DATE: December 8, 2015

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Proposed Rule: MaineCare Benefits Manual, Chapter 21, Section II, Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder

This letter gives notice of a proposed rule: MaineCare Benefits Manual, Chapter 21, Section II, Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder. This rule is a companion to Section III, Chapter 21, Allowances for Home and Community Benefits for Adults with Intellectual Disabilities. The rule will only become effective upon approval by the Centers for Medicare and Medicaid Services (CMS).

This rule is being proposed for persons with Intellectual Disabilities and Autism Spectrum Disorder being served through the Home and Community Based Services Waiver under Chapter 21, Section II of the MaineCare Benefits Manual.

The section is being renamed from Home & Community Benefits for Members with Intellectual Disabilities or Autism to Home and Community Benefits for Members with Intellectual Disabilities and Autism Spectrum Disorder. DHHS is implementing a standardized assessment process and resource allocation model for this waiver program. The Supports Intensity Scale (SIS) will be utilized as the primary assessment and resource allocation tool. The proposed rule also includes definitions for several new services: Skilled Nursing for Persons with Intellectual Disabilities or Autism Spectrum Disorder, Qualified Extra Support Service, Semi-Independent Supported Living and Respite. Other additions include definitions and provider qualifications.

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) 624-4050. 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, MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapter II, Section 21, Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder

PROPOSED RULE NUMBER:

CONCISE SUMMARY: This waiver renewal proposes rule changes to the Comprehensive Home and Community-Based Services (HCBS) Waiver for Persons with Intellectual Disabilities and Autism. This rule is a companion to Section III, Chapter 21, Allowances for Home and Community Benefits for Adults with Intellectual Disabilities. The section is being renamed to Home and Community Benefits for Members with Intellectual Disabilities and Autism Spectrum Disorder. The rule will only become effective upon approval by the Centers for Medicare and Medicaid Services (CMS).

DHHS is implementing a standardized assessment process and resource allocation model for this waiver program. The Supports Intensity Scale (SIS) will be utilized as the primary assessment and resource allocation tool as developed by the American Association on Intellectual and Development Disabilities (AIDD). Upon completion of a SIS assessment, members will be assigned to a “Level.” A Level assignment will be used to determine the amount of supports that are needed for a member to be successful and will be tied to a set “Level-Based Budget” necessary to purchase these supports. In instances where it is felt that the Level-Based Budget is not adequate to support a member, there will be opportunities within the system to request additional resources to meet those needs.

Significant updates and changes to Section 21, Chapter II include:

- Expansion of the Introduction to include information about the SIS and its use as an assessment and resource allocation tool.
- Throughout Section 21, replacement of the term “Mental Retardation” with the more appropriate term, “Intellectual Disabilities.”
- Updating references to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.
  - In the Definitions section, the following new terms have been added: Extraordinary Review Committee (ERC)
  - Level-Based Budget
  - ME-Verify Portal
  - Supports Intensity Scale (SIS)
  - SIS Manager
  - SIS Venture
  - Supplemental Questions
  - Supplemental Verification Team
  - Supporting Individual Success
- In the Definitions section, Mental Retardation was removed.
- Under Personal Plan, the language was updated to ensure that the member is driving the process and that the process is more closely aligned with the CFR §441.301 and §441.303. Direct references to the CFR were included.
- In the Covered Services section:
  - Addition of clarifying language for Assistive Technology on limits exclusions.
  - Addition of Community Support Services - Community Based and Community Support Services - Facility-Based. Added language to provide guidance on what constitutes
Community Support Services
- Community Based and Community Support Services - Facility Based.
- Under Home Support - Agency per Diem added weekly staff hour limits based upon SIS Levels.
- Addition of Qualified Extra Support Service.
- Addition of Respite.
- Addition of Semi-Independent Supported Living.
- Addition of Skilled Nursing Service for Persons with Intellectual Disabilities or Autism Spectrum Disorder.

- In the Limits section:
  - Addition of language which disallows duplicative services covered by other sections in the MaineCare Benefits Manual.
  - Definition of annual limits for: Occupational Therapy (Maintenance), QESS, Respite and Skilled Nursing for Persons with Intellectual Disabilities or Autism Spectrum Disorder.
  - Definition of (SIS) Level-Based Budgets for: Family Center Support, Agency Home Support, Shared Living, Living with Unpaid Caregivers, Living Independently and Semi-Independent Supported Living.

- In Provider Qualifications and Requirements, added:
  - Provider qualifications necessary to perform an Assistive Technology Assessment.
  - Qualified Extra Support Services.
  - Residential Settings Owned or Controlled by a Provider.
  - Semi-Independent Supported Living.
  - Shared Living (Foster Care, Adult).
  - Skilled Nursing Service for Persons with Intellectual Disabilities or Autism Spectrum Disorder.
  - Activities that support Personal Well-Being.
  - Clarification of Background Check Criteria.
  - Clarification of Reportable Events & Behavioral Treatment for Persons with Intellectual Disability.

- Appendix V - Added Requirements for Section 21 Providers of Home Support Services, Community Support Services, and Employment Specialist Services.
- Added Appendix VI-Supporting Individual Success & The Supports Intensity Scale.


Public Hearing:
Date: January 5, 2016
Time: 10:00am
Location: 19 Union Street, Room 110
Augusta ME 04333

The Department requests that any interested party requiring special arrangements to attend the hearing contact the agency person listed below before December 22, 2015.
DEADLINE FOR COMMENTS: Comments must be received by midnight January 15, 2016.

AGENCY CONTACT PERSON: Andrew Hardy, Comprehensive Health Planner II
AGENCY NAME: MaineCare Services
ADDRESS: 242 State Street, 11 State House Station
Augusta, Maine 04333-0011
TELEPHONE: 207-624-4058, FAX: (207) 287-1864
TTY: 711 (Deaf or Hard of Hearing)
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

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The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)
MAINECARE BENEFITS MANUAL
CHAPTER II

HOME AND COMMUNITY BENEFITS FOR MEMBERS
WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER

SECTION 21 ESTABLISHED 11/1/83

THE CHANGES IN THIS SECTION ARE DEPENDENT UPON APPROVAL BY
THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

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21.01 INTRODUCTION

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

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

This benefit assures that every waiver service setting (including home, community and work):
- Is integrated in and supports full access to the greater community;
- Is selected by the member from among setting options;
- Assures members rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

The benefit is a limited one. To be eligible for this Benefit under this section, members must meet medical eligibility requirements and there must be a funded opening. Each year the Department of Health and Human Services (DHHS) identifies the number of members who are eligible for services under this section. If there is no funded opening, or if a member is not eligible for a funded opening based on priority, the member will be placed on a waiting list as described in this rule, (See 21.03-8.)

Services provided in this section are delivered in accordance with the Personal Planning Process. The planning process includes identifying and documenting the member’s needs. Members will be assessed using the Support Intensity Scale (SIS). Members will receive an individualized budget based on a level of need determined by the SIS. This budget is known as a Level-Based Budget. The Level-Based Budget identifies the benefit limit available to a member to purchase needed services, as identified through the Personal Planning Process. Working within the limits of the Level-Based Budget, the member’s Personal Plan describes certain habilitative, therapeutic and intervention services with an overall goal of increased independence and community inclusion. Other covered services are available and are not included in the Level-Based Budget package.
21.01 INTRODUCTION (cont.)

The SIS will be utilized by the Department to assist in the determination of the level of supports needed by a member. The SIS was developed by the American Association on Intellectual and Developmental Disabilities (AAIDD). It is a strength’s based assessment tool, focusing on a member’s daily support needs. The AAIDD reports that with proper administration, the SIS is a valid and reliable tool.

Upon the completion of a SIS assessment, a member will be assigned to a “level.” A level represents the support needs necessary for the member to be successful within their residential and community setting. A member who is assigned to Level I would require the least amount of supports, while a member assigned to Levels IV or V would require the highest level of supports. A level assignment determines the amount of supports that are needed for a member to be successful. A level assignment is tied to a Level-Based Budget, necessary to purchase these supports.

Through the planning process, members will be able to use their Level-Based Budget to decide and purchase the services they want and need in the upcoming year. In any Level-Based Budgeting system, it is expected that a small percentage of members will have extra support needs that are beyond their assigned budget limit. As such, OADS has developed additional services such as the Qualified Extra Support Service (QESS) and Skilled Nursing for Persons with Intellectual Disabilities and Autism Spectrum Disorder to provide extra support. OADS may approve additional support services for any assigned Support Level in accordance with limits and requirements set forth in this section. See Appendix VI, Supporting Individual Success & The Supports Intensity Scale.

In addition, the planning process includes identifying and documenting the member’s needs in a Personal Plan. The Personal Plan describes certain habilitative, therapeutic and intervention services and supplies with an overall goal of community inclusion.

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

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

21.02 DEFINITIONS

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

21.02-2 Activities of Daily Living (ADL) are:

A. Bed Mobility: How a person moves to and from lying position, turns side to side, and positions body while in bed;
B. Transfer: How a person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);
C. Locomotion: How a person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;
D. Eating: How a person eats and drinks (regardless of skill);
E. Toilet Use: How a person uses the toilet room (or commode, bedpan, urinal), transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes;
F. Bathing: How a person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and
G. Dressing: How a person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

21.02-3 Administrative Oversight Agency is an agency
• Is approved by DHHS-Office of Aging and Disability Services -(OADS),
• Enters into a contractual agreement with the that holds a contract with a Shared Living Provider for to provide supervision oversight and monitoring services.
• Bills and receives MaineCare reimbursement.

21.02-4 Agency Home Support means a Provider Managed Service Location that routinely employs direct care staff to provide direct support services.

21.02-56 Autism Spectrum Disorder means a diagnosis that falls within the category of Pervasive Developmental Disorders, as defined in Section 299.0-299.80 in the current edition of 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.

21.02-6 Authorized Entity is the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.

21.02-7 Case Manager is a person responsible for assuring the timely convening of the service planning team, developing the Personal Plan, monitoring the planned services received by the member, and for insuring that those services meet the requirements set forth in the member’s Personal Plan. This person may also be referred to as an Individual Support Coordinator.
21.02 DEFINITIONS (cont.)

21.02-8 **Correspondent** is a person designated by the Maine Developmental Services Oversight and Advisory Board to act as a next friend of a person with Intellectual Disabilities or Autism.

21.02-9 **Designated Representative** means the DHHS staff or Authorized Agent authorized by DHHS to perform specified functions.

21.02-10 **Direct supports** are a range of activities that contribute to the health and well-being of the member and his or her ability to live in or be part of the community. Direct support activities may include personal assistance or activities that support personal development, or activities that support personal well-being. Direct support activities are provided as Home Support, Community Support, Employment Specialist Services or Work Support. The emphasis and purpose of the direct support provided may vary depending on the type of service.

Direct support activities include the following:

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

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

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

**Activities that support personal development** include teaching or modeling for a member self-care and self-management skills, physical fitness, behavior
21.02 DEFINITIONS (cont.)

management; sensory, motor and psychological needs; interpersonal skills to cultivate supportive personal, family, work and community relationships; resources and opportunities for participation in activities to promote social and community engagement; participation in spiritual activities of the member’s choice; motivating the pursuit of personal development and opportunities; teaching or modeling informed choice by gathering information and practicing decision making; and learning to exercise.

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

21.02-11 Employment Setting for either Work Support-Individual or Work Support-Group must be one with the highest level of integration possible. The job must be one that is available to a non-disabled employee with the same expectations for the member’s job performance and attendance. The member works under similar work conditions as others without disabilities in similar positions; including access to lunchrooms, restrooms, and breaks. The member performs work duties with ongoing interaction with other workers without disabilities, and has contact with customers, suppliers and the public to the same degree as workers without disabilities in the same or comparable occupations. The member cannot be excluded from participation in company-wide events such as holiday parties, outings and social activities. Provider owned/operated businesses are subject to the same integration standards as other businesses. Staff providing employment services at the worksite are not considered non-disabled employees in determining the level of integration. For those agencies that currently operate under an award from AbilityOne (http://AbilityOne.org), the federal workforce guidelines associated with this funding source will apply to the services funded by the contract. The member can be on the employer’s payroll or the provider agency payroll.

Members may receive additional employment supports from a provider agency. A member must be supervised in a manner identical to other employees. It is permissible, on a case by case basis to have the support agency provider offer and provide this supervision as long as the above conditions are met.
21.02 DEFINITIONS (cont.)

21.02-12 **Exploitation** means the illegal or improper use of an incapacitated or dependent member or that member’s resources for another’s profit or advantage as defined in 22 MRSA §3472.

21.02-13 **Extraordinary Review Committee (ERC)** is designated by OADS to review all requests for Qualified Extra Support Service and Skilled Nursing Services. The ERC is comprised of staff with a variety of expertise and background and may include contracted experts for consultation on an as needed basis.

21.02-14 **Family-Centered Support** is a model designed to provide enhanced home support to a member in a family environment, with the family and the member sharing a home that is not owned by the member or member’s family. No more Family Centered Support will be approved after December 30, 2007. The Family Centered Provider must be a Certified Direct Support Professional (DSP) who has met all the requirements to provide this service.

21.02-15 **Habilitation** is a service that is provided in order to assist a member to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising the level of physical, mental, and social functioning of a member. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.

21.02-16 **Instrumental Activities of Daily Living (IADL)** include only the following: main meal preparation; routine housework; grocery shopping and storage of purchased groceries; and laundry either within the residence or at an outside laundry facility.

21.02-17 **Intellectual Disability** means a diagnosis of Mental Retardation as defined in Section 317-319 in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 34-B MRSA § 5001. The terms “mental retardation” and “intellectual disability” are used interchangeably in these regulations. Use of the term “intellectual disability” in no way alters the criteria for eligibility set forth in s. 21.03-3(B).

21.02-18 **Level-Based Budget** Members are assessed using the Supports Intensity Scale (SIS) to determine the member’s overall support need. Based on the SIS, the member is assigned a support level. Levels range from one (1), the lowest level of support need, through five (5), the highest level of support need. The level assignment corresponds to a predetermined Level-Based Budget for home support services, community supports and work supports.
21.02 DEFINITIONS (cont.)

21.02-19 **ME-Verify Portal** is the web-based secure database to track and update reviews completed by the Supplemental Verification Team (SVT) in response to Supplemental Questions. The database is also used to track and update the level assignment after the completion of a SIS assessment and convert raw SIS scores into standardized SIS scores resulting in both a support level and a Level-Based Budget.

21.02-20 **Medical Add On** Effective with this rule change, Medical Add On is only valid for those members who have yet to transition to a Level-Based Budget. Medical Add On is a component of Home Support, Community Support, Employment Specialist Services and Work Support and is included in the established authorization (as described in Section 21.04-1). It is not a separately billable activity. Billing may not exceed the Home Support, Community Support, Employment Specialist Services or Work Support authorized units of service. Documentation must clearly identify and support periods of such activity. Refer to Appendix II for more information.

21.02-21 **Member** is a person determined to be eligible for MaineCare benefits by the Office for Family Independence (OFI) in accordance with the eligibility standards published by the OFI in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

21.02-19 **Mental Retardation** means a diagnosis of Mental Retardation as defined in Section 317-319 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 24-B-MRSA § 5001. The terms “mental retardation” and “intellectual disability” are used interchangeably in these regulations. Use of the term “intellectual disability” in no way alters the criteria for eligibility set forth in s. 21.03-3(B).

21.02-20 **Neglect** means a threat to an member’s health or welfare by physical or mental injury or impairment, deprivation of essential needs or lack of protection from these as defined in 22 MRSA §3472.

21.02-23 **On Behalf Of** is a billable activity that is provided for individual members and is not necessarily a direct face-to-face service. On Behalf Of is a component of Home Support, Community Support, Employment Specialist Services and Work Support. It is included in the established authorization and is not a separately billable activity. Documentation detail must clearly identify and support periods of such activity. On Behalf Of is a service for those members who have yet to obtain a level assignment and transition to a Level-Based Budget. Refer to Appendix III for more information.
21.02 DEFINITIONS (cont.)

21.02-242 Personal Plan is a member’s plan developed at least annually that lists the services offered under the waiver benefit. The Personal Plan may also include services not covered by the waiver but identified by the member. Only covered services included on the Personal Plan are reimbursable. The Personal Plan may also be known as a person centered plan, a service plan, an individual support plan, or an individual education plan, as long as the requirements of Section 21.04-2 are met.

21.02-253 Prior Authorization is the process of obtaining prior approval as to the medical necessity and eligibility for a service.

21.02-2624 Qualified Intellectual Disability Professional (QIDP) is a person who has at least one year of experience working directly with persons with intellectual disabilities or other developmental disabilities and is one of the following: 1) a doctor of medicine or osteopathy; 2) a registered nurse; or 3) an individual who holds at least a bachelor’s degree as specified in title 42 Code of Federal Regulations (CFR) 483.430, paragraph B5.

21.02-2725 Qualified Vendor is a provider approved by DHHS to provide waiver services to eligible members receiving services under this Section. DHHS requires agencies to provide high quality services that, at a minimum, meet the expectations of the members who utilize those services. DHHS may authorize agencies to provide services under this Section after an application, along with supporting documentation, has been submitted to a Designated Representative for review and approval. The Designated Representative will authorize only agencies that meet DHHS expectations in the areas of organization and operation, operation of individual programs or services, personnel administration, environment and safety, and quality management. Only Qualified Vendors will receive DHHS referrals and authorizations for reimbursement.

21.02-2826 Shared Living (Foster Care-adult) is a model in which services are provided to a member by a person who meets all of the requirements of a Direct Support Professional with whom that member shares a home. The home may belong to the provider or the member, but the provider must enter into a contractual relationship with an Administrative Oversight Agency in order to provide services under this model. Only one member may receive services in any one Shared Living arrangement at the same time, unless a relationship existed prior to the service arrangement and the arrangement is approved by DHHS. In such case, no more than two members may be served in any one Shared Living arrangement concurrently.

The Shared Living Provider/Direct Support Professional must enter into a contractual relationship with the Administrative Oversight Agency in order to provide services in a Shared Living arrangement. The agency supports the provider in fulfilling the...
21.02 DEFINITIONS (cont.)

Shared Living Provider is a provider who subcontracts with an agency to provide direct support to a member, with whom they share a home. The Shared Living Provider must be a Certified Direct Support Professional (DSP) and comply with the Shared Living Handbook provided by DHHS. The Shared Living Provider must enter into a contractual relationship with the Administrative Oversight Agency in order to provide services to a member. The agency supports the provider in fulfilling the requirements and obligations agreed upon by the DHHS, the Administrative Oversight Agency and the member’s Personal Plan.

SIS Manager is the designated person employed by OADS to manage incoming SIS requests, organize and manage the Extraordinary Review Committee (ERC) as well as the Supplemental Verification Team (SVT). The SIS Manager is also responsible for training initiatives, communication to members, stakeholders, Major Life Change and Interview Protocol Determination and ongoing program management in relation to the implementation of the SIS and Supporting Individual Success Initiative.

SIS Venture is the web-based secure online database provided by the American Association on Intellectual and Developmental Disabilities (AAIDD) through a contract with OADS. The database tracks, stores and compiles all SIS Assessments completed by certified SIS Interviewers and provides detailed reports, data and information in relation to the SIS.

Supplemental Questions are additional questions asked at SIS assessments to help determine if a member may have higher support needs. There are four primary areas: severe medical need, severe community safety risk non-convicted, severe community safety risk convicted and severe risk of self-injury. If a member’s support need in response to these questions indicate a potential higher level of support, then the case will be referred to the Supplemental Verification Team (SVT) for review. The SVT will complete a paper review to validate if a higher level of need exists.

Supplemental Verification Team (SVT) is comprised of OADS staff, to review members who through a SIS assessment have triggered a supplemental review. The SVT reviews case documentation submitted by the member’s case manager to verify that a higher level of support is required. The SVT determines if the member requires a higher support level to meet medical or behavioral needs. A support level
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21.02 DEFINITIONS (cont.)

will not assigned to a member until the SVT completes the required review.

21.02-34 Supporting Individual Success, is Maine's initiative to utilize a standardized assessment to implement a resource allocation model. Members with Intellectual Disabilities and Autism Spectrum Disorder are interviewed using a tool called the Supports Intensity Scale. Assessment results, and other information are used to develop individual budget amounts for member use during their Personal Planning process. Supporting Individual Success promotes member; self-direction, personal choice and community inclusion. See Appendix VI.

21.02-35 Supports Intensity Scale (SIS) is a nationally recognized assessment tool developed by the American Association on Intellectual Disabilities and Developmental Disabilities (AAIDD). The SIS is strengths based, focusing on a member's daily support needs.

21.02-3628 Utilization Review is a formal assessment of the medical necessity, efficiency and appropriateness of services on a prospective, concurrent or retrospective basis.

21.02-3729 Year Services are authorized on the state fiscal year, July 1 through June 30. Once a member has transitioned to a Level-Based Budget, authorized services will begin on the effective date of the Personal Plan.

21.03 DETERMINATION OF ELIGIBILITY

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

21.03-1 Funded Opening

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

21.03-2 Reserved Capacity

The DHHS reserves a portion of the participant member capacity of the waiver for specified purposes subject to CMS review and approval in order to:
21.03 DETERMINATION OF ELIGIBILITY (cont.)

- Meet the needs of incapacitated or dependent adults who require adult protective services to alleviate the risk of serious harm resulting from abuse, neglect and/or exploitation; and
- Meet the needs of those individuals who choose to leave an ICF/IID or other institutional setting; and
- Meet the needs of members under 21 in out of state residential placements funded by MaineCare or State funds.

The number reserved associated with Section 21.03-2 above is an average based on the DHHS’s data for those in need of adult protective services in recent years. The number reserved for ICF/IID or other institutional residents is based on currently known referrals. The number reserved for members in out of state residential placements is based on the number of current out of state residential placements funded by MaineCare or State funds.

21.03-3 General Eligibility Criteria

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

A. Is age eighteen (18) or older (members who were younger than age 18 and were already receiving services under this Section as of December 30, 2007 may continue to receive benefits under this Section); and
B. Has an Intellectual Disability Mental Retardation as defined by Sections 317-319 in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association) (DSM) IV or Autism Spectrum Disorder as defined by Section 299.00 in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM) IV or Pervasive Developmental Disorder (NOS) as defined by Section 299.80 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition - (American Psychiatric Association) (DSM) IV; and
C. Meets the medical eligibility criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) as set forth under the MaineCare Benefits Manual, Chapter II, Section 50; and
D. Does not receive services under any other federally approved MaineCare home and community based waiver program; and
E. Meets all MaineCare eligibility requirements as set forth in the MaineCare Eligibility Manual; and
F. The estimated annual cost of the member’s services under the waiver is equal to or less than two hundred percent (200%) of the state-wide average annual cost of care for a non institutionalized individual with Intellectual Disabilities (ICF/IID), as determined by the Department of Health and Human Services (DHHS).

21.03-4 Establishing Medical Eligibility

In order to determine medical eligibility, the member and Case Manager must provide to DHHS the following:

A. A completed copy of the assessment form (BMS99) or current functional assessment approved by the DHHS Department; and
B. A copy of the member’s Personal Plan developed, approved and signed by the member or guardian and the Case Manager within the preceding six months and any other relevant material indicating the member’s service needs.

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

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

If the member is found to be medically eligible, DHHS must send the member or guardian written notice that the member can receive ICF/IID services or services under this Section. The member or guardian must submit to the Case Manager a signed choice letter documenting the member’s choice to receive services under this section.

21.03-5 Calculating the estimated annual cost

Prior to formal determination of eligibility for services under this section, each applicant and the applicant’s planning team must identify the required mix of services to meet the applicant’s needs and to assure the applicant’s health and welfare. The applicant and the applicant’s planning team shall submit a detailed
21.03 DETERMINATION OF ELIGIBILITY (cont.)

estimate of the total annual cost, annual budget for waiver services identified in the Personal Plan, including the specific services and the number of units for each service.

21.03-6 Priority

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

A. **Priority 1:** Any member on the waiting list shall be identified as Priority 1 if the member has been determined by DHHS to be in need of adult protective services in accordance with 22 M.R.S.A. §3473 et seq., and if the member continues to meet the financial and medical eligibility criteria at the time that need for adult protective services is determined.

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

1. a member whose parents have reached age sixty (60) and are having difficulty providing the necessary supports to the member in the family home; or
2. a member living in unsafe or unhealthy circumstances but who is not yet in need of adult protective services, as determined by DHHS Adult Protective Services.

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

1. a member living with family, who has expressed a desire to move out of the family home;
2. a member whose medical or behavioral needs are changing and who may not be able to receive appropriate services in the current living situation;
3. a member who resides with family, if the family must be employed to maintain the household but cannot work in the absence of the benefit being provided to the member; or
21.03 DETERMINATION OF ELIGIBILITY (cont.)

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

21.03-7 Choosing Whom to Serve Within the Same Priority

If the number of openings is insufficient to serve all members on the waiting list who have been determined, at the time that any opening is determined to be available, to be within the same priority group, DHHS shall first determine whether each member continues to meet the financial and medical eligibility criteria to be served through this benefit. For those who continue to meet such criteria, DHHS will utilize the most current assessment that is entered into the Enterprise Information System (EIS) and submitted by the individual member, guardian or Case Manager. Upon review of information concerning all members within the same priority group who continue to meet financial and medical eligibility criteria and for whom current service plans are in place, DHHS shall determine which members to serve. The determination will be based on a comparison of the members’ known needs, the availability of capable service providers who can adequately meet those needs, and the comparative degree of abuse, neglect or exploitation or risk of abuse, neglect or exploitation that each member will likely experience in the absence of the provision of the benefit.

21.03-8 Waiting List

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

A member has sixty days from the receipt of notification by DHHS of a funded opening to respond with intent to accept waiver services. A member has six months from the receipt of notification to start receipt of services. If the member fails to respond with intent to accept the funded opening within 60 days of this notice or fails to begin services within 6 months, the member shall be removed from the waitlist. A member may reapply at any time for waiver services.

21.03-9 Redetermination of Eligibility

When determining continued eligibility, Every 12 months from the date of initial eligibility approval, and every 12 months thereafter, the Member’s Case Manager will submit to OADS; a Current Personal Plan that is less than six (6) months old, an updated Assessment Form (BMS 99) or current functional assessment approved by
21.03 DETERMINATION OF ELIGIBILITY (cont.)

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

21.04 PERSONAL PLAN

Medically necessary services and units of services must be identified in the Personal Plan. Requests for services must be submitted to DHHS or its Authorized Entity for Prior Authorization in order for the services to be reimbursed. For members who have yet to transition to a member Level-B budget, compliance to the authorization is determined if the average of actual delivered services fall within the range established for that setting or member. If the average falls within the range, then billing at the approved level is authorized. If the average falls below the pre-set level, then billing must reflect the lower level of service provided. All Prior Authorizations are time-limited, and the length of the authorization may vary by member and service as documented in the Personal Plan. Upon expiration of an authorization, a new authorization must be obtained before reimbursement may be provided for the service.

DHHS and its Authorized Entity reserve the right to conduct Utilization Review of any service authorized under this Section, applying the service-specific eligibility
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21.04 PERSONAL PLAN (cont.)

standards set forth in this Section. DHHS and its Authorized Entity may terminate or
revise a service authorization upon finding that the member no longer satisfies the
eligibility standards for the service or level of service authorized.

21.04-2 Plan Requirements

The Case Manager will ensure that the Planning Team is convened to initiate
development of the Personal Plan prior to services being initiated. Case Managers
must meet with the member absent of current providers to ensure conflict free
planning and informed choice. The planning process must reflect cultural
conventions of the member. The planning process must be conducted by providing
information in plain language and in a manner that is accessible to the member and
when applicable, their legal representative.

The plan must be current, less than six (6) months old at the time of the member’s
eligibility determination or redetermination. As described in CFR §441.303, The
Personal Plan must include the following; describe at a minimum:

A. All MaineCare Benefit services determined medically necessary by the team
   including all other services that may not be covered under this section but the
   member identifies and may pursue;
B. The frequency of provision of the services;
C. How services contribute to the member’s health and well-being and the
   member’s ability to reside in a community setting;
D. The member’s goals for strengthening and cultivating personal, community,
   family, and professional relationships;
E. The role and responsibility of the Direct Support Professional, the
   Employment Specialist and the member’s other service providers in
   supporting the member’s goals, including goals for strengthening natural and
   supportive personal, family, community and professional relationships;
F. Members who choose to receive Home Support-Remote Support must have a
   safety/risk plan, which shall describe the potential risks to the member’s
   health and welfare while receiving Home Support-Remote Support and the
   reasonable steps to alleviate those risks; and
G. In order for the Plan to be authorized the Plan must include signatures of (1)
   the member, or guardian, if applicable, and (2) the case manager and (3) per
   CFR §441.301, all the individuals and providers responsible for the
   implementation of the plan.

The Personal Plan will be used by DHHS to identify the type and units of authorized
services the member may receive under this Section. If more than one provider is
21.04 PERSONAL PLAN (cont.)

is reimbursed for the same category of direct support activities, an explanation of the differences in roles and responsibilities of each provider and how services will not be duplicated is required.

All providers must ensure that notice of the Grievance process outlined in 14-197 CMR Chapter 8 is regularly provided to members served by the provider. Providing notice includes, at a minimum, ensuring that written notice of the grievance process is provided to the member and/or their guardian at any planning meeting; posting notice of the grievance process in an appropriate common area of all facilities operated by the Provider; and posting notice of the grievance process on any website maintained by the Provider. In addition, the provider must ensure that all staff are trained in the grievance process.

21.04-3 Planning Team Composition

Each member or guardian will determine the composition of the Planning Team. Planning will occur in a manner that is respectful and reflective of the member’s preference. The member will lead the Person-Centered Planning Process whenever possible. The member’s guardian should have a participatory role as needed and as defined by the member, unless State law confers decision-making authority to the legal guardian.

The Case Manager is responsible for convening the planning team and assisting the member to facilitate the Person Centered Planning process. The Case Manager or Case Management Supervisor has sole authority for scheduling and rescheduling the planning team at the request of the member or their legal guardian. In addition to the Case Manager, the planning team may include the following members, if applicable:

A. Case Manager;
B. The member;
C. The member’s parent, guardian; or
D. An approved Correspondent through the Maine Oversight Advisory Board;
E. The member’s advocate or friend or any additional individual invited by the member;
F. Operator of the member’s home or a Direct Support Professional providing services to the member;
G. Staff from the member’s Community Support, Work Support, Employment Specialist Services, Assistive Technology or Career Planning Provider; and
H. Any professionals involved or likely to be involved with the member’s Personal Plan.
21.04 PERSONAL PLAN (cont.)

21.04-4 Updating the Personal Plan

The member’s Personal Plan must be reviewed, revised and updated at least annually or at the request of the member, and in addition when other significant changes occur relating to the member’s physical, social, or psychological needs, or the member’s significant progress toward his or her goals. When a member’s residential placement changes, the case manager must reconvene the Planning Team to revise and update the Personal Plan, within thirty days of the move. The Case Manager must reconvene the Planning Team to revise and update the Personal Plan as service needs change, including the location where services are received. Planning meetings must be held both prior to and 30 days subsequent to the planned move of a member to a new residence service in order to coordinate supports and services and to evaluate the member's satisfaction with the change.

21.05 COVERED SERVICES

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

21.05-1 Assistive Technology- 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.

If Authorized, the Department expects that Home Support Remote Support Hours will be implemented within 90 days of assessment.

Assistive Technology includes:

Assistive Technology-Assessment:

- 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 services to the member in the customary environment of the member;
- The coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
21.05 COVERED SERVICES (cont.)

- The training or technical assistance for the member, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the member; and
- The 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- Assessment is subject to a combined limit per year. See Section 21.07.

Assistive Technology-Devices:

- The purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for members; and
- The selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices. Assistive Technology- Devices is subject to a combined limit per year. See Section 21.07 below.

Assistive Technology-Transmission (Utility Services):

- The transmission of data required for use of the Assistive Technology Device via internet or cable utility. Assistive Technology-Transmission is subject to a combined limit per month. See Section 21.07 below.

The components above are subject to the following limits:

1. Assistive Technology- Assessments are subject to a limit of 32 units, per state fiscal year.
2. Assistive Technology- Devices and services are subject to a combined limit $6,000 annually, per state fiscal year.
3. Assistive Technology- Transmission (Utility Services) are limited to $50.00 per month.

21.05-2 Career Planning is a person-centered, comprehensive direct support provided to a member that enables a member to obtain, maintain or advance in competitive employment or self-employment. Career Planning assists with identifying a career direction and developing a plan for achieving competitive, integrated, individual employment or self-employment at or above the State’s minimum wage. Services assist in identifying skills, priorities, and capabilities determined through an individualized discovery process. A Department approved Career Planning curriculum -may include a referral to benefits planning, referral of assessment for use
of assistive technology to increase independence in the workplace, and development of experiential learning opportunities and career options consistent with the member’s skills and interests. Career Planning may be used in preparation to gather information for a referral to Vocational Rehabilitation.

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

Career Planning services can be provided within a variety of community settings such as a Career Center, the community and local business and must be documented in the Person Centered Plan with related goals.

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

**Communication Aids** are devices or services necessary to assist individuals, 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;

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

C. Facilitated communication. Providers must submit a written plan for DHHS’s approval defining the facilitated communication services that will be offered to the member. The provider of this service must have a Certificate of Clinical Competence-Speech Pathology (CCC-SP).

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


21.05 COVERED SERVICES (cont.)

21.05-4 Community Support is Direct Support provided by a Direct Support Professional in order to increase or maintain a member’s ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on community inclusion, personal development, and support in areas of daily living skills if necessary.

Community Support provides opportunities for career exploration and the facilitation of discussion about the benefits of working. Activities and discussions related to work should be relevant to identifying a member’s employment interests, employment related strengths and goals, as well as the conditions necessary for the member to achieve successful employment.

Community Support is intended to be flexible, responsive and provided to members as defined by the member’s choice and needs as documented in the member’s Personal Plan, consistent with his or her personal plan. Nothing in this rule prohibits one-to-one (1:1) service delivery. The location of the service and staffing level may vary, allowing for a mix of individualized and group services.

Both types of Community Support (community or facility based) allow for opportunities for career exploration and the facilitation of discussions about the benefits of working. Activities and discussions related to work should be relevant to identifying a member’s employment interests, their individual strengths as related to employment, employment goals and the conditions necessary for the member to achieve and maintain successful employment.

A member may not receive Community Support while enrolled in high school. Community Support is not provided in the member’s place of employment. The cost of transportation related to the provision of Community Support is a component of the rate paid for the service and is not separately billable. For specific limits of this service refer to 21.07.

For those members who have yet to transition to a Level-Based-Budget:

- The average staff to member ratio for Community Support for each program location must not exceed 1:3.
- On Behalf Of will continue as a component of Community Support and is included in the established authorization. It is not a separate billable activity.
- The member may receive Community Support services in addition to Work Support Group and/or Work Support-Individual. The combined cost of Community Support, Work Support-Individual, and Work Support-Group may not exceed $26,455.00 annually.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS).

### 21.05 COVERED SERVICES (cont.)

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

**Nothing in this rule prohibits one to one (1:1) service delivery.**

On Behalf of is a component of Community Support and is included in the established authorization and is not a separate billable activity. The maximum annual allowance for Community Support is eleven hundred twenty-five (1,125) hours per year.

Community Support is either in the community or is facility based.

Facility Based Community Support is delivered outside of the member’s home. The services occur in a provider owned or operated facility for members with Intellectual Disabilities or Autism Spectrum Disorder. The services are based on member preferences, are primarily habilitative and can provide both personal care and therapeutic activities.

For Facility Based Community Support, the maximum number of members to staff is five (5) members to one (1) staff person. See Chapter III, Section 21, Allowances for Home and Community Benefits for Members with Intellectual Disabilities or Autism.

Non-Facility-Based Community Support is delivered outside of the member’s home and outside of a facility. These are integrated services, supporting full access to the greater community. Members engage in community life, control personal resources and receive services in the community, to the same degree of access as individuals not receiving MaineCare Home and Community Based Services.

For Non-Facility-Based Community Support, the maximum number of members to staff is five (5) members to two (2) staff persons. This does not preclude 1:1 or 2:1 staffing. See Chapter III, Section 21, Allowances for Home and Community Benefits for Members with Intellectual Disabilities or Autism.

**21.05-5 Counseling** is a direct service to assist the member in the resolution of the member’s behavioral, social, mental health or alcohol or drug substance abuse issues. Counseling services, as recommended in the Personal Plan, must be approved by DHHS. The provider of this service must be a Licensed Clinical Social Worker (LCSW) or a Licensed Clinical Professional Counselor (LCPC). Counseling is limited to 16.25 hours annually.
21.05 COVERED SERVICES (cont.)

21.05-6 Consultation Services are services provided to persons responsible for developing or carrying out a member’s Personal Plan. Consultation Services include:

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

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

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

D. Monitoring progress of a member in accordance with his or her Personal Plan appropriate, to make necessary adjustments; and

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

Consultation is available in the following specialties: Occupational Therapy, Physical Therapy, Speech Therapy, Behavioral and Psychological services. The provider of this service must be an Occupational Therapist, Registered (OTR) for Occupational Therapy Consultation or a Registered Physical Therapist (RPT) for Physical Therapy consultation or have a Certificate of Clinical Competence-Speech Pathology (CCC-SP) for Speech Therapy Consultation. For Psychological Consultation, the provider of this service must be a Licensed Psychological Examiner or Licensed Clinical Psychologist. For Behavioral Consultation, the provider of this service must be a Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC) or a Board Certified Behavior Analyst (BCBA). Reimbursement for Consultation Services may only be made to those providers not already reimbursed for consultation as part of another service. Personnel who provide services under Targeted Case Management, Section 13 of the MaineCare Benefits Manual may not be reimbursed for Consultation Services. Consultation is limited to 16.50 hours annually per discipline.
21.05 COVERED SERVICES (cont.)

21.05-7 Crisis Assessment is a comprehensive clinical assessment of a member who has required intervention by the DHHS Crisis Team on at least three occasions within a two-week period. The assessment includes: a clinical evaluation to identify causes or conditions that may precipitate the crisis, specific crisis prevention activities, and to develop a plan for early intervention and stabilization in the event of a crisis. The required members of a clinical team are a psychiatrist or licensed psychologist and a clinical liaison. Depending upon client need, other team members may include a physician, occupational, physical or speech therapist.

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

21.05-8 Crisis Intervention Services are direct intensive supports provided to members who are experiencing a psychological, behavioral, or emotional crisis. The scope, intensity, duration, intent and outcome of Crisis Intervention must be documented in the Personal Plan. Crisis Intervention is commonly provided on a short-term intermittent basis.

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

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

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

For those members who have transitioned to a Level-Based Budget, the first six hours (24 units) of support delivered in a calendar day are billed at the short-term rate. All units after the first 24 units are billed at the long-term rate.

21.05-9 Employment Specialist Services include services necessary to support a member in maintaining employment. Services include: (1) periodic interventions on the job site to identify a member’s opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

21.05 COVERED SERVICES (cont.)

expected safety practices, and promoting successful employment and workplace inclusion; (2) assistance in transitioning between employers when a member’s goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the member in acclimating to a new job; and (3) Employment Specialist Services for job development, if Vocational Rehabilitation denies services under the Rehabilitation Act and the member is unable to benefit from Vocational Rehabilitation. If Employment Specialist Services are used for job development, current documentation of ineligibility from Vocational Rehabilitation is required.

Employment Specialist Services are provided by an Employment Specialist, who may work either independently or under the auspices of a Supported Employment agency provider but must have completed the approved Employment Specialist training as outlined by DHHS in order to provide Employment Specialist Services. The need for continued Employment Specialist Services must be documented in a Personal Plan as necessary to maintain employment over time.

Employment Specialist Services are provided at work locations where non-disabled individuals are employed as well as in entrepreneurial situations. Employment Specialist Services may be utilized to assist a member to establish and/or sustain a business venture that is income-producing. MaineCare funds may not be used to defray the expenses associated with the start-up or operating a business.

A member may not receive Employment Specialist Services while enrolled in high school.

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

For those members who have not yet transitioned to a Level Based-Budget, On Behalf Of will continue as is a component of Employment Specialist Services Support and is included in the established authorization and is not a separate billable activity.

Employment Specialist Services are provided on an intermittent basis with a maximum of 10 (ten) hours each month. Nothing in this rule prohibits a member from working under a Special Minimum Wage Certificate issued by the Department of Labor under the Fair Labor Standards Act. Employment Specialist Services cannot be provided at the same time as Work Support-Group or Work Support-Individual.
21.05 COVERED SERVICES (cont.)

21.05-10 Home Accessibility Adaptations are those physical adaptations to the private residence of the member or the member’s family required by the member’s Personal 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 their home. These include adaptations that are not covered under other sections of the MaineCare Benefits Manual and are determined medically necessary as documented by a licensed physician and approved by DHHS.

Adaptations commonly include:

- Bathroom modifications;
- Widening of doorways;
- Light, motion, voice and electronically activated devices;
- Fire safety adaptations;
- Air filtration devices;
- Ramps and grab-bars;
- Lifts (can include barrier-free track lifts);
- Specialized electric and plumbing systems for medical equipment and supplies;
- Lexan windows (non-breakable for health & safety purposes);
- Specialized flooring (to improve mobility and sanitation).

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

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

This service applies to member-owned or a member’s family-owned home only; it is not available in Provider-owned or -operated homes. Home Accessibility Adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
21.05 COVERED SERVICES (cont.)

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

21.05-11 Home Support-Agency Per Diem is direct support provided in the member’s home (Agency Home), by a Direct Support Professional to improve and maintain a member’s ability to live as independently as possible. Home Support is direct support to a member and includes primarily habilitative training and/or personal assistance with Activities of Daily Living (ADL) and/or Instrumental Activities of Daily Living (IADL) (self-care, self-management), development and personal well-being. Agencies will provide protective oversight and supervision in accordance with the member’s Personal Plan.

Agency Home Support is constant daily support may be provided as either a regularly scheduled “round the clock” service or as individual hours, or blocks of hours, of service depending upon the member’s activities.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

Payment is not made directly, or indirectly, to the member's immediate family.

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

A 15-day absence factor is built into the reimbursement rate for Agency Home Support such that providers can bill a full year of revenue over 350 billing days. Billing for Agency Home Support is therefore limited to 350 days per year. Nothing in this rule prohibits or limits a member’s stay outside the agency home when a member may be supported by a natural support, such as family or friends. The daily unit may only be billed if the member is in the home at 11:59 PM.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS).

21.05 COVERED SERVICES (cont.)

For members who have not transitioned to a Level Based-Budget, On Behalf Of will continue as a component of Home Support and is included in the established authorization and is not a separate billable activity. The cost of transportation related to the provision of Home Support is a component of the rate paid for the service and is not separately billable.

21.05-12 Home Support-Family Centered Support is a direct support billed per diem where the member shares a home with a family in a provider owned building. The provider is a Direct Support Professional and provides supports to improve and maintain a member’s ability to live as independently as possible. Home Support is direct support to a member and includes primarily habilitative training and/or personal assistance with Activities of Daily Living (ADL) and/or Instrumental Activities of Daily Living (IADL), development and personal well-being.

Payment is not made 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. Payment is not made directly, or indirectly, to the member's immediate family.

Within the scope of Home Support, there may be activities that require that the service be carried over into the community. Nothing in this rule is intended to prohibit community inclusion as a reimbursable service accompanied by documentation on the Personal Plan provided that the service has a therapeutic and habilitative outcome. An example is shopping for food, which may later be prepared in the home.

This is allowable as long as it does not duplicate Community Support. Home Support cannot be provided at a Member’s employment site.

For members who have not yet transitioned to a Level Based-Budget, On Behalf Of will continue as a component of Home Support and is included in the established authorization and is not a separate billable activity.

There is an increased level of support may be available for members in Family Centered Support based on the documented needs of the member. The member must require an increased level of staffing as documented in the member’s Personal Plan. Refer to Appendix I for more information.

As provided in 21.10-58, the Department DHHS is discontinuing Family Centered Support, and no new placements will be approved.
21.05 COVERED SERVICES (cont.)

21.05-13 Home Support-Quarter Hour is direct support (billed per unit) provided in the member’s home, by a Direct Support Professional to improve and maintain a member’s ability to live as independently as possible. Home Support is direct support to a member and includes primarily habilitative training and/or personal assistance with Activities of Daily Living (ADL) and/or Instrumental Activities of Daily Living (IADL), development and personal well-being.

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

Home Support cannot be provided at a Member’s employment site.

For members who have not yet transitioned to a Level Based Budget, On Behalf Of will continue as On Behalf Of is a component of Home Support and is included in the established authorization and is not a separate billable activity. The cost of transportation related to the provision of Home Support is a component of the rate paid for the service and is not separately billable.

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

Payment is not made directly, or indirectly, to members of the member's immediate family.

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

For those members who have not yet transitioned to a Level-Based Budget, the first six hours (24 units) of support delivered in a calendar day are billed at the short-term rate. All units after the first 24 units are billed at the long-term rate.

The service may be provided to up to 3 members at once. When the service is provided to a group, the appropriate group rate must be billed.
21.05 COVERED SERVICES (cont.)

21.05-14 Home Support-Remote Support- This service provides real time, remote communication and support through a wide range of technological options including electronic sensors, video conferencing, environmental sensors (movement, doors, temperature, smoke, CO, etc.), video cameras, microphones and speakers, as well as health monitoring equipment. This assistive technology links each member’s residence to the Remote Support provider.

The Remote Support provider has staff available 24 hours per day 7 days per week to deliver direct 1:1 care when needed. If a member chooses this service, the member’s Personal Plan must include a safety/risk plan that identifies at least two levels of emergency back-up.

The use of this service is based upon the member’s assessed needs and the resulting Personal Plan. The Personal Plan reflects the member’s consent and commitment to the plan elements including all assistive communication, environmental control and safety components. An thorough evaluation of all assistive Technology Assessment must be completed by a qualified provider. Prior to the finalization of the Personal Plan the Case Manager and the member with the assistance of the Case-Manager-Planning Team will ensure the appropriateness of the identified assistive technology, and use of appropriate assistive technology consultants.

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

There is no overlap between Assistive Technology and Home Support Remote Support. As set forth in § 21.05-1, Assistive Technology may be used to provide for assessments, equipment, and the cost of the monthly data transmission utility necessary to facilitate Home Support-Remote Support services. Home Support-Remote Support provides the staff what that is are monitoring the member.

There are two types of Remote Support: Interactive Support and Monitor Only. Chapter III reflects the billing for each type. Interactive Support includes only the time that staff is actively engaging a member in 1 to 1 direct support through the use of the Assistive Technology Device. Monitor Only is when Assistive Technology equipment is being used to monitor the member without interacting.
21.05 COVERED SERVICES (cont.)

21.05-15 Non-Medical Transportation Service is offered in order to enable members to gain access to Section 21 services, as specified by the Personal Plan. Transportation services for Section 21 services are provided under the MaineCare Benefits Manual, Section 113 (Non-Emergency Medical Transportation Services).

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

Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, must be utilized.

21.05-16 Non-Traditional Communication Assessments determine the level of communication present via gesture, sign language or unique individual communication style. The assessment examines signed or gestured vocabulary for everyday objects or actions, as well as the ability to combine gestures and the ability to understand similar communication. Assessment recommendations are made to optimize communication to maximize social integration. The provider of this service must be approved by The DHHS Office of Multi-Cultural Affairs.

21.05-17 Non-Traditional Communication Consultation is provided to members and their direct support staff and others to assist them in order to maximize communication ability as determined from their assessment. The goal is to allow for greater participation in the service planning process and to enhance communication within the member’s environment. The provider of this service must be a Visual Gestural Communicator approved by DHHS.

21.05-18 Occupational Therapy (Maintenance) is a service that has maintenance of current abilities and functioning level as its goal. Evaluative and rehabilitative Occupational Therapy is included under other Sections of the MaineCare Benefits Manual and is not covered as a component of maintenance therapy under this Section. The provider of this service must be an Occupational Therapist, Registered (OTR) for Occupational Therapy Maintenance or a Certified Occupational Therapy Assistant (COTA) under the supervision of an Occupational Therapist, Registered (OTR).

Services provided by a COTA must be billed at the COTA rate. The service may be provided to up to 3 members at once. When the service is provided to a group, the appropriate group rate must be billed.
21.05 COVERED SERVICES (cont.)

21.05-19 Physical Therapy (Maintenance) is a service that has maintenance of current abilities and functioning level as its goal. Evaluative and rehabilitative Physical Therapy is included under other Sections of the MaineCare Benefits Manual and is not covered as a component of maintenance therapy under this Section. The provider of this service must be a Registered Physical Therapist (RPT) for Physical Therapy Maintenance.

The service may be provided to up to 3 members at once. When the service is provided to a group, the appropriate group rate must be billed.

21.05-20 Qualified Extra Support Service (QESS) is an additional support service designed to cover medical and behavioral support needs that are beyond the limit of a member’s Level-Based Budget. The service will be available to a member upon completion of a review process and an approval by the Extraordinary Review Committee (ERC). The ERC will review the necessity for additional hours of qualified staffing to meet a documented extraordinary support need. Upon approval the service is reviewed at regular timeframes, not to exceed 12 months. The Direct Support Professional (DSP) providing this service must meet the qualifications in 21.10-6, Provider Qualifications and Requirements.

A. This service can be provided in the member’s home and in community settings, such as the workplace.
B. This service is to be provided concurrently with Home Supports, Community Supports or Work Supports.

The purpose of the service is to improve and maintain the member’s ability to live as independently as possible in their home and in the community. This service is a direct support to a member and includes habilitative instruction, training and, or personal assistance with ADL’s and IADL’s, development and personal well-being that is directly related to the member living as independently as possible. This service assists in the assessment and mitigation of behavioral and medical risks.

21.05-21 Respite - Services provided to members unable to care for themselves. Respite is furnished on a short-term basis due to the absence of, or need for relief of, persons who normally provide care for the member. Respite may be provided in the member’s home, provider’s home or other location as approved by a respite agency, provider or DHHS; (example a motel in case of emergency.) Respite is a billable service only for members residing with unpaid caregivers.
HOME AND COMMUNITY BENEFITS FOR MEMBERS
WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER

SECTION 21  ESTABLISHED 11/1/83
LAST UPDATED

The changes in this section are dependent upon approval by
the Centers for Medicare and Medicaid Services (CMS)

21.05  COVERED SERVICES (cont.)

21.05-20  Shared Living (Foster Care, adult) is direct support billed per diem and includes:
personal care, protective oversight and supervision and supportive services (e.g.,
homemaker, chore, attendant care, companion, medication oversight (to the extent
permitted under State law)) provided in a private home by a principal care provider
who lives in the home and is a Direct Support Professional. Residential habilitation
means individually tailored supports that assist with the acquisition, retention, or
improvement in skills related to living in the community. These supports include
adaptive skill development, assistance with activities of daily living, community
inclusion, transportation, adult educational supports and social and leisure skill
development that assist the member to reside in the most integrated setting
appropriate to the member’s needs.

In this model, respite is a component of the rate paid to the Administrative Oversight
Agency and therefore not a separate billable service. The record must accurately
reflect the location of the member during the receipt of respite.

Only one member may receive services in any one Shared Living arrangement at the
same time, unless a relationship existed prior to the service arrangement and the
arrangement has been approved by DHHS. In such case, no more than two members
may be served in any one Shared Living arrangement concurrently.

An increased level of support may be available for members in Shared Living based
on the documented needs of the member. The member must require an
increased level of staffing as documented in the member’s Personal Plan.
See Appendix I for additional requirements.

21.05-23  Semi-Independent Supported Living is a service provided to a member in their
own home that is separate from other members and has availability of direct support
staffing seven (7) days per week, twenty-four (24) hours per day. A member can
request assistance by direct support staff that are available for immediate response.
This model promotes member independence to the fullest extent, integration into the
community while maintaining ready access to support without the need to have staff
in the home. This service includes: habilitative training and/or personal assistance
with ADL’s and IADL’s, development and personal well-being. The member’s
Personal Plan must include a safety/risk plan to identify and mitigate potential risks.

21.05-24  Skilled Nursing Service for Persons with Intellectual Disabilities or Autism
Spectrum Disorder is an additional support service to address unique
medical and healthcare needs that exceed the qualifications of staff providing care to
the member. This service requires approval from the Extraordinary Review
Committee (ERC) and is subject to regular review not to exceed 12 months. This
service provides specialized nursing care or training to meet a documented medical
need to be delivered by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) with Developmental Disabilities Nursing Association (DDNA) Certification. The goal of the service is to maintain and improve a member’s ability to live as independently as possible in their home and in the community.

A. This service can be provided in the home, and community settings such as the workplace.
B. This service is to be provided concurrently with Home Supports, Community Supports or Work Supports.

21.05-254 Specialized medical equipment and supplies include devices, controls, or appliances specified in the plan of care that enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This benefit also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and nondurable medical equipment not available under the MaineCare Benefits Manual. Items reimbursed under this waiver benefit are in addition to any medical equipment and supplies furnished under the MaineCare Benefits Manual. All items must meet applicable standards of manufacture, design and installation. If used in vehicle modification, this benefit applies to member owned or a member’s family owned vehicle only; it is not available in agency provider owned, leased or operated vehicles. All items shall be considered the property of the member and must remain at the member’s disposal at all times regardless of where the member resides.

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

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

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

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

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

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

21.05-262 Speech Therapy (Maintenance) is a service that has maintenance of current abilities and functioning level as its goal. Evaluative and rehabilitative Speech Therapy is included under other Sections of the MaineCare Benefits Manual and is not covered as a component of maintenance therapy under this Section. The provider of this service must have a Certificate of Clinical Competence—Speech Pathology (CCC-SP) for Speech Therapy Maintenance. The service may be provided to up to 3 members at once. When the service is provided to a group, the appropriate group rate must be billed.

21.05-273 Work Support-Group is Direct Support provided to improve a member’s ability to independently maintain employment.

Work Support-Group is provided at the member’s place of employment.

Work Support-Group comprises services and training activities that are provided in regular business, industry and community settings for groups of two to six members. Mobile work crews and business-based workgroups (enclaves) employing small groups of workers in employment in the community are examples of the models allowed.

Work Support-Group must be demonstrably structured and provided in a manner that promotes the integration into the workplace and interaction between members and people without disabilities in those workplaces. The primary focus of the support is job related and also encompasses adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care.

To receive this service, a member must have received an assessment and services under the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act.
21.05 COVERED SERVICES (cont.)

and need for on-going support must have been determined and documented in the Personal Plan.

The outcome of this service must be sustained paid employment and work experience leading to further career development and individual integrated community based employment for which the member is compensated at or above the minimum wage, and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Work Support-Group does not include vocational services provided in a facility-based work setting in specialized facilities that are not part of the general workforce. Work Support-Group may be used to support a member in a job that pays less than the minimum wage only if the employer complies with section 14(c) of the Fair Labor Standards Act (29 U.S.C. § 214(c)) and 26 M.R.S. § 666. Documentation must be maintained in the file of each member receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Work Support-Group does not include volunteer work.

Work Support-Group cannot be used to cover incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program;

2. payments that are passed through to users of supported employment programs; or

3. payments for training that is not directly related to a member’s supported employment program.

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

**No more than six (6) members may be supervised by a Direct Support Professional.**

**The appropriate group rate must be billed.**

**The provider will submit a group work site schedule to the OADS Resource Coordinator listing members, work sites, units of service, and staff. The provider will submit schedules quarterly thereafter to the Resource Coordinator.**
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

21.05 COVERED SERVICES (cont.)

Information must be provided to the member at least yearly that career planning and individual employment is available to the member in order to make an informed decision regarding the services the member receives.

For members who have not yet transitioned to a Level-Based Budget, The combination of Work Support Group and Work Support-Individual may not exceed the maximum annual allowance of 850 hours. Where the member may receive Community Support services in addition to Work Support Group and/or Work Support-Individual, the combined cost of Community Support, Work Support-Individual, and Work Support-Group may not exceed $26,455.00 annually.

21.05-284 Work Support-Individual is Direct Support provided to improve a member’s ability to independently maintain employment. Work Support-Individual is primarily provided in a member’s place of employment, but may be provided in a member’s home in preparation for work if it does not duplicate services already reimbursed as Home Support, Community Support or Employment Specialist Services.

Work Support-Individual must be provided to the member in an integrated employment setting in the general workforce and the member must be compensated at or above the minimum wage, and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

This service is provided after the member has received an assessment and services under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act and need for on-going support has been determined and documented in the Personal Plan. Work Support-Individual may be provided to self-employed members where the member requires support operating his or her own business. Support may be used for customized employment for members with severe disabilities to include long term support to successfully maintain a job due to the ongoing nature of the member’s support needs, changes in life situation, or evolving and changing job responsibilities. The primary focus of the support is job related and also encompasses adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care.

Work Support-Individual does not include volunteer work.

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

Work Support-Individual cannot be used to cover incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program; 2) payments that are passed through to users of supported employment programs; or 3) payments for training that is not directly related to a member’s supported employment program.

For members who have not transitioned to a Level Based-Budget, On Behalf Of will continue as a component of Work Support-Individual and is included in the established authorization, and is not a separate billable activity. The maximum annual allowance for work support is eight hundred fifty (850) hours, $26,445.00 annually.

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

The combination of Work Support Group and Work Support Individual may not exceed the maximum annual allowance of 850 hours. Where the member receives Community Support services in addition to Work Support Group and/or Work Support Individual, the combined cost of Community Support, Work Support Individual, and Work Support Group may not exceed $26,445.00 annually.

21.06 NONCOVERED SERVICES

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

21.06.1 Duplicative Services A member may not receive services that are comparable or duplicative under another Section of the MaineCare Benefits Manual concurrent to services provided under this waiver benefit. Such services include, but are not limited to services covered under the MaineCare Benefits Manual, Section 2, Adult Family Care Services; Section 18, Home and Community-Based Services for Adults with Brain Injury Section; 19, Home and Community Benefits for the Elderly and for Adults with Disabilities; Section 20, Home and Community-Based Services for Adults with Other Related Conditions; Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations; Section 29, Support Services for Adults with Intellectual Disabilities or Autistic Disorder, Section 45, Hospital Services; Section 46, Psychiatric Facility Services; Section 50, ICF/IID Services; Section 67, Nursing Facility Services and Section 97, Private Non-Medical Institution Services.

21.06-12 Services not identified by the Personal Plan;
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

21.05 COVERED SERVICES (cont.)

21.06-23 Services to any MaineCare member who receives services under any other federally approved MaineCare Home and Community based waiver program;

21.06-34 Services to any member who is a nursing facility resident, or ICF/IID resident;

21.06-45 Services that are reimbursable under any other sections of the MaineCare Benefits Manual;

21.06-56 Any service otherwise reimbursable under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act, including but not limited to job development and vocational assessment or evaluations;

21.06-67 Room and board; The term “room” means shelter type expenses, including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term “board” means three meals a day or any other full nutritional regimen. Board does not include the provision of a meal at an adult day health or similar facility outside the member’s home. Board also does not include the delivery of a single meal to a member at his/her own home through a meals-on-wheels service;

21.06-78 Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the member’s parent, sibling or other biological family member. This rule will not be avoided by adult adoption. Persons appointed by a probate court as legal guardian prior to and up to December 30, 2007, who are not biological family, and who are directly or indirectly reimbursed for services, may continue to receive reimbursement under this Section;

21.06-89 Work Support-Individual, Work Support-Group or Employment Specialist Services when the member is not engaged in employment. Work Support Group must be provided at the member’s place of employment; it may be provided in a member’s home in preparation for work if it does not duplicate services already reimbursed as Home Support, Community Support or Employment Specialist Services;

21.06-910 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.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

21.07 LIMITS

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

21.07-21 Level-Based Budget For those members who have not yet transitioned to a Level-Based Budget, the maximum annual allowance for Community Support is eleven hundred twenty-five (1,125) hours per year. The maximum combined annual allowance for Work Support-Group and Work Support-Individual Services is eight hundred and fifty (850) hours per year. Where the member receives Community Support services in addition to Work Support-Group and/or Work Support-Individual services, the combined cost of Community Support, Work Support-Individual and Work Support-Group may not exceed $26,455.00 annually.

21.07-32 Home Accessibility Adaptations are limited to a ten thousand dollar ($10,000.00) limit in a five (5) year period with an additional annual allowance up to three hundred dollars ($300.00) for repairs and replacement per year. Home Accessibility Adaptations that exceed five hundred dollars ($500) require documentation from a physician or other appropriate professional such as an OT, PT or Speech Therapist, indicating that the purchase is appropriate to meet the member’s need.

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

21.07-53 For Specialized Medical Equipment and Supplies (costing more than five hundred dollars ($500), the member must obtain documentation from a physician or other appropriate professional such as an OT, PT or Speech therapist assuring that the purchase is appropriate to meet the member’s need and is medically necessary.

Specialized Medical Equipment and Supplies are limited to only specialized medical equipment and supplies that cannot be obtained, as a covered service under other sections of the MaineCare Benefits Manual will be reimbursed under this Section. These services are to be considered the property of the member.

21.07-64 For Communication Aids costing more than five hundred dollars ($500), the member must obtain documentation from a licensed speech-language pathologist, Licensed Audiologist or a Certified Assistive Technology Professional (ATP)
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS).

21.07 LIMITS (cont.)

assuring that the purchase is appropriate to meet the member’s need and assures the medical necessity of the devices or services. Only communication aids that cannot be obtained as a covered service under other sections of the MaineCare Benefits Manual will be reimbursed under this Section.

21.07-75 Consultation Services are limited to those providers not already reimbursed for consultation as part of another service. Personnel who provide services under targeted case management may not be reimbursed for consultation services. Consultation is limited to 16.5 hours annually, per type of consultation.

21.07-86 Crisis Intervention Services that have not been included on the Personal Plan are limited to a period not to exceed two weeks and must be authorized by the DHHS or its Authorized Entity. Crisis Intervention Services may not extend past two (2) weeks without a recommendation from the member’s Person Centered Team and additional approval from DHHS.

21.07-97 Crisis Assessment Services are limited to one (1) assessment in a three-year (3) period and includes all related follow-up activities.

21.07-8 Occupational Therapy (Maintenance) provided by an occupational Therapist, Registered, Licensed (OTR/L) is limited to forty-eight (48) quarter hour units per year. Occupational Therapy (Maintenance) provided by a Certified Occupational Therapist Assistant (COTA) is limited to forty (40) quarter hour units per year. When a COTA is providing Occupational Therapy (Maintenance) it must be under the supervision of an OTR.

21.07-109 Enrollment in High School A member may not receive Community Support, Employment Specialist Services or Work Support while enrolled in high school.

21.07-110 Place of Employment A member may not receive Community Support or Home Support at his or her place of employment.

21.07-112 Family Centered Support Providers No additional Family Centered Support providers will be approved and enrolled after 12/20/2007.

21.07-123 Nursing Facility or Hospital 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 the Department to continue holding the funded opening.

21.07-134 Work Support-Individual services are limited to one DSP per member at a time.
The changes in this section are dependent upon approval by
the Centers for Medicare and Medicaid Services (CMS)

21.07  LIMITS (cont.)

21.07-145  **Home Support- Agency per Diem** As of December 24, 2012, Home Support-
Agency per Diem placements will only be approved at sites where at a minimum
two (2) members receiving Home Support- Agency Per Diem reside.

21.07-156  **Home Support Quarter Hour** For members who do not have a Level-Based
Budget, Home Support Quarter Hour may not exceed three hundred and thirty six
(336) quarter hour units or eighty four (84) hours a week.

21.07-167  **Out of State Services** Authorizations for services to be provided out of state will not
exceed sixty (60) days of service within a given fiscal year and not exceed sixty (60)
days within any six (6) month period except as provided in 42 C.F.R. § 431.52 (b).

21.07-178  **Annual MaineCare Expenditures** for services under this waiver for an individual
member are limited to two hundred percent (200%) of the state-wide average annual
cost of care for an individual in an Intermediate Care Facility for Individuals with
Intellectual Disabilities (ICF/IID), as determined by DHHS the Department.

21.07-19  **Assistive Technology services** are not covered under this rule if they are available
under another MaineCare rule. Assistive Technology Assessment is subject to a
combined limit of 32 units (8 hours) per year. Assistive Technology Devices,
including the selecting, fitting, customizing, adapting, applying, maintaining,
repairing or replacing of assistive technology devices, is subject to a combined limit
of $6,000 per year. Assistive Technology-Transmission (Utility Services) is subject
to a combined limit of $50 per month.

21.07-20  **Career Planning** is limited to 60 hours annually to be delivered in a six-month
period. No two six month periods may be provided consecutively.

21.07-21  **Counseling** is limited to 16.25 hours annually.

21.07-21  **Employment Specialist Services** are provided on an intermittent basis with a
maximum of ten hours each month.

21.07-22  **Home Support-Remote Support** is limited to 48 units (12 hours) per day.

21.07-22  **Qualified Extra Support Services (QESS)**

A. Staff providing this service cannot be counted towards the staffing ratio for
home, community or work support services.

A-B. This service is only available to members needing a level of support that
exceeds 100% of the combined staffing expectation in the rate for that residence
or program.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

21.07 LIMITS (cont.)

C. This service is not available to members in Shared Living or Family Centered Support residential settings.

21.07-23 Respite

A. Maximum approval of 350 hours per planning year for respite service as identified and approved by the member and when applicable the guardian, as identified in the Personal Plan.
B. This service is excluded from the member’s Level-Based Budget and cannot be mixed or matched within the Level-Based Budget to add services to another area.
C. Respite is a billable service only for members residing with unpaid caregivers.
D. Respite cannot be billed concurrently with Home Support, Community Support, Employment Specialist Services or Work Support.

21.07-24 Agency Home Support

All Level-Based Budget limits are annual. Authorized services will begin on the effective date of the Personal Plan.

1. One Member Group Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $203,336.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $177,688.00.
   ○ Members assessed at a Support Level I and who reside in an Agency Supported One Member setting prior to July 1, 2015 are eligible to continue to receive Agency Supported One Member service so long as the member with their planning team review the residential setting annually. During the annual review the member must be informed of other residential options. If the member and their planning team agree that this is the best setting for that member, then the member can continue to receive services in this setting.
B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $206,002.00. Within this limit, the member may have a combination of Community Support or
21.07 LIMITS (cont.)

Work Support- Group or Individual up to $27,855.00 and Home Support up to $178,147.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $241,453.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $38,750.00 and Home Support up to $202,703.00.

2. Two Member Group Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $134,330.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $108,682.00.

B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $141,101.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $27,855.00 and Home Support up to $113,246.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $177,578.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $38,750.00 and Home Support up to $138,828.00.

3. Three Member Group Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $107,818.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $82,170.00.

B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $114,585.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $27,855.00 and Home Support up to $86,730.00.
21.07 LIMITS (cont.)

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support-Group or Individual up to $165,646.00. Within this limit, the member may have a combination of Community Support or Work Support-Group or Individual up to $38,750.00 and Home Support up to $126,896.00.

4. Four or More Member Group Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support-Group or Individual up to $92,274.00. Within this limit, the member may have a combination of Community Support or Work Support-Group or Individual up to $25,648.00 and Home Support up to $66,626.00.

A-B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support-Group or Individual up to $109,202.00. Within this limit, the member may have a combination of Community Support or Work Support-Group or Individual up to $27,855.00 and Home Support up to $81,347.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support-Group or Individual up to $162,202.00. Within this limit, the member may have a combination of Community Support or Work Support-Group or Individual up to $38,750.00 and Home Support up to $123,452.00.

21.07-25 Family Centered Support

All Level-Based Budget limits are annual. Authorized services will begin on the effective date of the Personal Plan.

1. One Member Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support-Group or Individual up to $63,671.00. Within this limit, the member may have a combination of Community Support or Work Support-Group or Individual up to $25,648.00 and Home Support up to $38,022.00.

A-B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support-Group or Individual up to $64,076.00. Within this limit, the member may have a combination of Community Support or Work Support-Group or Individual up to $25,648.00 and Home Support up to $38,022.00.
21.07 LIMITS (cont.)

Support- Group or Individual up to $26,054.00 and Home Support up to $38,022.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $70,636.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $38,022.00.

2. Two Member Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $56,965.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $31,317.00.

B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $57,371.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $31,317.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $63,931.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $31,317.00.

3. Three Member Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $52,348.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $26,700.00.

B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $52,754.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $26,700.00.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

21.07 LIMITS (cont.)

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $59,314.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $26,700.00.

4. Four Member Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $48,275.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $22,626.00.

B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $48,680.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $22,626.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $55,241.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $22,626.00.

5. Five Member Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $45,829.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $20,181.00.

B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $46,235.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $20,181.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $52,795.00.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS).

21.07 LIMITS (cont.)

Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $20,181.00 and Home Support up to $32,614.00.

21.07-26 Family Centered Support - Increased Level of Support

All Level-Based Budget limits are annual. Authorized services will begin on the effective date of the Personal Plan.

1. One Member Home

   A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $104,839.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $79,190.00.

   B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $105,244.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $79,190.00.

   C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $111,805.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $79,190.00.

2. Two Member Home

   A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $97,473.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $71,825.00.

   B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $97,879.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $79,190.00.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

21.07 LIMITS (cont.)

Support- Group or Individual up to $26,054.00 and Home Support up to $71,825.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $104,439.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $71,825.00.

3. Three Member Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $90,764.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $65,116.00.

B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $91,170.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $65,116.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $97,730.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $65,116.00.

4. Four Member Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $84,837.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $59,188.00.

B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $85,242.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $59,188.00.
21.07 LIMITS (cont.)

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $91,803.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $59,188.00.

5. Five Member Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $81,282.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $55,633.00.

B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $81,687.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $55,633.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $88,248.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $55,633.00.

21.07-27 Living Independently

All Level-Based Budget limits are annual. Authorized services will begin on the effective date of the Personal Plan.

A. Support Level 1: May have a combination of Home Support, Community Support, or Work Support- Group or Individual up to $69,270.00. Within this limit, the participant may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $43,622.00.

A-B. Support Level 2 and 3: May have a combination of Home Support, Community Support, or Work Support- Group or Individual up to $88,371.00. Within this limit, the participant may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00.
21.07 LIMITS (cont.)

A. Support Level 1: May have a combination of Home Support, Community Support, or Work Support- Group or Individual up to $59,183.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00, Respite up to $2,376.00 and Home Support up to $31,158.00.

B. Support Level 2 and 3: May have a combination of Home Support, Community Support, Respite or Work Support- Group or Individual up to $65,820.00. Within this limit, the participant may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00, Respite up to $2,376.00 and Home Support up to $37,390.00.

C. Support Level 4 and 5: May have a combination of Home Support, Community Support, Respite or Work Support- Group or Individual up to $108,211.00. Within this limit, the participant may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00, Respite up to $2,376.00 and Home Support up to $73,220.00.

21.07-28 Living with Unpaid Caregivers

All Level-Based Budget limits are annual. Authorized services will begin on the effective date of the Personal Plan.

A. Support Level 1: May have a combination of Home Support, Community Support, or Work Support- Group or Individual up to $77,739.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00, Respite up to $2,376.00 and Home Support up to $37,390.00.

B. Support Level 2 and 3: May have a combination of Home Support, Community Support, Respite or Work Support- Group or Individual up to $126,601.00. Within this limit, the participant may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00, and Home Support up to $93,987.00.

21.07-29 Semi-Independent Supported Living

All Level-Based Budget limits are annual. Authorized services will begin on the effective date of the Personal Plan.

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $77,739.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00, Respite up to $2,376.00 and Home Support up to $37,390.00.
21.07 LIMITS (cont.)

Support Group or Individual up to $25,648.00 and Home Support up to $52,091.00.

B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support Group or Individual up to $92,346.00. Within this limit, the member may have a combination of Community Support or Work Support Group or Individual up to $27,855.00 and Home Support up to $64,491.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support Group or Individual up to $118,883.00. Within this limit, the member may have a combination of Community Support or Work Support Group or Individual up to $38,750.00 and Home Support up to $80,133.00.

1. The provider is not responsible for full time care of the member.
2. This cannot be combined with Remote Support or any other home support.
3. Staff is not required to be in the home at all times.
4. Allows for maximum independence with allowances for safety and supports on an as needed basis.
5. The member’s Personal Plan must include a safety/risk plan to identify potential risks.

21.07-30 Shared Living

All Level-Based Budget limits are annual. Authorized services will begin on the effective date of the Personal Plan.

1. One Member Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support Group or Individual up to $71,708.00. Within this limit, the member may have a combination of Community Support or Work Support Group or Individual up to $25,648.00 and Home Support up to $46,059.00.

A-B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support Group or Individual up to $72,113.00. Within this
limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $46,059.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $78,674.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $46,059.00.

2. Two Member Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $48,680.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $23,032.00.

B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $49,086.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $23,032.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $55,646.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $23,032.00.

21.07-31 Shared Living - Increased Level of Support

All Level-Based Budget limits are annual. Authorized services will begin on the effective date of the Personal Plan.

1. One Member Home

A. Support Level 1: A combination of Home Support, Community Support or Work Support- Group or Individual up to $92,633.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $66,985.00.
21.07 LIMITS (cont.)

B. Support Level 2 and 3: A combination of Home Support, Community Support or Work Support- Group or Individual up to $93,039.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $66,985.00.

C. Support Level 4 and 5: A combination of Home Support, Community Support or Work Support- Group or Individual up to $99,599.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $66,985.00.

2. Two Member Home

A. Support Level 1 May have a combination of Home Support, Community Support or Work Support- Group or Individual up to $69,602.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $25,648.00 and Home Support up to $43,953.00.

B. Support Level 2 and 3: May have a combination of Home Support, Community Support or Work Support- Group or Individual up to $70,007. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $26,054.00 and Home Support up to $43,953.00.

C. Support Level 4 and 5: May have a combination of Home Support, Community Support or Work Support- Group or Individual up to $76,568.00. Within this limit, the member may have a combination of Community Support or Work Support- Group or Individual up to $32,614.00 and Home Support up to $43,953.00.

21.08 DURATION OF CARE

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

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

A. The member has been determined to be financially or medically ineligible for this benefit or MaineCare;
B. The member has been determined to be a nursing facility resident or ICF/IID resident without an approved Personal 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 Personal Plan or other benefit policies;
   2. The home or home environment of the member becomes unsafe to the extent that benefit services cannot be provided without risk of harm or injury to the member or to individuals providing covered services to the member; or
   3. There is no approved Personal Plan.
F. The member has not received at least one service in a thirty (30) day period; or
G. The annual cost of the member’s services under this waiver exceeds two hundred percent (200%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the Department DHHS.

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

- The provider cannot terminate a member’s service without written authorization from DHHS.
- The provider cannot terminate a member from any service under this section without the provision of a safe and appropriate discharge plan and in accordance with Chapter 1.
21.09 MEMBER RECORDS

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

In addition, the member’s records must contain:

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

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

21.09-3 The member’s Personal Plan: and

21.09-4 Written progress notes that identify actions related to the progress toward the achievement of the goals, activities and needs established by the member’s Personal Plan signed by the staff performing the service.

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

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

Services requiring a 2:1 ratio staffing may be documented by 1 (one) staff member, but both staff must sign the progress note. If services are provided by two (2) or more staff working different shifts, then each shift must be documented separately.

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

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

Shared Living Providers and Family Centered Support Providers must also document the level of service provided.
21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS

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

21.10-1 Direct Support Professional (DSP) is a person who has:

A. Successfully completed the Direct Support Professional curriculum as adopted by DHHS, or demonstrated proficiency through DHHS’s approved Assessment of Prior Learning, or has successfully completed the curriculum from the Maine College of Direct Support within six (6) months of date of hire. The Maine College of Direct Support is accessed on the internet at: http://www.maine.gov/dhhs/oads/disability/ds/cds/index.shtml;

B. Completed the following Department sponsored trainings, also within the first six (6) months from date of hire:
   a. Reportable Events Training (14-197, Ch. 12)
   b. Behavior Regulations Training (14-197, Ch. 5)
   c. Rights of Persons with Intellectual Disabilities or Autism Training (Title 34-B §5605)

C. Has a background check consistent with Section 21.10-513;

D. Has an adult protective and child record check;

E. Is at least 18 years of age;

F. Has graduated from high school or acquired a GED;

G. Has current CPR and First Aid Training.

H. Completed the following four modules from the College of Direct Support prior to providing services to a member alone:

1. Introduction to Developmental Disabilities
2. Professionalism
3. Individual Rights and Choice
4. Maltreatment

Documentation of completion must be retained in the personnel record.

GI. A DSP is legally authorized to assist with the administration of medication if the DSP is certified as a Certified Nursing Assistant-Medications (CNA-M); as a Certified Residential Medication Aide (CRMA); a Registered Nurse (RN); or otherwise has been trained to administer medications through a training program specifically for Family Centered or Shared Living model homes and authorized, certified, or approved by DHHS.

H. A DSP who also provides Work Support- Individual or Work Support-Group must have completed the additional employment modules in the Maine College of Direct Support in order to provide services.
21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

I. A DSP who also provides Career Planning must have completed the additional employment modules in the Maine College of Direct Support and an additional 6 hours of Career Planning and Discovery training provided through Maine’s Workforce Development System.

J. A DSP who also provides Crisis Intervention must have behavioral intervention training as approved by DLRS.

K. A DSP who also provides QESS must also meet the requirements necessary to provide QESS. See 21.10-6.

All new staff or subcontractors shall have six (6) months from their date of hire to obtain DSP certification. Evidence of date of hire and enrollment in the training must be documented in writing in the employee’s personnel file or a file for the subcontractor.

Services provided during this time are reimbursable as long as the documentation exists in the personnel file.

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

A DSP can supervise another DSP.

Only a DSP who is certified as a Certified Nursing Assistant-Medications (CNA-M), a Certified Residential Medication Aide (CRMA), or a Registered Nurse (RN) may administer medications to a member.

21.10-2 Assistive Technology Assessment- In order to provide an Assistive Technology Assessment, an enrolled provider must possess the following qualifications (Either A or B).

A. License Requirements
   1. Occupational Therapist or;
   2. Speech Pathologist

Or B.

B. Certificate Requirements
   1. Direct Support Staff must be a certified DSP and Certification as Rehabilitation Engineering Technologist (RET) or:
   2. an Assistive Technology Professional (ATP) from the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) is required to provide an Assistive Technology Assessment.
21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

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

A. Neuropsychiatrist or psychiatrist, who has worked with persons with developmental disabilities as a primary part of their practice;
B. Psychologist or behaviorist who has worked with persons with developmental disabilities as a primary part of their practice;
C. Clinic liaison person, having a bachelor’s degree or a nursing degree; direct experience with persons with developmental disabilities; and extensive experiences that provide a working knowledge of medical, psychiatric, and behavioral perspectives;
D. General medical practitioner;
E. Occupational therapist;
F. Physical therapist; or
G. Speech therapist.

21.10-4 An Employment Specialist is a person who provides Employment Services or Work Support and has:

A. Successfully completed an Employment Specialist Certification program as approved by DHHS. Certification must occur within six months of date of hire; approved courses are listed at: http://www.employmentforme.org/providers/crp-training.html
B. Supervision during the first six months of hire must be from a Certified Employment Specialist in order to provide services;
C. Work Support staff can either be certified as an Employment Specialist or complete the Approved Direct Support Curriculum along with additional modules specific to employment;
D. Graduated from high school or acquired a GED;
E. Has a background check consistent with Section 21.10-513; and
F. Worked for a minimum of one (1) year with a person or persons having an Intellectual Disability or Autism Spectrum Disorder in a work setting.
G. An Employment Specialist who also provides Career Planning must have completed the additional 6 hours of Career Planning and Discovery provided through Maine’s Workforce Development System.

21.10-5 Phase-Out of Family Centered Support

The Department DHHS is discontinuing the Family Centered Support service. If a bed becomes vacant in a Family Centered Support home, that vacancy may be filled.
Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II
HOME AND COMMUNITY BENEFITS FOR MEMBERS
WITH INTELLECTUAL DISABILITIES OR AUTISM SPECTRUM DISORDER

SECTION 21
Established 11/1/83
Last Updated

The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

No new licenses or license transfers for Family Centered Support homes will be approved.

Providers of Family Centered Support shall not transfer, in whole or in part, ownership, management, or responsibility for day-to-day operations of the Family Centered Support home to another individual or entity. The Department of Health and Human Services (DHHS) will not authorize Family Centered Support services under a new license.

21.10-6 Qualified Extra Support Services (QESS)

Staff who provide QESS must meet the following core requirements:

A. Has certification as a Direct Support Professional. See 21.10-1
B. Has a minimum of three (3) years experience working as a DSP in either Home, Community, or Work Supports.
C. Has completed a Positive Behavioral Supports Intervention module or similar training as approved by OADS.
D. Has a Medication Administration certificate or similar.
E. Is a Mental Health Support Specialist (MHSS).

QESS for behavioral needs: in addition to the core requirements, a DSP must meet the following additional requirement:

A. Has a DHHS-DLRS approved Behavioral Intervention Certification including; Physical Intervention component, for example but not limited to, Non-Abusive Physical and Psychological Intervention (NAPPI) and Mandt Training.

QESS for medical needs, in addition to the core requirements, a DSP must meet the following additional requirement:

A. Is a Personal Support Specialist (PSS) or has a non-annotated active CNA Certification.

The ERC will determine the training required to meet the member’s needs.

A DSP has a maximum of 16 months to obtain the additional requirements necessary to provide QESS unless otherwise directed by the ERC. This is necessary to ensure the health and safety of members who receive the service.

21.10-7 Residential Settings Owned or Controlled by a Provider

Where the member receives Home Support Services in a residential setting owned or controlled by the provider, including Shared Living and Family Centered, the
21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

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

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

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

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

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

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

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

H. The setting must be physically accessible.

Any modification of requirements B through H must be supported by a specific assessed need, justified in the Personal Plan, and meet the requirements set forth in 42 CFR § 441.301(c)(4)(vi)(F). Modifications require clinical documentation supporting the need.

21.10-89 Residential Vacancies in Two-Person Homes

A. No later than twenty-four hours from the time of vacancy, the provider shall provide notice of the vacancy to the responsible Resource Coordinator in the Office of Aging and Disability Services and the case managers for both the departing and remaining members.

B. No later than three business days from the time of vacancy, the provider shall submit a new proposed staffing pattern for the home that adjusts for the vacancy and is sufficient to maintain the remaining member’s safety.

C. If the vacancy is the result of hospitalization, the provider may hold the vacant bed for the hospitalized member for a period of thirty calendar days. If, after thirty calendar days, there is no imminent plan for the hospitalized member to return to his or her home, the provider shall issue a thirty-day discharge notice to the hospitalized member, his or her guardian, and the Department DHHS and proceed with the steps below.

D. If the provider determines that the remaining member cannot be safely served in the current residence with a new housemate, the provider shall issue a thirty-day discharge notice to the remaining member and the Department DHHS within five business days of the vacancy (or, where the...
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

vacancy results from hospitalization, from the passage of thirty days from the time of hospitalization).

E. If the provider determines that the remaining member can be safely served in the current residence with a new housemate, the provider and assigned case manager Department shall attempt to identify another member to fill the vacancy.

1. Ninety-Day Letter: If no suitable candidate to fill the vacancy has been found after ninety calendar days from the date of vacancy (or, where the vacancy results from hospitalization, from the passage of thirty days from the time of hospitalization), the provider shall send a letter to the remaining member and his or her guardian, where applicable, stating that no suitable housemate has been located and that the member should consider looking for other residential options within or outside the provider agency. The letter shall state clearly that, should the provider be unable to fill the vacancy within thirty days of the letter, the provider will issue a thirty-day discharge notice.

2. Thirty-Day Discharge Notice: If no suitable candidate to fill the vacancy has been found after thirty calendar days from the mailing of the ninety-Day Letter, the provider shall issue a thirty-day discharge notice to the member, his or her guardian, where applicable, and DHHS the Department. The provider shall cooperate with the resident’s planning team in developing a transition plan for the member to move to other housing, whether permanent or interim, within thirty days.

Should the provider fail to meet the obligations set forth above, the Department DHHS may suspend reimbursement to the provider for the remaining member’s home support.

21-10.09 Semi-Independent Supported Living

When a member receives Semi-Independent Supported Living, the provider must ensure that the following requirements are met:

A. Prior to the service, members must complete a safety/risk plan qualifying them to be able to reside in a more independent setting.
B. A lease or other legally enforceable written agreement must be arranged between the member and landlord.
C. Staff must be located on the grounds of the apartment building or other structure at all times.
D. The location must be integrated into the community, not on the grounds of an institutional setting.
E. Cannot be combined with any other Home Support.
21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

21.10-10 Shared Living (Foster Care, Adult)

The Shared Living Home Provider maintains a supportive home environment that promotes community inclusion with an appropriate level of support. The Shared Living Home Provider is required to:

A. Maintain a clean and healthy living environment addressing any necessary member-specific environmental or safety standards (see Appendix V).
B. Attend to the member’s physical health and emotional well-being.
C. Participate as a part of the member’s Person-Centered Planning Team and maintain open communication with the Case Manager, Administering Agency, guardian and Person-Centered Planning Team.
D. Assist in transition, admission or discharge plans.
E. Include the member in family and community life, assisting the member to develop healthy relationships and increased community independence.
F. Provide community access to services and activities desired by the member but not limited to; religious affiliation (if desired), physical activities, shopping, volunteering, etc.
G. Maintain professional daily documentation in accordance with MaineCare requirements.
H. Maintain daily documentation of all medication administered to the member or by self-administration.
I. Report any unusual incidents to the member’s team (Case Manager, Administering Agency and guardian) and, when required, through the Reportable Events Reporting System.
J. Reports to the member’s team all changes in household members or legal status of household members.
K. Maintain current homeowner’s or renter’s insurance at all times.
L. Provide the transportation to appointments and activities.
M. Maintain a valid Maine driver’s license and a properly registered, inspected, insured and maintained vehicle.
N. Enter into a contract for professional support with the Administering Agency.

21.10-11 Skilled Nursing Service for Persons with Intellectual Disabilities or Autism Spectrum Disorder

In order to provide this service, a provider must be a; Registered Nurse (RN) with Certification by the Developmental Disabilities Nursing Association (DDNA) or a Licensed Practical Nurse (LPN) with a DDNA certification and under the supervision of an RN with DDNA Certification. RNs and LPNs without DDNA certification will be granted a 16 month grace period from their date of hire with a Section 21 provider or 16 months from the effective date of this rule, to obtain the DDNA certification.
21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

During this grace period, it is permissible for the LPN or RN to provide Skilled Nursing Services so long as the previously mentioned qualifications are met. No RN or LPN, 16 months after the effective date of this rule or who has been employed longer than 16 months with any Section 21 provider, shall be eligible to provide this service without obtaining DDNA Certification.

21.10-12 Activities that Support Personal Well-Being

Providers must ensure staff are trained in identifying risks, such as risk of abuse, neglect or exploitation; participating in a member’s risk assessment; identifying and reporting to an immediate supervisor changes in health status and behavior; anticipating or preventing unsafe or destructive behavior; and safely intervening against undesirable behavior according to an intervention plan. In the absence of a plan, intervention must be consistent with the DHHS’s rule governing emergency intervention and behavioral treatment for persons with intellectual disabilities (14-197 CMR Chapter 5). It may also be necessary to seek emergency medical or safety assistance when needed and comply with Reportable Events reporting requirements.

All staff regardless of length of employment must have Behavioral Regulations (14-197 CMR, Chapter 5), Reportable Events training (14-197, ch12), and Rights of Persons with Intellectual Disabilities or Autism Training (Title 34-B §5605). These trainings are required every three years. Documentation of training must be maintained in provider personnel files.

21.10-135 Background Check Criteria

The provider must conduct background checks on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide direct support services under this Section. A background check is required for any other adult who may be providing direct or indirect services where the member receives Shared Living or Family Centered Support. Background checks on persons professionally licensed by the State of Maine will include a confirmation that the licensee is in good standing with the appropriate licensing board or entity. The provider shall not hire or retain in any capacity any person who may directly provide services to a member under this Section if that person has a record of:

A. any criminal conviction that involves abuse, neglect or exploitation;
B. any criminal conviction in connection to intentional or knowing conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person;
C. any criminal conviction resulting from a sexual act, contact, touching or solicitation in connection to any victim; or
21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

D. any other criminal conviction, classified as Class A, B or C or the equivalent of any of these, or any reckless conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person within the preceding two (2) years; 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 persons with records of such convictions more than five (5) years ago is a matter within the provider's discretion after consideration of the individual's criminal record in relation to the nature of the position. The provider shall contact child and adult protective services (including the Office of Aging and Disability Services) units within State government to obtain any record of substantiated allegations of abuse, neglect or exploitation against an employment applicant before hiring the same. In the case of a child or adult protective services investigation substantiating abuse, neglect or exploitation by a prospective employee of the provider, it is the provider’s responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with licensing standards. Providers are not required to obtain records from child protective services for employees who do not provide services to children.

21.10-14 Emergency Intervention and Behavioral Treatment

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

21.10-156 Informed Consent Policy

Providers must put in place and implement an informed consent policy approved by the Department of Health and Human Services. 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.
21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

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

21.10-167 Reportable Events & Behavioral Treatment for Persons with Intellectual Disability

Providers shall comply with all terms and conditions of DHHS’ Regulations Governing Reportable Events, Adult Protective Investigations and Substantiation Hearings regarding persons with Intellectual Disabilities or Autism as described in 14-197 CMR, chapter 12. All staff must receive training in mandatory reporting/reportable events and Behavioral Regulations either before they begin work with members or, at the latest, within thirty (30) days six (6) months of being hired. All staff must receive the following Department sponsored training:

a. Reportable Events (14-197, Ch. 12)
b. Behavior Regulations Training (14-197, Ch. 5)
c. Rights of Persons with Intellectual Disabilities or Autism Training (Title 34-B §5605)

Completion of trainings should occur before staff begin work with members or within six (6) months of the date of hire. All staff, regardless of length of employment must have documentation of training completion in their personnel file. Staff are required to complete the trainings every three years.

21.11 APPEALS

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

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

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

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

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.

21.13 BILLING INSTRUCTIONS

Providers must bill in accordance with DHHS's Billing Instructions.
21.14 APPENDIX I- Shared Living and Family Centered Per Diem Criteria for increased level of support.

The Standard support level is an all-inclusive reimbursement for Services defined in 21.05-. At times, a member may require increased levels of staff support due to more intensive needs. DHHS may authorize an increased level of support for the purposes of additional staff for those members who have current and documented challenging behavioral issues or high medical and safety needs. DHHS will use the following criteria to determine when this increased level of reimbursement to support the additional staff is utilized. Additional staff will not be used as a substitute for the current approved provider. This service is intended to work with the current provider to ensure all behavioral and medical needs are addressed.

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

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

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

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

1) The specific illness or condition to be addressed that requires increased support;
2) The manner in which increased support will be utilized;
3) The expected duration of the increased support. If the increased support is expected to be needed for an indefinite period of time then this expectation should be specified; and
4) The anticipated frequency of the increased support on a daily, weekly, or monthly basis.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

21.14 APPENDIX I- Shared Living and Family Centered Per Diem Criteria for increased level of support (cont.)

Process of Application for the increased level of service:

The Provider must complete the Home Support Frequency tool provided by DHHS that will summarize the support needs of the member and submit the tool along with identified materials to the case manager. The Home Support Frequency tool can be found at this website, http://www.maine.gov/dhhs/oads/disability/ds/MaineCare/protocol/index.shtml

The Case Manager will be responsible for reviewing the information provided, verifying that the Personal Plan and all other information is most current.

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

The central review team will issue a written decision within twenty (20) working days of receipt of all required documentation. If additional information is required, a written request will be issued to the case manager. Upon receipt of the additional information, DHHS will approve or deny the request in writing within ten (10) working days.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

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

Appendix II is valid only for those members who have not yet transitioned to a Level-Based Budget

The purpose of this Appendix is to detail guidelines for Office of Aging and Disability Services personnel or Authorized Entity in approving a Medical Add On to the established published rate. All current statutes, regulations, decree provisions, policies, and licensing standards regarding medical services are unaffected by these guidelines. This Appendix develops criteria that warrant an adjustment to the Department DHHS’s established published rate for Home Support, Community Support, Employment Specialist Services and Work Support Services-Individual.

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

A. Physician Order

1. There must be a written physician’s order for the member. This order must specify:
   a. The specific illness or condition to be addressed;
   b. The specific procedure(s) that will be utilized;
   c. The time span over which the treatment or intervention is expected to be needed. If the treatment or intervention is expected to be needed for an indefinite period of time then this expectation should be specified;
   d. The anticipated frequency of treatment or intervention on a daily, weekly, or monthly basis;
   e. Where applicable and possible:

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

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

B. Planning Team

1. The team must meet or otherwise confer for the following purposes:
   a. To determine whether the setting where the member is served is appropriate to carry out the physician’s recommended treatment or intervention;

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The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS).

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

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

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

C. Provider Requirements

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

D. Approval Process

1. The DHHS or Authorized Entity will issue a written decision for the Medical Add On, within twenty (20) working days of receipt of all required documentation. If additional information is required, a written request will be issued. Upon receipt of the additional information DHHS or Authorized Entity will approve or deny the request within five (5) working days.
2. Documents will be reviewed by a designated representative.
3. Approvals will include a specification of the authorized daily or weekly units of service which require the Medical Add On. Approval may be retroactive to the date of application of the Add On based on documentation.
4. Treatments or interventions that are anticipated to be needed for an extended or indefinite period of time must be reviewed at minimum, annually by the team. Verification of this continued need must be provided to the DHHS or Entity within a year of the original approval, in order for the Medical Add On to continue.
APPENDIX III- On Behalf of Covered Activities

Appendix III is valid only for those members who have not yet transitioned to a Level-Based Budget.

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

Examples of acceptable activities include:

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

Services, activities and time that are directly related to a member that are associated with that member’s Personal Plan, medical plan or behavioral plan including in-service training specific to a member’s plan of support, consultations with supervisors, therapist, clinicians, member’s employer and or medical staff; activities relating to a member’s parent, guardian or Maine Developmental Services Oversight and Advisory Board (MDOAB) representative; documentation, reports and presentations to review committees.

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

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

**On Behalf of Non Covered Activities**

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

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

Services, activities and time that are related to staff training, unless the training is specific and exclusive to the member.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

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

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

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

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

Services, activities and time provided by a salaried staff member unless there is evidence that the salaried staff was working as a Direct Support Professional for the time being claimed.
21.17 APPENDIX IV- 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 assist 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 DHHS and MaineCare providers.

21.17-1 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.

21.17-2 Performance Measures

a. 65% of members receiving Work Support-Individual services will have worked a total number of hours of paid employment during the quarter that is greater than the total number of Work Support-Individual support hours they received during the quarter.

b. 100% of members receiving Work Support-Group employment making less than minimum wage, will have a Personal Plan in place that identifies how Work Support is being utilized to increase the member’s productivity and ensure good job match in order to move toward an hourly wage that meets or exceeds the State of Maine minimum wage standard.

21.17-3 Performance Measure Data Source

Providers must electronically enter individual member level data into a DHHS defined web-based data collection system by the 15th of the month following the quarter end.

21.17-4 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.
21.17 APPENDIX IV- Performance Measures (Cont.)

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;
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 of Health and Human Services (DHHS); 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 V - Additional Requirements for Section 21 Providers of Home Support Services, Community Support Services and Employment Specialist Services

Providers must first be approved by OADS and subsequently enroll in MaineCare in order to provide services and be reimbursed under this Benefit.

Prior to approval and thereafter, the Provider, any contractor or subcontractor of the Provider, or other individuals compensated by the Provider for assisting in the care of member(s) is subject to site visits and interviews to ensure compliance with Federal and State laws and regulations and the operational, health, safety and environmental requirements set forth herein. The Provider shall permit OADS representative(s) to visit the member and the member’s home and program as often as DHHS deems necessary to assure quality services, including unscheduled visits.

The Provider must submit the following to the OADS District Resource Coordinator:

A. Application Form. Initial applications shall be submitted using DHHS forms to the OADS District Resource Coordinator. The initial application shall be signed and dated by the provider owner and the presiding officer of the Governing Body, if applicable.

B. The initial application shall be accompanied by documents described in this section of rule demonstrating compliance with requirements described in the following portions of these rules:

1. Organizational Structure
   a. Ownership
      i. Authority. The Provider shall maintain documented evidence of its source(s) of authority to provide services. Such evidence will include articles of incorporation, corporate charter, or similar documents.
      ii. Records. Corporations, partnerships or associations shall maintain records of the contact information for officers, directors, charters, partnership agreements, constitutions, articles of association and/or by-laws, as applicable.
   b. Capacity
      i. Professional Qualifications. Provider shall have written job descriptions for all positions within the agency. The Provider shall acquire and retain evidence to demonstrate that all persons engaged in the provision of services regulated by the State of Maine, other applicable government entities, professional association or similar bodies are appropriately qualified, certified and or licensed.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

21.18 APPENDIX V- Additional Requirements for Section 21 Providers of Home Support Services, Community Support Services and Employment Specialist Services (Cont.)

1. The management shall have related experience demonstrating competency and experience in the health or human service setting and remain in good standing of licensure or certification.

2. Supervisors of Home Support Services, Employment Specialist Services or Community Support Services shall be required to meet all of the requirements of the DSP position.

3. Copies of contracts or service agreements that will support business operations and service delivery. When the provider manages services delivered by another provider, a documented cooperative, affiliated service or subcontracting agreement shall exist. This agreement shall be updated and renewed at least annually. The provider shall ensure that services provided through an affiliation agreement or subcontract complies with these rules and any contractual requirements.

c. Organization Chart.

i. The Provider will outline the business structure in an organization chart, and identifying management, staff and other individuals compensated by the Provider for assisting in the care of member(s) and illustrating the supervisory responsibilities; include credentials if required for the service delivery.

2. Personnel Management.

a. General Orientation Program. The Provider shall have a written orientation program that is relevant to the organization as a whole and provided to all new employees, interns and volunteers. This orientation shall include, but not limited to:

i. an overview of the service delivery system as a whole, including the availability of peer and family supports and other elements of services;

ii. the provider's mission, philosophy, clinical services and therapeutic modalities, policies and procedures;

iii. member's right to privacy and confidentiality;

iv. safety and emergency procedures general to the provider;

b. Position Specific Orientation and Training. The Provider shall have a personnel policy that includes a description of the education, experience and training required for Direct Support Professionals, Supervisors and Program Directors.
APPENDIX V- Additional Requirements for Section 21 Providers of Home Support Services, Community Support Services and Employment Specialist Services (Cont.)

i. The policy shall address any provider requirement for a valid driver’s license, personal insurance limitations, computer proficiency, and any specific training specified by the Provider and include a component specific to monitoring continued compliance. The policy should note any requirement that the DSP will receive additional training specific to member(s) needs as addressed in the Personal Plan.

ii. The Provider shall provide to all employees, interns, volunteers, orientation specific to the duties and responsibility for which they were retained or accepted, and ensure the appropriate certification and training requirements specified in this rule and applicable governing regulations which includes but not limited to the following:

1. Person Centered Planning Process as outlined in CFR §441.303
2. Medication Administration Training required for all DSPs who assist members with over-the-counter and prescribed medication
3. Cultural competence training relevant to the populations served, including; age, gender, race, religion, culture and sexual orientation.

3. Operational Policies and Procedures

a. General Policies. The Provider shall maintain policies governing essential elements of service provision. Policies include and are not limited to:

i. Behavioral Regulations. The Provider shall comply, and ensure that all staff and other individuals compensated for assisting in the care of member(s) comply with the DHHS’ “Regulations Governing Emergency Interventions and Behavioral Treatment for People with Intellectual Disabilities and/or Autism, 14-197 CMR Ch. 5.

ii. Rights and Protection. The Provider shall comply, and ensure that all staff and other individuals compensated for assisting in the care of member(s) comply with 34-B M.R.S.A. §5605, Rights and Basic Protections of a Person with an Intellectual Disability or Autism.

i-iii. Reports of Abuse, Neglect or Exploitation. The Provider shall maintain a specific policy and procedure governing the reporting, recording and review of allegations of abuse, neglect or exploitation of persons receiving services, in accordance with applicable laws, rules and regulations, including but not necessarily limited to the Adult Protective Statute. The Provider shall comply and shall ensure that all staff and other individuals compensated by the Provider for assisting in the care of member(s) comply with DHHS’ Reportable Events regulation (14-197 CMR Ch. 12, Regulations Regarding Reportable Events, Adult Protective Investigations and
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

### APPENDIX V - Additional Requirements for Section 21 Providers of Home Support Services, Community Support Services and Employment Specialist Services (Cont.)

Substantiation Hearings Regarding Persons with Intellectual Disabilities or Autism), and state law on reportable events and reports of abuse, neglect and exploitation (22 MRSA §3477, Persons Mandated to Report Suspected Abuse, Neglect or Exploitation; 34-B M.R.S.A. §5604-A, Duty to Report Incidents; Adult Protective Services Act and Rights Violations; and 22 M.R.S.A. §3740, et. seq., Adult Protective Services Act).

iv. The Provider shall maintain written policies and procedures and have reporting forms available at each site where members are served to ensure compliance with the above mentioned laws and regulations governing Reportable Event, Rights and Basic Protections and Reporting of Abuse, Neglect and Exploitation.

v. Duration of Care. The Provider shall maintain policies that outline admission process, discharge procedures for planned or unplanned termination of services, the referral of individuals deemed inappropriate or not qualified for a particular program, to other programs to meet the individual’s needs, and the mechanisms undertaken to eliminate wait lists or the justification for having no wait list.

vi. Medication Management. The Provider shall maintain specific policies and procedures ensuring that any staff and other individuals compensated for assisting in the care of member(s) receive appropriate training in and comply with medication administration protocol that is in accordance with DHHS expectations.

4. Quality Management. There shall be written policies governing the development and maintenance of an effective quality management program to ensure quality service delivery consistent with Federal and State laws and regulations. The plan shall:

   a. identify areas determined by the Provider to be critical to quality service provision.
   b. describe goals set by the provider to improve services or service delivery and shall describe indicators to measure achievement of the goals.
   c. include on-going, year-round, regular activities to measure goal achievement.
   d. include a component describing the system to monitor compliance with Federal and State laws and regulations.

   i. Evaluation. The findings of the quality management process shall be reviewed at least annually.
   ii. Plan of Correction. Finding of deficiency in violation of Federal or State laws or regulations shall be reported to DHHS within a 30 day period and be accompanied by a Plan of Correction to be deemed acceptable by the DHHS.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

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21.18 **APPENDIX V- Additional Requirements for Section 21 Providers of Home Support Services, Community Support Services and Employment Specialist Services (Cont.)**

5. **Financial Management.**

   a. The Provider shall make available to DHHS upon request, a Federal Income tax return for the year in question, a statement of finances including income statement, balance sheet, cash flow statement, operations and program budget, and profit projection.

6. **Environment**

   a. **Fire and Safety Inspections.** Upon receipt of the completed application, fire and safety inspections may be conducted by authorized representatives of organized fire departments, by the State Fire Marshall's office and code enforcement officers.

      i. Fire drills shall be conducted and documented at least four times per year
      ii. Emergency Management Plan shall address the event of loss of essential services such as electricity, water and heat

   b. **Insurance.** The Provider shall ensure and maintain record of all homes in which home support services are provided have adequate homeowner liability insurance and all any vehicle and driver comply with all applicable Maine law including valid driver’s license, auto registration, inspection and automobile insurance coverage.

   c. **Structures.** The Provider shall meet current requirements of the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Maine Human Rights Act. New construction, renovation, remodeling or repair shall be in full compliance with the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Maine Human Rights Act. All structures used in the delivery of waiver services shall be maintained in good repair, free from danger to the member’s health or safety and shall be appropriate to the services provided.

      i. furnishings and equipment are appropriate to the age and physical conditions of the members
      ii. rooms and areas are clean, appropriately lit, and adequately heated and ventilated based on the needs of the members.
      iii. the square footage of rooms (i.e. bathrooms, bedroom, dining areas) must be appropriate and adequate for the level of privacy, purpose of the space and to accommodate users
      iv. utilities are maintained in good repair and in a manner consistent with applicable codes.
      v. a storage area shall provide secure space used for the proper storage of potentially harmful materials (i.e. chemicals, medications and firearms)
APPENDIX V - Additional Requirements for Section 21 Providers of Home Support Services, Community Support Services and Employment Specialist Services (Cont.)

c. Integrated Settings. The setting in which residential, community supports and employment specialist services are provided shall be integrated in and support full access to the greater community to the fullest extent and

i. be one of choice and based on the needs of the individual as indicated in the member’s Personal Plan and

ii. ensure an member’s rights of privacy, dignity and respect and freedom from coercion and restraint and

iii. have in place for each member residing in a provider owned, rented or managed home, a lease or other legally enforceable agreement providing similar protections and

iv. support opportunities to promote competitive, integrated employment and

v. support opportunities to seek employment in competitive integrated settings, engage in community life, control personal resources, optimize autonomy and choice in activities and schedules, facilitate choice of services and providers, and access to services in the community or

vi. The Providers may modify programs as needed to comport with HCB settings requirements above or assist individuals to relocate to compliant settings of choice

In the event that any provider fails to meet the requirements set forth in this Appendix, DHHS will notify the provider in writing of any remedies needed to bring the provider into full compliance. DHHS also will issue a plan of correction setting forth the timeframes within which the provider’s compliance must be achieved. Failure to comply with the plan of correction within the stated timeframes may result in the provider’s disenrollment for services and/or any other penalties allowed under the MaineCare Benefits Manual or other state or federal law.
21.19 APPENDIX VI: SUPPORTING INDIVIDUAL SUCCESS & THE SUPPORTS INTENSITY SCALE

SIS POLICY & PROCEDURES:

The Supports Intensity Scale (SIS) is the Department’s approved assessment tool for determining the budget allocation based on identified support needs of members with Intellectual/Developmental Disabilities and Autism Spectrum Disorder who are receiving services through the Department’s Home and Community Based Services Waiver, Section 21. While a member’s level of Intellectual/Developmental Disability & Autism Spectrum Disorder has traditionally been measured by a member’s deficits, the SIS shifts the focus to the supports needed to live as independently as possible in the community. The SIS is administered by a Certified SIS Interviewer employed by the Single Assessing Agency designated by the Department. The assessment is conducted by a trained and certified AAIDD interviewer through an interview process with the member and other Respondents who know the member well.

Interviews will be conducted by the Department or its Authorized Agent whenever a member:

- Is determined eligible to receive Section 21 HCBS waiver services.
- Is receiving Section 21 HCBS waiver and a reassessment is due for continuation of Section 21 HCBS waiver (at least once every 36 months/3 years).
- Is receiving Section 21 HCBS waiver and a reassessment is deemed necessary due to a Major Life Change that will affect the member’s support needs for more than six (6) months or at the discretion of the Extraordinary Review Committee (ERC).

After a SIS assessment has been finalized a member is assigned a set of raw SIS scores that are then converted into standardized scores in accordance with the American Association on Intellectual and Developmental Disabilities (AAIDD) guidance by a contracted consultant. The consultant then applies these scores to the Maine Support Need Level and Decision Rules (Table 1, Appendix VI) to determine a level assignment between levels one (1) and five (5) based on the member’s support needs. The level assignment will relate to a member’s Level-Based Budget that will be used to guide their service choices during the Personal Planning Process.

Implementation:

The Department plans to implement the use of the SIS as an assessment and allocation tool as of July 1, 2015 or upon CMS Approval. Current waiver members will transition to the new resource allocation model according to the effective date of their annual Personal Plan. It will take a full year to transition all of the current members into the new service allocation model. During the first year of the waiver renewal, the Department will operate a dual system until all members on the waiver transition into the new model.
The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS)

21.19 APPENDIX VI: SUPPORTING INDIVIDUAL SUCCESS & THE SUPPORTS INTENSITY SCALE (cont.)

The Supports Intensity Scale:

A. Maine Support Need Levels and Decision Rules

When calculating the Maine Support Need Levels (Table 1.), five parts of the Supports Intensity Scale are used along with an exceptional need verification process. The SIS is used to group members with similar needs into the same level to ensure that members receive an adequate amount of funding and supports. In addition to the five parts of the SIS used to assign members to a level, a verification process is used to ensure that members who have potential exceptional need are systematically identified and promoted to a higher level when needed.

B. Sections of the Supports Intensity Scale

The SIS has three sections. Section 1 – Support Needs, Section 2 – Supplemental Supports & Advocacy, and Section 3 – Exceptional Medical & Behavioral Needs.

Section 1 - Support Needs asks about general support needs and is divided into six parts.
- Part A: Home Living Activities
- Part B: Community Living Activities
- Part C: Lifelong Learning Activities
- Part D: Employment Activities
- Part E: Health and Safety Activities
- Part F: Social Activities

Section 2 - Supplemental Protection and Advocacy asks questions about the types of activities the member performs to advocate for him or herself.

Section 3 – Exceptional Medical and Behavioral Needs documents extra support need for medical and behavioral support and has two parts.

C. Support Need (Sum Parts A, B, E)

The five parts of the SIS that are used to assign members to levels include Section 1 Part A: Home Living Activities, Part B: Community Living Activities, and Part E: Health and Safety Activities. Each section has a raw score, and a standardized score. The raw score on the scale are adjusted, or standardized, so that a member’s scores can be compared across the population. These standardized scores are calculated by the creator of the SIS, the American Association on Intellectual and Developmental Disabilities (AAIDD), and are the same across all jurisdictions where the SIS is used. The standardized scores are then added together to get the Sum of Section 1, Parts A, B, and E (Sum of A,B,E)
21.19 APPENDIX VI: SUPPORTING INDIVIDUAL SUCCESS & THE SUPPORTS INTENSITY SCALE (cont.)

D. Behavior Support Need and Medical Support Need

The total scores from Section 3A: Medical Supports Needed and Section 3B: Behavioral Supports Needed are also used. In Section 3, each item’s response is scored as:

- 0 for no need,
- 1 for some support needed, or
- 2 for extensive support needed.

These scores are then added together to get the total for each part. The following table; Maine Support Need Levels and Decision Rules; outlines the standardized score requirements to be assigned to each level including the outcome of the Behavioral and Medical Support (3A and 3B) sections. For level assignment, a member is placed at the level for which the highest score is indicated.

Members will start transitioning to the new system in 2016 upon the 2016 effective plan date. The notification provides for a six month pre-planning period for members and their planning teams.

SIS Re-Administration

Re-administration of the SIS assessment may occur for the following reasons:

A. Reassessment Due:

A member will receive a new SIS assessment within thirty-six (36) months after the most recent SIS assessment (once implementation is complete, see above “Implementation”). It is the Case Manager’s responsibility to track when a SIS assessment is due and submit a referral to the Single Assessing Agency within six (6) months prior to the thirty six (36) months expiration. The SIS assessment will not be considered current after three years have passed. All members are required to receive a new SIS assessment every thirty-six (36) months, at a minimum and this must be completed no later than 48 months. If a renewal SIS assessment is not completed by 48 months, the member’s services will cease until the assessment is completed.

B. SIS Interviewer’s Professional Judgment:

In the event that the SIS Interviewer determines the information provided by respondents during the SIS interview did not represent the supports needed by the member, the SIS Interviewer can dispose of the assessment data and conduct another assessment sometime in the next four (4) to six (6) months, possibly with new respondents. This decision will be made in conjunction with the SIS Interviewer’s supervisor and in consultation with the SIS Manager at OADS.
APPENDIX VI: SUPPORTING INDIVIDUAL SUCCESS & THE SUPPORTS INTENSITY SCALE (cont.)

This may occur if:

- The skills and support needs reported by respondents are inconsistent with the skills and support needs demonstrated during the interviewer’s observation of the member.

OR

- Respondents consistently disagree on the skills and support needs of the member.

In some cases a member or their guardian may feel that policy and procedure were not adhered to and may make a request for review and re-administration of the SIS. In this case, a member or their guardian may make a request for review of the SIS interview process to determine compliance with Department policies and with procedures set forth in this Rule.

A request for review regarding the interview protocol must be submitted within thirty (30) business days of the SIS interview taking place. Requests submitted after the initial thirty (30) business day period will not be considered.

Members or their guardians can request a review of the SIS process for any one (1) of the following reasons:

1. Guardian(s) were not informed of the interview prior to it happening.
2. Guardian(s) expressed that they would like to attend, were not able to attend and the meeting proceeded without them.
3. At least two Respondents who know the member for at least three (3) months were not present throughout the SIS interview.
4. Questions in the interview were not explained prior to being scored.
5. Questions were not asked or discussed during the interview.
6. The member was not present at the interview, or the interviewer did not meet and observe the member prior to Interview.

If it is determined by the SIS Manager or designee that the administration of the SIS interview did not adhere to the procedure, a new SIS will be scheduled within thirty (30) business days.

C. Major Life Change:

A major life-changing event, such as a serious illness, injury, or behavioral change, may warrant a new SIS assessment if these changes will affect a member’s support needs for six (6) months or longer. A Major Life Change may trigger the need to conduct a review of a member’s situation to determine if it is necessary to conduct a new SIS assessment outside of the usual
APPENDIX VI: SUPPORTING INDIVIDUAL SUCCESS & THE SUPPORTS INTENSITY SCALE (cont.)

The changes in this section are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS).

21.19  APPENDIX VI: SUPPORTING INDIVIDUAL SUCCESS & THE SUPPORTS INTENSITY SCALE (cont.)

thirty-six (36) month cycle that each member is assessed. Major Life Changes are limited to the following:

1. A change in natural Home or family living situation including the loss of natural supports for a member.
2. Loss of living situation that significantly impacts the member’s support needs.
3. Significant change in medical health or development of new conditions/diagnosis that pose a significant change to support needs/functioning of a member.
4. Change in diagnosis or condition of a serious mental health or behavioral need that poses a significant change to support needs or functioning of a member.

If a Major Life Change has been identified, it is the responsibility of the authorized case management provider to submit to the attention of the SIS Manager a Major Life Change Review using the form designated by the Department.

The SIS Manager or designee reviews and approves all Major Life Change Requests as designated by OADS.

The SIS Manager or designee will provide notification of the outcome of the Major Life Change request to the case manager and the member or guardian in writing. Upon approval a new SIS assessment will be scheduled within thirty (30) business days.

The Supplemental Verification Process:

If there are potential areas of severe risk identified through Supplemental Questions during the SIS Assessment, the Supplemental Verification Team (SVT) will then request additional information for review. The SVT will review the additional information to verify that the member has a higher support needs in at least one (1) of four (4) specific areas; (1) Severe Medical Risk, (2) Severe Community Safety Risk- Non-Convicted, (3) Severe Community Safety Risk- Convicted, and (4) Severe Risk to Self-Injury.

Based on review of the member’s file and other records received from the case manager, the Supplemental Verification Team (SVT) will determine whether the member requires the higher level of support indicated by the Supplemental Questions or whether they have been accurately evaluated by the SIS assessment. If the SVT verifies that a member’s support needs are higher, then the member will be assigned a higher support level due to this verified need.

The Supplemental Verification Team consists of OADS staff with a multi-disciplinary background to include but not limited to medical, behavioral, crisis and program experience with Intellectual Disabilities and Autism Spectrum Disorder populations. The SVT is required to have a minimum of

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21.19 APPENDIX VI: SUPPORTING INDIVIDUAL SUCCESS & THE SUPPORTS INTENSITY SCALE (cont.)

three members present to verify cases and a secondary review is done by the SIS Manager or designated staff prior to final approval.

The Supplemental Verification Team does not consider individual budgets. The SVT confirms or denies the existence of a higher behavioral or medical need. If the evidence of a higher need is supported, then a higher Support Level will be assigned unless member is already at highest support level assignment in which case the level will remain the same.

Request for Extraordinary Support Services:

In any Level-Based Budgeting system, it is expected that a small percentage of members will have extra support needs that are beyond their assigned budget. As such, OADS has developed additional services such as the Qualified Extra Support Service (QESS) and Skilled Nursing for persons with Intellectual Disabilities and Autism Spectrum Disorder to provide extra support. The ERC may approve additional support services for any assigned Support Level in accordance with MaineCare Benefits Manual, Chapter II.

A member or guardian, through their case manager can request a formal review based on a claim of an Extraordinary Support need by submitting an ERC Referral with supplemental documentation and evidence to the Extraordinary Review Committee (ERC). An extraordinary support need is considered to be a need that exceeds supports and services provided within the Level-Based Budget.

The following documentation is required to accompany the request:

- Person Centered Plan
- ERC Referral Forms
- Functional Assessment
- Proposed Budgetary usage (in accordance with allowances)
- Demonstration of 100% budgetary expenditure of current Level-Based Budget
- Supporting documentation-current clinical or behavioral assessments, relevant evaluations, behavior logs, approved safety plans, approved Severely Intrusive Plans (SIP), crisis interventions including, but not limited to, Individual Support Team (IST) Meeting Minutes, reportable event information and forensic history.

The approval of the Extraordinary Support Services will be granted on a case by case basis and the amount of approved services will depend on the documented and verifiable need of the member. The ERC is the sole committee responsible for approving services such as Qualified Extra Support Services and Skilled Nursing for Persons with Intellectual Disabilities and Autism Spectrum Disorder as well as setting applicable review time frames and standards.
Within ten (10) business days of the ERC decision, the member, guardian and case manager will be notified in writing of the decision and their appeal rights.

A series of regular reviews of the approved services will be scheduled by the ERC to determine ongoing need, appropriate use of additional service, and review further need or extensions of the service. Documentation must be provided on a regular basis to the ERC to substantiate the ongoing need and effective use of the service.

The Extraordinary Review Committee completes all reviews based on Extraordinary Support Need. The ERC cannot change a member’s assigned level.

(See Next Page for Table 1, Maine Support Need Levels and Decision Rules)
## Table 1. Maine Support Need Levels and Decision Rules

<table>
<thead>
<tr>
<th>Support Level &amp; Description</th>
<th>Support Need Sum of A,B,E</th>
<th>Behavior Support Section 3B</th>
<th>Medical Support Section 3A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Members in Level 1 have low support needs, including little to no support need for medical and behavioral challenges. They can manage many aspects of their lives independently or with little assistance; including instrumental activities like eating or dressing, also daily living activities like shopping or going out into the community. Supports are typically intermittent rather than 24 hours a day, 7 days a week (24/7).</td>
<td>≥0 to ≤24</td>
<td>≥0 to ≤6</td>
<td>≥0 to ≤6</td>
</tr>
<tr>
<td><strong>2</strong> Members in Level 2 have moderate support needs and little to no support need for medical behavioral challenges. Although they need more support than those in Level 1, their support needs are minimal in a number of life areas. They may also receive intermittent support rather than 24/7.</td>
<td>≥25 to ≤32</td>
<td>≥0 to ≤6</td>
<td>≥0 to ≤6</td>
</tr>
</tbody>
</table>
| **3** Members in Level 3 may need 24/7 supports due to their daily support needs and/or behavioral challenges. Members have either:  
• Low to moderate support needs as in Levels 1 & 2 but also above average, non-extensive support need due to behavioral challenges; or  
• Above average support needs and up to moderate support need due to behavioral challenges. | ≥0 to ≤32 | ≥7 to ≤10 | ≥0 to ≤6 |
| **4** Members in Level 4 have either:  
• High to maximum support needs; or  
• Significant need for support due to medical conditions. Members in Level 4 have behavioral support needs that are not significant but range from none to above average. Members in this level may need additional 24/7 supports due to their daily support needs and/or medical conditions. | ≥33 to ≤36 | ≥0 to ≤10 | ≥0 to ≤6 |
| **5** All members in Level 5 have significant behavioral challenges, regardless of their support need to complete daily activities or for medical conditions. Members in this level may need enhanced 24/7 supports due to their behavioral challenges. *Members that meet Level 5 criteria due to behavioral challenges and have significant medical need may require additional review to ensure their medical and behavioral needs are addressed appropriately. | Any | ≥11 or verified community safety or self-injury risk | #See Level 5 Description |

*Members that meet Level 5 criteria due to behavioral challenges and have significant medical need may require additional review to ensure their medical and behavioral needs are addressed appropriately.