DATE: April 2, 2013

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Proposed Rule: Chapter 101, MaineCare Benefits Manual, Chapters II & III, Section 20, Home and Community Based Services for Adults with Other Related Conditions

This letter gives notice of a proposed rule: MaineCare Benefits Manual, Chapters II & III, Section 20, Home and Community Based Services for Adults with Other Related Conditions.

The Department is creating a new Section of the MaineCare Benefits Manual outlining the covered services, program requirements, and reimbursement rates for a home- and community-based program for adults with “Related Conditions.” A “Related Condition” (defined in full at 42 C.F.R. § 435.1010) is a condition that causes impairment of general intellectual functioning or adaptive behavior similar to the impairment characteristic of an intellectual disability. This new MaineCare program, provided to eligible members through a Home and Community Based Waiver program approved by the Centers for Medicare and Medicaid Services, will provide supports necessary to assist individuals with a Related Condition to live in the community rather than in institutional settings. Chapter II of Section 20 (titled “Home and Community Based Services for Adults with Other Related Conditions Services”) will detail the program requirements and services offered under the waiver. Those services include Assistive Technology, Care Coordination, Communication Aids, Community Support, Consultation and Assessment, Employment Specialist Services, Home Accessibility Adaptations, Home Support, Non-Medical Transportation Services, Non-Traditional Communication Assessment, Non-Traditional Communication Consultation, Occupational Therapy (Maintenance) Service, Personal Care, Physical Therapy (Maintenance) Service, Specialized Medical Equipment, Speech Therapy (Maintenance) Service, and Work Support. Chapter III of Section 20 (titled “Allowances for Home and Community Based Services for Adults with Other Related Conditions”) establishes billing procedure codes (based on HIPAA compliant CPT coding) and reimbursement rates for the waiver services.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/index.shtml or 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 concise summary of the proposed rule is provided in the Notice of Agency Rule-making Proposal, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency Rule-making Proposal.
Notice of Agency Rule-making Proposal

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

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapters II & III, Section 20, Home and Community Based Services for Adults with Other Related Conditions

PROPOSED RULE NUMBER:

CONCISE SUMMARY: The Department is creating a new Section of the MaineCare Benefits Manual outlining the covered services, program requirements, and reimbursement rates for a home- and community-based program for adults with “Related Conditions.” A “Related Condition” (defined in full at 42 C.F.R. § 435.1010) is a condition that causes impairment of general intellectual functioning or adaptive behavior similar to the impairment characteristic of an intellectual disability. This new MaineCare program, provided to eligible members through a Home and Community Based Waiver program approved by the Centers for Medicare and Medicaid Services, will provide supports necessary to assist individuals with a Related Condition to live in the community rather than in institutional settings. Chapter II of Section 20 (titled “Home and Community Based Services for Adults with Other Related Conditions Services”) will detail the program requirements and services offered under the waiver. Those services include Assistive Technology, Care Coordination, Communication Aids, Community Support, Consultation and Assessment, Employment Specialist Services, Home Accessibility Adaptations, Home Support, Non-Medical Transportation Services, Non-Traditional Communication Assessment, Non-Traditional Communication Consultation, Occupational Therapy (Maintenance) Service, Personal Care, Physical Therapy (Maintenance) Service, Specialized Medical Equipment, Speech Therapy (Maintenance) Service, and Work Support. Chapter III of Section 20 (titled “Allowances for Home and Community Based Services for Adults with Other Related Conditions”) establishes billing procedure codes (based on HIPAA compliant CPT coding) and reimbursement rates for the waiver services.


DATE AND PLACE OF PUBLIC HEARING:

Date: May 1, 2013
Time: 1:00 PM
Location: Department of Health and Human Services
242 State Street
SHS #11
Augusta, Maine 04333

The Department requests that any interested party requiring special arrangements to attend the hearing contact the agency person listed above before Monday, April 22, 2013.

COMMENT DEADLINE: Comments must be received by midnight, Saturday May 11, 2013.

AGENCY CONTACT PERSON: Ginger Roberts-Scott, Comprehensive Health Planner II
AGENCY NAME: MaineCare Services
ADDRESS: 242 State St.
11 State House Station
Augusta, Maine 04333-0011

TELEPHONE: 207-287-9365 FAX: (207) 287-9369
TTY: 711 (Deaf or Hard of Hearing)

IMPACT ON MUNICIPALITIES OR COUNTIES (if any): The Department does not anticipate that this rulemaking will have any impact on municipalities or counties.

CONTACT PERSON FOR SMALL BUSINESS INFORMATION (if different): N/A
STATUTORY AUTHORITY FOR THIS RULE:  22 M.R.S.A. §§ 42, 3173

SUBSTANTIVE STATE OR FEDERAL LAW BEING IMPLEMENTED (if different):

E-MAIL FOR OVERALL AGENCY RULE-MAKING LIAISON:  kevin.wells@maine.gov
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20.01 INTRODUCTION

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

20.02 DEFINITIONS

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

20.02-2 Assessing Services Agency (ASA) is an Authorized Agent of the Department for Medical Eligibility Determinations that conducts face-to-face assessments, using the Department’s Medical Eligibility Determination form or other Department approved form.

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

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

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

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

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

20.02-8 Exploitation means the illegal or improper use of an incapacitated or dependent member or that member’s resources for another’s profit or advantage as defined in 22 MRSA §3472.
20.02 DEFINITIONS (cont)

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

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

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

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

20.02-13 **Money Follows the Person-Homeward Bound Transition Assistance Coordinator** is person who is chosen by the member to provide transition Assistance from the agencies contracted by the Department for the Money Follows the Person-Homeward Bound program.

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

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

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

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

20.03-1 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.

20.03-2 General Eligibility Criteria

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

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

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

1. It is attributable to;
   a. Cerebral Palsy or Epilepsy; or
   b. Any other condition, other than mental illness, found to be closely related to Intellectual Disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with Intellectual Disabilities and requires treatment or services similar to those required for these persons. These conditions include but are not limited to Neurofibromitosis, Other Choreas, Anoxic Brain Damage, Cerebral Laceration and Contusion, Subarachnoid- Subdural and Extradural Hemorrhage following injury, Other and Unspecified Intracranial Hemorrhage following injury or Intracranial injury and unspecified nature. Any other conditions will be reviewed for eligibility by the Office of MaineCare Services Medical Director.

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

3. It is likely to continue indefinitely.

4. It results in substantial functional limitation in three (3) or more of the following areas of major life activity:
Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 20  Home and Community Based Services for Adults with Other Related Conditions

20.03  DETERMINATION OF ELIGIBILITY (cont)

a. Self-care,
b. Understanding and use of language,
c. Learning,
d. Mobility,
e. Self-direction,
f. Capacity for independent living; and

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

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

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

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

20.03-3  Establishing Medical Eligibility

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

A. Completion of a Medical Eligibility Determination (MED) assessment by the Assessing Services Agency (ASA);
B. Completion of the BMS 99 or current functional assessment, as approved by the Department, by the Care Monitor; and
C. Documentation from a physician that the waiver services are medically necessary.

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

20.03-4 Priority

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

A. **Priority 1:** A member shall be identified as Priority 1 if the member is currently residing in an institution, and if the member continues to meet the financial and medical eligibility criteria at the time that an approved opening becomes available. Order of enrollment will be based on date of application; an application will be considered complete on the date upon which items A. through D. from Section 20.04-2, Procedures for Developing the Care Plan, have been completed to the Department’s satisfaction has received all documents. If there are two applications received on the same day, the applicant with the longest continuous stay in institutional care will be prioritized first.

B. **Priority 2:** A member shall be identified as Priority 2 if the member has been determined to be residing in the community. A higher priority will be given to those members who are at imminent risk of abuse, neglect or exploitation followed by those at anticipated risk of abuse, neglect or exploitation or homelessness and institutionalization with the next year.

If applications exceed approved openings in any given year, a waiting list will be established. The list will be prioritized as specified above.

20.03-5 Redetermination of Eligibility

Eligibility for services under this section must be redetermined annually. When determining continuing eligibility, the Care Coordinator will initiate an updated Medical Assessment tool and updated BMS 99 form or current functional assessment, as approved by the Department. This assessment will be conducted by DHHS or its Authorized Agent. Updated assessments must be completed twelve (12) months from the date of initial approval, and every twelve (12) months thereafter. Once the assessment has been updated, the Care Plan will be updated annually. If the updated Assessment Referral is received after the due date, reimbursement for services will resume upon completion of the assessment. Whenever there is a significant change in the member condition that requires an alteration in the level of care, the Care Coordinator will provide notice to DHHS or its Authorized Agent and request an updated assessment.
20.04 CARE PLAN DEVELOPMENT

20.04-1 Content of the Care Plan

At a minimum the Care Plan must describe:

A. All MaineCare Benefit services determined medically necessary by DHHS;

B. The frequency of provision of the services;

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

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

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

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

G. A budget for the services to be provided under this section; and

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

20.04-2 Procedures for Developing the Care Plan

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

A. Choice Letter: The process begins by the member signing and submitting a “choice letter” to the Office of Aging and Disability Services (OADS) requesting services under the ORC waiver. The choice letter is a form that the Department sends to individuals who may be eligible for services under this section requesting that the individual indicate their preference between receiving services in an institutional setting (such as a nursing facility) or receiving services in a community setting under this section.

B. Application: After receiving the choice letter, the Department’s Care Monitor will meet with the member and guardian or legal representative (where applicable) and complete the initial ORC application and Money
20.04 CARE PLAN DEVELOPMENT (cont)

Follows the Person/Homeward Bound (MFP/HB) application (where applicable). If the member qualifies for MFP/HB, the member will then select their MFP/HB Transition Assistance Coordinator.

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

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

E. Selection of Residential Option and Development of Final Care Plan: The member with work with the Care Monitor, guardian or legal representative (where applicable), and the MFP/HB Transition Assistance Coordinator (where applicable) to select an approved residential option as outlined in 20.05-8. Once selected, the provider for Home Support will assist the member in developing the final Care Plan including the budget, selection of services, and safety/risk plan.

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

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

H. Utilization Review: All Care Plans will be reviewed and approved by OADS. OADS determines that the member continues to be eligible for services as outlined in 20.03-1, 2 and 3.
20.04 CARE PLAN DEVELOPMENT (cont)

20.04-3 Review and Updating of the Care Plan

The Care Plan must be reviewed and updated at a minimum annually, or when there are significant changes in the member’s condition requiring a review to see if the services in place are adequate.

20.05 COVERED SERVICES

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

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

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

(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, 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 Care Plan;

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

Assistive Technology Services excludes services available under the State Plan.

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

**20.05-3 Communication Aids** - Communication Aids are devices or services necessary to assist members with hearing, speech or vision impairments to effectively communicate with service providers, family, friends, and other community members.

Communication Aids include:

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

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

**20.05-4 Community Support Services** - is the assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the member's private residence or other residential living arrangement; however this service can originate or terminate in the member’s private residence or other residential living arrangement. Community Support Services expose the member to activities and environments designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week or as specified in the member’s Care Plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

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

**20.05-5 Consultation Services and Assessment** - is the clinical and therapeutic services that assist unpaid caregivers and/or paid support staff in carrying out Care Plans, and that are not covered by the Medicaid State Plan, and are necessary to improve the member’s independence and inclusion in their community. Consultation Services and
20.05 COVERED SERVICES (cont)

Assessments are provided by professionals in Psychology, Occupational Therapy, Physical Therapy, Speech Therapy, and Behavioral Health. The service may include assessment, the development of a Care Plan, training and technical assistance to carry out the Care Plan and monitoring of the member and the provider in the implementation of the Care Plan. This service may be delivered in the member’s home or in the community as described in the Care Plan.

Consultation Services include:

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

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

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

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

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

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

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

20.05-6 Employment Specialist Services- are services necessary to support a member in maintaining employment. Services include:
20.05 COVERED SERVICES (cont)

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

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

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

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

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

20.05-7 Home Accessibility Adaptations- are those physical adaptations to the private residence of the member or the member’s family, required by the member's Care Plan, that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the member. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

20.05-8 Home Support Services- There are three types of Home Support Services:

(A) Home Support Services (Per Diem)- for a member who requires 24/7 care usually provided in a provider- owned facility with not more than 4
20.05 COVERED SERVICES (cont)

members. The service offers individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, and social and leisure skill development, that assist the member to reside in the most integrated setting appropriate to his/her needs. These supports also include personal care and protective oversight and supervision.

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

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

The use of this service is based upon the member’s assessed needs and the resulting Care plan. The Care Plan reflects the member’s and, where applicable, his or her guardian’s informed consent and commitment to the Care Plan elements including all assistive communication, environmental control and safety components. A thorough evaluation of all Assistive
20.05 COVERED SERVICES (cont)

Technology will be completed prior to the finalization of the Care Plan with the assistance of the Care Coordinator and use of appropriate Assistive Technology consultants. The member will be provided educational support in order to fully understand the risks and benefits of all elements of the Care Plan and this will be documented and acknowledged by the member served. All assistive devices and systems must allow the member served to “opt out.” The member must be informed as to the methods for ending a service, either on a short-term basis or permanently. These options will be delineated in the member’s Care Plan. If a member served experiences a change in support needs or status, the provider will 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 made under this section for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

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

This service must be delivered in the State of Maine. Services out of state are not covered unless authorized as required by Chapter I of the MaineCare Benefits Manual.

20.05-9 Non-Medical Transportation Services are offered in order to enable members to gain access to Section 20 services, as specified by the Care Plan. Transportation services for Section 20 services are provided under the MaineCare Benefits Manual, Section 113 Non-Emergency Medical Transportation Services. Whenever possible, family, friends or community agencies, which can provide this service without charge, are utilized.

20.05-10 Non-Traditional Communication Assessments determine the member’s level of communication present via gesture, sign language or unique individual communication style. The assessment examines signed or gestured vocabulary for everyday objects or actions, the ability to combine gestures as well as the ability to understand similar communication. Assessment recommendations are made to optimize communication to maximize social integration.
20.05 COVERED SERVICES (cont)

20.05-11 Non-Traditional Communication Consultation- is provided to members, their direct support staff and others to assist the member to maximize communication ability as determined from a Non-Traditional Communication Assessment. The goal is to allow for greater participation in the Care Planning process and to enhance communication within the member’s environment. This service enables members of the team to communicate expressively and receptively with the member during all day-to-day activities, which helps the member to actively participate in his/her Care Plan.

20.05-12 Occupational Therapy (Maintenance) Services- These services include direct therapy and consultation services to maintain the member's optimal level of functioning within the member's current environment. The intent is to prevent regression, loss of movement, injury and medical complications that would result in a higher level of skilled care.

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

20.05-13 Personal Care Services- are a range of assistance to enable waiver members to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the member to perform a task. Personal Care Services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law. An individual Personal Care Assistant, Personal Support Specialist or Direct Support Professional shall not be reimbursed for providing more than a total of 40 hours per week of services delivered to an individual waiver member. Personal Care may be provided outside the member's home.

Personal Care is available to members who do not require protective oversight and supervision that is provided in Home Support. In order to avoid duplication, Home Support (Per diem, ¼ hour or Remote Support) Community Support or Personal Care Services are not available at the same time as other Home Support (Per diem, ¼ hour or Remote Support) Community Support or Personal Care Services.

This service must be delivered in the state of Maine. Services out of state are not covered unless authorized as required by Chapter I of the MaineCare Benefits Manual.

20.05-14 Physical Therapy (Maintenance) Services- These services include direct therapy and consultation services to maintain the member's optimal level of functioning within the member's current environment. The intent is to prevent regression, loss of
movement, injury and medical complications that would result in a higher level of skilled care.

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

20.05 COVERED SERVICES (cont)

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

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

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

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

This service is only available in the absence of a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S. C. 1401 et seq.). Members cannot receive these services while working under a Special Minimum Wage Certificate issued by the Department of Labor under the Fair Labor Standards Act.

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

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

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

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

20.06 NONCOVERED SERVICES

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

20.06-1 Services not authorized by the Care Plan.

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

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

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

20.06-5 Services provided directly or indirectly by the legal guardian will not be reimbursed.
20.06 NONCOVERED SERVICES (cont)

20.06-6 Work Support or Employment Specialist Services when the member is not engaged in employment. Employment means traditional employment or telecommuting that is compensated at a competitive wage; or self employment or business ownership. A competitive wage is a wage at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an employee without a disability. Employment does not include work in a setting in which the member has little or no interaction with customers or other employees not having a disability, unless the member is telecommuting, self-employed, or owns his or her own business.

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

20.06-8 Non-Duplication of Services

Services as defined 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. A member may not receive services under this section, if they are in a residential treatment facility or if they are receiving services in an institution, including, but not limited to Section 2, Adult Family Care Services, Section 45, Hospital Services, Section 46, Psychiatric Facility Services, Section 50, ICF/IID, Section 67, Nursing Facilities and Section 97, Private Non-Medical Institutions. A member may not receive services if they are in another Home and Community Based Waiver such as Section 19, Home and Community-Based Benefits for the Elderly and for Adults with Disabilities, Section 21, Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder, Section 22, Home and Community Benefits for the Physically Disabled, Section 29, Support Benefits for Adults with Intellectual Disabilities or Autistic Disorder and Section 32, Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders. A member receiving services under this section may not receive services from Section 26, Adult Day Health.

20.07 LIMITS

The following service limits apply to each member:

20.07-1 Assistive Technology Services- Assistive Technology Services are limited to $6000.00 per service year.

20.07-2 Care Coordination Services- Care Coordination Services are limited to 400 units in the member’s first year of services on the waiver. Care Coordination Services are
20.07 LIMITS (cont)

limited to 144 units, each year thereafter. The Care Coordination provider may not offer any other services to the member under the Section.

20.07-3 Communication Aids- Communication Aids are limited to $2000.00 per service year.

20.07-4 Community Support Services- Community Support Services are limited to 64 units per week, for an annual total of 3328 units per service year.

20.07-5 Consultation Services- Consultation Services are limited to 64 units per service year.

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

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

20.07-8 Home Support Services- Home Support (1/4 hour) is limited to 44 units per day. Home Support (Remote Support) is limited to 44 units per day.

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

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

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

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

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

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

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

20.07-16 Work Support Services- Work Support Services are limited to 64 units per week up to 3328 units per service year.
20.07 LIMITS (cont)

20.07-17 Section 20 Home and Community Based Services for Adults with Other Related Conditions may not be provided in a residence where other Home and Community Based Waiver services are provided.

20.08 DURATION OF CARE

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

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

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

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

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

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

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

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

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

3. There is no approved Care Plan.

F. The member 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 consecutive thirty (30) day period;
20.08 DURATION OF CARE (cont)

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

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

20.09 RECORDS

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

The member’s records must contain:

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

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

20.09-3 The member’s Care Plan;

20.09-4 A summary of authorized services; and

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

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

The provider must document each service provided, the date of each service, the type of service, the activity, need or goal to which the service relates, the length of time of the service, and the signature of the individual performing the service.
20.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS

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

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

A. An Licensed Occupational Therapist; or
B. A Licensed Speech Pathologist; or
C. A certified Direct Support Professional (DSP) who is also certified as a Rehabilitation Engineering Technologist (RET) or an Assistive Technology Professional (ATP).

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

A. A Registered Nurse; or
B. A Registered Occupational Therapist; or
C. A Licensed Social Service or health professional with four years of education in health or social services field and one year of community experience to provide the direct service.

20.10-3 Communication Aids- In order to provide Communication Aids, an independent provider must possess a Certificate of Clinical Competence-Speech Pathology (CCC-SP). An agency provider of Communication Aids must be a licensed speech and hearing agency or Home Health Agency and the staff person must possess a Certificate of Clinical Competence-Speech Pathology (CCC-SP).

20.10-4 Consultation Services- In order to provide Consultation Services a provider must possess:

A. A certificate of Clinical Competence in Speech Pathology for Speech Consultation; or
B. A Licensed Occupational Therapist for Occupational Therapy Consultation; or
C. A Physical Therapist for Physical Therapy Consultation; or
20.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont)

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

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

20.10-5 Community Support, Home Support, Work Support Services- Community Support, Home Support, and Work Support Services must be provided by a Direct Support Professional (DSP), a Personal Support Specialist (PSS) or a Personal Care Assistant (PCA), and the individual providing the services must:

A. Either:

i. Have successfully completed the appropriate training as a Direct Support Professional curriculum as adopted by DHHS, or demonstrated proficiency through DHHS’s approved Assessment of Prior Learning, or have successfully completed the curriculum from the Maine College of Direct Support; or

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

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

Documentation of completion must be retained in the personnel record.

B. Have a background check consistent with Section 20.10-15;

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

D. Be at least 18 years of age;

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

F. Have completed Reportable Events and Behavior Regulations Training.
20.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont)

20.10-6 Employment Specialist Services- In order to provide Employment Specialist Services, a provider must possess:

A. A national certification by the Association of Community Rehabilitation Educators (ACRE); and

B. A background check consistent with Section 20.10-15; and

C. A valid driver’s license, if transporting members; and

D. At least 18 years of age; and

E. A high school degree or GED; and

F. One year of experience working with people with disabilities in a work setting.

20.10-7 Home Accessibility Adaptations- In order to provide Home Accessibility Adaptations, a provider must be approved by the Office of Aging and Disability Services (OADS).

20.10-8 Non Traditional Communication Assessment and Consultation- In order to provide Non Traditional Communication Assessment and Consultation a provider must:

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

B. Be a Licensed Speech Language Pathologist.

20.10-9 Occupational Therapy (Maintenance)- In order to provide Occupational Therapy (Maintenance) Services a provider must be a Licensed Occupational Therapist.

20.10-10 Personal Care- In order to provide Personal Care Services a provider must:

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

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

C. If a CNA’s status on the Maine Registry of Certified Nursing Assistants has lapsed, or an individual holds a valid certificate of training meeting the standards of the Maine State Board of Nursing nursing assistant program
20.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont)

issued more than three (3) years ago, the individual must pass the competency-based examination of didactic and demonstrated skills from the Department’s approved personal support specialist curriculum. A certificate of training as a personal care assistant/personal support specialist will be awarded upon passing this examination; or

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

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

F. Be qualified as a DSP as described 20.10-5.

20.10-11 Physical Therapy (Maintenance) Services- In order to provide Physical Therapy (Maintenance) Services a provider must be a Licensed Physical Therapist.

20.10-12 Specialized Medical Equipment- In order to provide Specialized Medical Equipment, a provider must be approved by the Office of Aging and Disability Services (OADS).

20.10-13 Speech Therapy (Maintenance) Services- In order to provide Speech Therapy (Maintenance) Services a provider must be possess a Certificate of Clinical Competence in Speech Pathology (CCC-SP).

20.10-14 Emergency Intervention- All providers must meet training requirements on approved behavioral interventions procedures (e.g., Mandt) if applicable and indicated as a need in the member’s Care Plan.

20.10-15 Background Check Criteria- The provider must conduct background checks on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide services under this Section. Background checks on persons professionally licensed by the State of Maine will include a confirmation that the licensee is in good standing with the appropriate licensing board or entity.

The provider shall not hire or retain in any capacity any person who may directly provide services to a member under this section if that person has a record of:
20.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont)

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

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

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

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

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

Employment of individuals with records of such convictions more than five (5) years prior to the time of the background check is a matter within the provider's discretion after consideration of the individual's criminal record in relation to the nature of the position. The provider shall contact child and adult protective services (including the Office of Aging and Disability Services) units within DHHS to obtain any record of substantiated allegations of abuse, neglect or exploitation against an employment applicant before hiring the same. In the case of a child or adult protective services investigation substantiating abuse, neglect or exploitation by a prospective employee of the provider, it is the provider’s responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with licensing standards. The member receiving services must approve the employment of such staff in writing if the provider decides to hire a staff person with a conviction. Providers are not required to obtain records from child protective services for employees who do not provide services to children.

20.10-16 Informed Consent Policy

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

treatment, with the same supporting information as is required regarding the proposed procedure(s) or service(s), and the prognosis if no treatment is provided.

At a minimum, a provider’s informed consent policy must ensure that members served by the provider (and their guardians, where applicable) are informed of the risks and benefits of services and the right to refuse or change services or providers.

20.10-17 Reportable Events

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

20.11 APPEALS

In accordance with Chapter I of the MaineCare Benefits Manual, members have the right to appeal in writing or orally any decision made by DHHS to reduce, deny or terminate services provided under this benefit. The right to appeal does not extend to changes in law or policy adversely affecting some or all recipients.

The appeal must be (a) requested in writing and mailed to the address below, or (b) requested by telephone by calling Local: 207-287-6598, Toll Free: 1-800-606-0215 or TTY: 711.

Office of Aging and Disability Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

20.12 REIMBURSEMENT

Reimbursement methodology for covered services shall be the amount listed in Chapter III, Section 20, Allowances for Home and Community Based Services for Adults with Other Related Conditions or the provider’s usual and customary charge, whichever is lower.

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

20.13 BILLING INSTRUCTIONS

Providers must bill in accordance with DHHS’s Billing Instructions.
20.14 QUALITY REPORTING

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

A. The Care Plan
   1. Meeting Member’s personal goals
   2. Meeting health and safety needs
   3. Member receiving services outlined in the Care Plan
   4. Freedom of choice is offered both for services and provider selection
   5. Reviewed and Approved on an annual basis

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

C. Reportable Events are reported by providers within the required timeframe.
## Allowances for Home and Community Based Services for Adults with Other Related Conditions

<table>
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<th>PROC CODE</th>
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<td>U8</td>
<td>Care Coordination (Case Management)</td>
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<td>U8</td>
<td>Communication Aids</td>
<td>Per invoice</td>
<td></td>
</tr>
<tr>
<td>G9007</td>
<td>U8 GN</td>
<td>Consultation -Speech</td>
<td>¼ hour</td>
<td>5.40</td>
</tr>
<tr>
<td>G9007</td>
<td>U8 GO</td>
<td>Consultation -Occupational Therapy</td>
<td>¼ hour</td>
<td>5.40</td>
</tr>
<tr>
<td>G9007</td>
<td>U8 GP</td>
<td>Consultation -Physical Therapy</td>
<td>¼ hour</td>
<td>5.40</td>
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<tr>
<td>H0031</td>
<td>U8</td>
<td>Consultation -Psychological (Psychologist, Psychological Examiner)</td>
<td>¼ hour</td>
<td>19.80</td>
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<tr>
<td>G9007</td>
<td>U8 HI</td>
<td>Consultation –Behavioral (LCSW,LCPC)</td>
<td>¼ hour</td>
<td>13.50</td>
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<tr>
<td>S5165</td>
<td>U8</td>
<td>Home Accessibility Adaptations (Home Modifications)</td>
<td>Per invoice</td>
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<tr>
<td>S5165</td>
<td>U8 CG</td>
<td>Home Accessibility Adaptations (Home Modifications)-Repairs</td>
<td>Per invoice</td>
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<tr>
<td>T2029</td>
<td>U8</td>
<td>Specialized Medical Equipment</td>
<td>Per invoice</td>
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<tr>
<td>S8990</td>
<td>U8 GO</td>
<td>Maintenance-Occupational Therapy</td>
<td>¼ hour</td>
<td>9.54</td>
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<tr>
<td>S8990</td>
<td>U8 GN</td>
<td>Maintenance-Speech Therapy</td>
<td>¼ hour</td>
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<tr>
<td>S8990</td>
<td>U8 GP</td>
<td>Maintenance-Physical Therapy</td>
<td>¼ hour</td>
<td>9.72</td>
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<td>92507</td>
<td>U8</td>
<td>Non-Traditional Communication-Assessment (Treatment of speech, language, voice, communication, and or auditory processing disorder; individual)</td>
<td>¼ hour</td>
<td>9.00</td>
</tr>
<tr>
<td>G9007</td>
<td>U8</td>
<td>Non-Traditional Communication-Consultation</td>
<td>¼ hour</td>
<td>9.00</td>
</tr>
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### Table for Modifiers

- GT - Remote Support
- GN - Speech Therapy Services
- GO - Occupational Therapy Services
- GP - Physical therapy Services
- HI - Behavioral Services
- CG - Repairs
- U8 - All Section 20 services