requirements for Providers of Services for Children’s Home and Community Waiver

1. Certification as Behavioral Health Professional

Provider agencies must assure that all non-licensed direct service providers under this Section are certified or provisionally certified as a Behavioral Health Professional. Provider agencies must maintain documentation of certification in personnel files.

MaineCare will not reimburse providers for services performed by staff without appropriate certification. DHHS may recoup reimbursement from providers not appropriately certified.

To be certified as a Behavioral Health Professional (BHP), the employee must meet the following minimum requirements:
32.05 POLICIES AND PROCEDURES (Cont)

a. Be at least eighteen (18) years of age;

b. Have a high school diploma or equivalent;

c. Have successfully completed the Behavioral Health Professional training; and

d. Have current certification in first aid and CPR, and a blood borne pathogens training.

2. Provisional Approval as a Behavioral Health Professional

Non-licensed staff who provide direct service must begin the Behavioral Health Professional training within thirty (30) days of hire and obtain provisional certification. The provisional candidate must complete the training and obtain full certification within one (1) year from the date of hire.

Providers may employ on a provisional basis Behavioral Health Professionals who meet all of the requirements, but have not yet obtained DHHS certification.

3. Administration of Medication by Behavioral Health Professionals

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

4. Supervision of a Behavioral Health Professional

Provider agencies must identify supervisors meeting the professional qualifications in the next section for each direct care position. On-site supervision for each Behavioral Health Professional must occur at least quarterly. Behavioral Health Professionals employed full time must be supervised a minimum of four (4) hours per month. Behavioral Health Professionals employed part time must receive a prorated amount of supervision, with a minimum requirement of one (1) hour per month.

Provisionally approved Behavioral Health Professional must be supervised at least six (6) hours per month. Part-time provisionally
approved Behavioral Health Professional must receive prorated supervision with no less than one (1) hour of supervision per month.

5. Professional Qualifications for Supervisors

Supervisors of Behavioral Health Professional must meet the following professional qualifications:

a. Have a Bachelor’s degree in a human services or social services field and at least two (2) years’ related experience; or

b. Have a Master’s degree in a human services or social services field and at least one (1) year of related experience; or

c. Be a licensed social worker (LSW) with at least one (1) year of related experience; or

d. Be a licensed social worker (LSW) who has attained a related Master’s degree; or

e. Be a licensed professional counselor (LPC), licensed clinical professional counselor (LCPC), licensed clinical social worker (LCSW), psychologist, physician, or advanced practice registered nurse; or

f. Be a registered professional nurse with three (3) years’ related experience, or

g. Be a Board Certified Behavior Analyst (BCBA).

6. Consultation Services.

Consultation staff must be licensed as an Occupational Therapist; Physical Therapist; Speech Therapist; Child Psychiatrist; Child Psychologist; Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker Conditional Clinical (LMSW-Conditional Clinical); Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-Conditional (LCPC-Conditional); License Marriage and Family Therapist (LMFT); or Licensed Marriage and Family Therapist-Conditional (LMFT-Conditional). Consultation staff may also be a Certified Therapeutic Recreation Specialist (CTRS) or Board Certified Behavior Analyst (BCBA).
32.05 POLICIES AND PROCEDURES (Cont)

7. Respite Services.

Providers of Respite Services must be approved by DHHS or its Authorized Agent and be certified as a Behavioral Health Professional; or Certified as a Respite Provider; or a Licensed Clinical Social Worker (LCSW); or a Licensed Master Social Worker Conditional Clinical (LMSW-Conditional Clinical); or a Licensed Clinical Professional Counselor (LCPC); or a Licensed Clinical Professional Counselor-Conditional (LCPC-Conditional); or a License Marriage and Family Therapist (LMFT); or a Licensed Marriage and Family Therapist-Conditional (LMFT-Conditional).

32.06 LIMITATIONS

The following limitations apply to reimbursement of services:

A. MaineCare will limit reimbursement for services under this Section to those covered services documented and approved in the Waiver Service Plan. Reimbursement is also contingent upon the provider’s adherence to any applicable licensing standards and contractual agreements set forth by DHHS.

Annual MaineCare expenditures for a service under this waiver for an individual member will be limited to the amount approved by CMS in the waiver application as follows:

1. Members who meet the medical eligibility criteria for admission to an ICF/IID as set forth in MaineCare Benefits Manual, Chapter II, Section 50 will be limited to one hundred percent (100%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by DHHS.

2. Members who meet medical eligibility criteria for admission to a Psychiatric Hospital as set forth in MaineCare Benefits Manual, Chapter II, Section 46 will be limited to one hundred percent (100%) of the state-wide average annual cost of care for an individual in an inpatient psychiatric facility for individuals age 21 and under, as determined by DHHS.

B. Non-Duplication of Services

Comparable Services: Services under this Section are not covered if the member is receiving comparable or duplicative services under this or another Section of the MaineCare Benefits Manual.

MaineCare members can receive services under only one Home and Community Waiver Benefit at any one time.
If a current waiver recipient enters a nursing facility or a hospital, payment under the waiver will be temporarily suspended. If the waiver recipient remains in the nursing facility or hospital for more than thirty (30) consecutive days, enrollment in this waiver will be terminated unless there is a written request to DHHS to continue holding the funded opening and the request is approved.

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

All items in excess of five hundred dollars ($500) require documentation from a physician or other appropriate professional such as an Occupational Therapist, Physical Therapist or Speech Therapist that the item is medically necessary and appropriate to meet the member’s need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this section only if they meet all requirements of this Section. This benefit applies to private homes only; it is not available in agency owned or operated homes.

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

E. **Consultation Services** are limited to those providers not already reimbursed for consultation as part of another service. Personnel who provide targeted case management services to the member may not be reimbursed for consultation services.

F. **Respite Services** are limited to three (3) days per month.

**32.07 DURATION OF CARE**

**32.07-1 Voluntary Termination**

Whenever a member, or the member’s parent or guardian, as appropriate, provides written notice to DHHS that the Home and Community Waiver benefit is no longer wanted for that member, DHHS will terminate the benefit.

**32.07-2 Involuntary Termination**

DHHS will give written notice of termination to a member at least ten (10) days prior to the effective date of the termination, providing the reason for the termination, and
32.07 DURATION OF CARE (cont)

the member’s right to appeal such decision. A member may be terminated from this benefit for any of the reasons listed below:

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

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

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

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

E. The health and welfare of the member can no longer be assured because:
   1. The member or immediate family, guardian or caregiver refuses to abide by the Waiver Service Plan or other benefit policies;
   2. The home or home environment of the member becomes unsafe to the extent that benefit services cannot be provided without risk of harm or injury to the member or to individuals providing covered services to the member; or
   3. There is no approved Waiver Service Plan.

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

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

H. The annual cost of the member’s services under this waiver exceeds the limits in 32.06(A).

32.07-3 Provider Termination from the MaineCare Program

The provider must provide the member and DHHS thirty (30) days written notice prior to the effective date of termination.

32.08 NON-COVERED SERVICES

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

A. Services not identified by the Waiver Service Plan;
32.08 NON-COVERED SERVICES (cont)

B. Services to any MaineCare member who receives services under any other federally approved MaineCare waiver program;

C. Services to any member who is a nursing facility resident or ICF/IID resident;

D. Services that are reimbursable under any other sections of the MaineCare Benefits Manual;

E. Any service otherwise reimbursable under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act, including, but not limited to, job development and vocational assessment or evaluation;

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

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

32.09 REIMBURSEMENT

Beginning July 1, 2011, MaineCare will reimburse for services provided under this Section using the maximum allowance listed in Chapter III. Reimbursement will be limited to the maximum number of billable hours approved.

HOME SUPPORT REIMBURSEMENT: Family Home Support hours less than five (5) hours in a day (midnight to midnight) will only be reimbursed on a quarter hour rate.

RESPITE REIMBURSEMENT: Respite hours less than seven (7) hours in a day (midnight to midnight) will only be reimbursed on a quarter hour rate.
32.10 Increased Level of Support -- Family Home

DHHS may authorize an increased level of support for the purposes of additional staff for those members who have challenging behavioral issues or high medical and safety needs.

To qualify for the increased level of support, a member must have:

1) Documentation from a service provider of an extraordinary need listed in at least one of the categories below:

a) Behavioral issues-Members with behavioral issues and/or behavioral health challenges that raise significant health and safety concerns may have increased levels of support authorized to assist with behavioral issues. Significant health and safety concerns include the daily risk of severe injury to self or others, or a need for a high level of support and supervision. Members meeting these criteria would require 1:1 or more staff in a restrictive setting, such as a hospital, Intermediate Care Facility or residential treatment facility.

b) Medical Support- Members that require support over and beyond routine services such as ventilators, nebulizers, diabetes management-insulin dependent, suctioning, seizure management-uncontrolled, and chronic eating disorders, or persons with co-existing conditions that significantly affect physical movement and require near total physical assistance on a daily basis, may have an increased level of support authorized to assist with medical issues.

2) A written recommendation from a Physician, Psychologist or Psychiatrist specifying:

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

b) The manner in which increased support will be utilized;

c) The expected duration of the need for increased support. If the increased support is expected to be needed for an indefinite period of time then this expectation should be specified; and

d) The anticipated frequency of the increased support on a daily, weekly, or monthly basis.

Process of Application for the Increased Level of Support:

The Increased Level of Support can be requested as part of the initial Waiver Service Plan or later through an amended Waiver Service Plan. Either request is subject to Prior Authorization and Utilization Review by DHHS. The Waiver Service Plan must outline specific activities and desired outcomes of the service being provided, and those activities must be separately documented in the member’s record.
32.11 Performance Measures

The primary goal of Performance Measurement is to use data to determine the level of success a service is achieving in improving the health and well-being of members. Performance Goals and Performance Measures will be established to monitor quality, inform and guide reimbursement decisions and conditions of provider participation across MaineCare services. This focus on Performance Measurement is anticipated to enhance the overall quality of services provided and raise the level of public accountability for both the Department and MaineCare providers.

32.11-1 Performance Goals

Members receiving this service will experience improved or preserved functional abilities while being able to live in a safe and stable setting within the community.

32.11-2 Performance Measures

a. Percentage of members who remain in the community setting and do not return to institutional care for more than 30 days in a quarter (placement stability).

b. Percentage of members receiving this service whose functional/adaptive assessments scores improve or remain stable between initial assessment and follow-up assessments.

32.11-3 Performance Measure Data Source

Providers must electronically enter individual level data into a DHHS defined web-based data collection system by the second Friday after the quarter ends.

32.11-4 Performance Measurement Compliance

DHHS may exercise the following steps to ensure compliance:

Step 1: DHHS will notify the Provider in writing of any compliance and performance issues identified by DHHS staff. The notice will include the performance provision that is in noncompliance and a date by which the provider will correct or remedy the identified non-compliance/performance issue.

Step 2: If the compliance/performance issues described by DHHS in Step 1 have not been addressed by the specified dates, the Provider and a representative of DHHS will meet, discuss, and document the compliance/performance issues. DHHS and the Provider will develop a corrective action plan which must include:

1. A statement of the corrective actions required for compliance with the Performance Measures;

2. The date by which the Provider will comply with the terms of the Performance Measures;
32.11 Performance Measures (cont)

3. The consequences for non-compliance which may include the sanctions described in Chapter I of this manual or other consequences as determined by the Department; and

4. Signatures of the Provider and DHHS representative.

Step 3: In accordance with Chapter I, if the Provider fails to undertake the corrective actions in the corrective action plan, DHHS may impose sanctions, up to and including termination of the Provider Agreement in accordance with the procedures described in Chapter I, General Administrative Policies and Procedures, Section 1.03-4, Termination of Participation by Provider or DHHS and Section 1.19, Sanctions/Recoupments.
Appendix #1 Federal Substance Abuse and Mental Health Services Administration’s (SAMHSA) System of Care Principles (referenced in 32.05-1. (N)).

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Systems of Care must be: Family-driven and youth-guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided;

Community-based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level; and

Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

Definition of Cultural and Linguistic Competence

Cultural competence is the integration and transformation of knowledge, behaviors, attitudes and policies that enable policy makers, professionals, caregivers, communities, consumers and families to work effectively in cross-cultural situations. Cultural competence is a developmental process that evolves over an extended period of time. Individuals, organizations and systems are at various levels of awareness, knowledge and skills along the cultural competence continuum. (Cross, et. al, 1989).

Definition of Family-Driven Care

Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, State, tribe, territory and nation. This includes choosing supports, services, and providers, setting goals, designing and implementing programs, monitoring outcomes, and determining the effectiveness of all efforts to promote the mental health of children and youth.

Definition of Youth-Guided Care

Youth-guided means that youth are engaged as equal partners in creating systems change in policies and procedures. Providers are required to develop plans for infusing a youth-guided approach throughout the system of care, including plans for training and supporting youth in positions of leadership and system transformation.