DATE: February 28, 2017

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Adopted Rule: Chapter 101, MaineCare Benefits Manual, Chapter II, Section 21 Home and Community Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

This regulation governs a federal Medicaid home and community based federal Medicaid 1915C waiver service. In this rulemaking, the Department has made changes that help move the Section 21 waiver program towards compliance with 42 C.F.R. Sec. 431.301(c). This federal regulation, effective March 17, 2014, sets forth new provisions for Home and Community Based services (HCBS) waiver programs. The federal regulation requires states to engage in transition planning with the Centers for Medicare and Medicaid Services (CMS) to assure compliance with these provisions. The Department is currently engaged in this process with CMS. For this rulemaking, the Department has incorporated changes regarding the Person-Centered planning process. Attached to this Basis Statement is a copy of a portion of the federal regulation, 42 CFR 431.301(c)(1), which is incorporated into this rule by reference.

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Chapter II, Section 21 is a routine technical rule and does not require legislative approval prior to final adoption of the rule. The companion rule, Chapter III, Section 21 is a major substantive rule and requires legislative approval. With regard to the Chapter III rule, the Department adopted an emergency major substantive rule on September 28, 2016. The Department also went through proposed rulemaking for Chapter III, and provisionally adopted the rule on 24 February, 2017. The provisionally adopted rule will be submitted to the Maine Legislature for its approval and action.

This Chapter II proposed rule was publically noticed on September 28, 2016 and a public hearing was held on October 19, 2016 in Augusta. There were 54 people in attendance for the hearing. The Department received comments from 67 individuals until the close of the commenting period on October 29, 2016.

Changes to Chapter II, Section 21 include:

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Throughout Section 21 to be consistent with the DSM, replaced the term “Mental Retardation” with “Intellectual Disabilities.”

In the Definitions section:
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- Added clarifying language to Administrative Oversight Agency to include language that OADS needs to approve these agencies
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- Clarified Prior Authorization
- Moved language from Shared Living definition to the definition of Shared Living Provider.

Under Determination of Eligibility, added clarifying language to Reserved Capacity
- Updated General Eligibility Criteria added clarifying language and updated the diagnoses to be consistent with the DSM and added Rett Syndrome.
- Under Redetermination of Eligibility added the requirement that every twelve months from the date of initial eligibility approval, the member’s case manager will need to resubmit an updated personal plan and a BMS 99. This is the codification of a current requirement.

21.03-5 Substituted “annual cost” for “annual budget” in order to be consistent with the hearings (Calculating the Estimated Annual Cost)

21.03-8. Added language regarding “Offers for funded opening” to the effect that at the time a member is offered a funded opening the member will be removed from the waiting list. The reason is that once the Department has determined an offer to meet the members needs has been offered, then the member no longer has to wait for an offer.

21.03-9 (Redetermination of Eligibility). Added requirement that eligibility for the waiver for each member has to be redetermined every 12 months. This requirement ensures that the member continues to be eligible for the service.

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21.05 (Covered Services)/Duplicative Services, moved the introductory sentence which stated that duplicative services were not covered, to the 21.06.1 (Duplicative Services) which section elaborates on the services which would be considered duplicative.

Under Personal Plan and also Planning Team Composition, the language was updated throughout this section to ensure that the member is driving the process and that the process is more closely aligned with the CFR §441.301 and 34-B M.R.S.A. §5470-B(2). Direct references to the CFR were included.

21.04-2 (Personal Plan), added the requirement that grievance training be provided to all staff, upon hire, and retraining every thirty six months. The reason for this is because the grievance process is a very important process, and staff members need this training, which benefits members.
In the Covered Services section:
- Under Communication Aids, added Augmented communication services to replace Facilitated communication services as an update.
- Under Community Supports, added language that will allow for career exploration as part of the service, and allows a member to also receive Work Support services.
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- 21.05-6 (Consultation Services), the Department removed the cap on these services from this section and moved the cap to the Limit Section 21.07-7 (Consultation Services).
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- 21.05-19 (Physical Therapy Maintenance), added new language so that this service may be provided up to three members at a time.
- 21.05-20 (Shared living), added language to clarify that respite is not separate billable service because it is a component of the rate paid to the Administrative Oversight Agency.

In the Limits section:
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- Under Consultation Services, added information regarding limits.
- Definition of annual limits for: Occupational Therapy (Maintenance).
- 21.07-2, the Department increased the limit for combined cost of Community Support, Work Support-Individual and Work Support-Group.
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In the Duration of Care Section, added requirements for Provider Termination of a Member’s Services.

21.10 - In Provider Qualifications and Requirements, added language throughout to provide additional assurances for the health and safety of members as well as quality of services. These changes include updates to the following:
- Requiring providers to train staff in identifying risks such as risk of abuse, neglect or exploitation;
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Appendix I. Clarifies that it is the CRT which reviews all increased levels of support requests. The Department also added Physician Assistants to the list of providers who can write a recommendation for medical support.

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For a list of changes made from the proposed rule to the Adopted Rule, please review the Summary of Comments and Department’s Responses that were filed with this rule.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare 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 or Maine Relay number 711.

A concise summary of the proposed rule is provided in the Notice of Agency Rulemaking Proposal, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rulemaking process. Please address all comments to the agency contact person identified in the Notice of Agency Rulemaking Proposal.
Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual, Chapter II, Section 21 Home and Community Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

ADOPTED RULE NUMBER: 2016-P151

CONCISE SUMMARY:

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**EFFECTIVE DATE:** March 5, 2017

**AGENCY CONTACT PERSON:** Andrew Hardy, Comprehensive Health Planner

**AGENCY NAME:** Division of Policy

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

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The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.01 INTRODUCTION

The Home and Community Based Benefit (HCB or Benefit) for members with Intellectual Disabilities (ID) or Autism Spectrum Disorder (ASD) 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. It does not duplicate other MaineCare services.

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.

In addition, the planning process includes identifying and documenting the member’s needs in a Personal Plan. The Personal Plan describes certain facilitative, 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 other sections of Maine statute, regulation, or DHHS policy.

21.02 DEFINITIONS

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

21.02-2 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);
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.02 DEFINITIONS (cont.)

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-
   a. Is approved by DHHS-Office of Aging and Disability Services (OADS).
   b. Enters into a contractual agreement with the Shared Living Provider for oversight and monitoring services.
   c. Bills and receives MaineCare reimbursement; and
   d. See additional qualifications 21.10.

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

21.02-5 Autism Spectrum Disorder (ASD) means a diagnosis that falls within the category of Pervasive Developmental Disorders, as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, (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 assuring that those services meet the requirements set forth in the member’s Personal Plan.

21.02-8 Clinical Review Team (CRT) is a multi-disciplinary team of qualified professionals that have work experience with adults with Intellectual Disabilities or Autism Spectrum Disorder. The CRT will partner with the resource coordinators to review and approve the following: Increased level of support for Shared Living and Family-Centered Support; Medical Add-On; all initial classifications to the waiver; and home
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.02 DEFINITIONS (cont.)

support service requests. The CRT will also be responsible for systematic reviews to determine that members are authorized at an appropriate level of service in accordance with the member’s personal plan.

21.02-9 Correspondent is a person designated by the Maine Developmental Services Oversight and Advisory Board (MDSOAB), to act as a next friend of a person with Intellectual Disabilities or Autism Spectrum Disorder.

21.02-10 Designated Representative means the DHHS staff or Authorized Entity authorized by DHHS to perform specified functions.

21.02-11 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. 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 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.

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.
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.02 DEFINITIONS (cont.)

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 provider offer and provide this supervision as long as the above conditions are met.

21.02-13 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.

21.02-14 Family-Centered Support is a model designed to provide 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 meets 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 as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, (American Psychiatric Association), that manifested during the developmental period, in accordance with the definition of Intellectual Disability codified in 34-B MRSA § 5001.

21.02-18 Medical Add-On is an increase in the rate paid to address short-or-long term medical needs and is reviewed and approved by the CRT. Medical Add-On is a component of Home Support, Community Support, Employment Specialist Services and Work Support-Individual 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. It is not a separately billable activity. Documentation must clearly identify and support periods of such activity. Refer to Appendix II for more information.
21.02 DEFINITIONS (cont.)

21.02-19 **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.

21.02-20 **Neglect** means a threat to a 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.

21.02-21 **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. Refer to Appendix III for more information.

21.02-22 **Personal Plan** is a member’s plan developed at least annually based on the effective plan date, that identifies the services required under the waiver benefit. The Personal Plan must also include services and supports 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.

21.02-23 **Prior Authorization** is the process of obtaining written prior approval by the Department’s Designated Representative as to the medical necessity and eligibility for a service.

21.02-24 **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.

21.02-25 **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
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.02 DEFINITIONS (cont.)

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 authorizations for reimbursement.

21.02-26 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. Please see 21.10 for additional qualifications.

21.02-27 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) who has met all the requirements to provide this service. 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. See 21.10 for additional qualifications.

21.02-28 Utilization Review is a formal assessment of the medical necessity, efficiency and appropriateness of services on a prospective, concurrent or retrospective basis.

21.02-29 Year Services are authorized on the state fiscal year, July 1 through June 30.

21.03 DETERMINATION OF ELIGIBILITY

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

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,” and point in time approved by the
21.03 DETERMINATION OF ELIGIBILITY (cont.)

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 member capacity of the waiver for specified purposes subject to CMS review and approval in order to:

- Meet the needs of incapacitated or dependent adults who require adult protective services to alleviate the risk of serious harm resulting from abuse, neglect and/or exploitation; and
- Meet the needs of those individuals who choose to leave an ICF/IID, long term nursing home placement, state psychiatric hospital, or hospital and
- Meet the needs of members under age 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, long term nursing home placement, state psychiatric hospital or hospital 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 as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association) (DSM) or Autism Spectrum Disorder as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, (American Psychiatric Association) or Rett Syndrome as defined by the DSM; and
C. Meets the medical eligibility criteria for admission to an ICF/IID as set forth under the MaineCare Benefits Manual, Chapter II, Section 50; and
21.03 DETERMINATION OF ELIGIBILITY (cont.)

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 an individual in an ICF/IID, as determined by the 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 (BMS 99) or current functional assessment approved by the DHHS; and
B. A copy of the member’s Personal Plan developed, approved and signed by the member, guardian and the Case Manager within the preceding six months of the effective plan date and any other relevant material indicating the member’s service needs.

Based on review of the Assessment Form and the member’s Personal Plan, a QIDP 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 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 criteria and medical eligibility criteria 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, the DHHS will utilize the most current assessment that is entered into the Enterprise Information System (EIS), or current database, 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 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 and Offers For Funded Opening

DHHS will maintain a waiting list of eligible MaineCare members who cannot 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. At the time a member is offered a funded opening the member will be removed from the waiting list.

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 (6) months from the receipt of notification to start services. If the member fails to respond to DHHS with intent to accept the funded opening within sixty (60) days of this notice or fails to begin services within six (6) months, the waiver offer will then be withdrawn. A member may reapply at any time for waiver services.

21.03-9 Redetermination of Eligibility

Every twelve (12) months from the date of initial eligibility approval, the member’s Case Manager will submit to OADS: a Current Personal Plan based on the effective plan date that is less than six (6) months old and an updated assessment form (BMS 99) or current assessment approved by the Department.
21.03 DETERMINATION OF ELIGIBILITY (cont.)

If the updated Assessment Form and Personal Plan are not received by OADS, by the due date, reimbursement for services will be denied until receipt of the assessment form and Personal Plan. Reimbursement for services will resume upon receipt of the Assessment Form and a signed Personal Plan.

21.04 PERSONAL PLAN

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.

21.04-1 Prior Authorization for Reimbursable Services

Medically necessary services and units of services must be identified in the Personal Plan. Requests for services must be submitted to DHHS or its Authorized Entity for Prior Authorization in order for the services to be reimbursed. 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 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 without the current provider being present to ensure conflict-free planning and informed choice. The planning process must reflect the
section 21

HOME AND COMMUNITY BENEFITS FOR MEMBERS WITH INTELLECTUAL DISABILITIES OR AUTISM

Established: 11/1/83
Last Updated: 3/5/17

The Department is seeking and anticipates receiving CMS approval for this Section.
Pending approval, Covered Services will be provided as follows:

21.04 PERSONAL PLAN (cont.)

...
by the provider. In addition, the provider must ensure that all staff are trained in the grievance process. Staff must receive training in the grievance process upon hire, prior to working with members and then every thirty six (36) months thereafter.

21.04 PERSONAL PLAN (cont.)

Each member or guardian will determine the composition of the Planning Team. Planning will occur in a manner 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 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 must include the following members, if applicable:

A. The member;
B. The member’s guardian;
C. An approved Correspondent through the Maine Developmental Services Oversight and Advisory Board

The planning team may include the following members, if applicable:

D. The member’s advocate or friend or any additional individual invited by the member;
E. Operator of the member’s home or a Direct Support Professional providing services to the member;
F. Staff from the member’s providers; and
G. Any professionals involved or likely to be involved with the member’s Personal Plan.

21.04-4 Updating the Personal Plan

The member’s Personal Plan must be reviewed, revised and updated at least annually, based on the plan’s effective date or at the request of the member or guardian; or when other significant changes occur relating to the member’s physical, social, behavioral, medical, communication, or psychological needs; or when the member has made significant progress toward his or her goals. 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 thirty (30) days subsequent to the planned move of a
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.04 PERSONAL PLAN (cont.)

member to a new service in order to coordinate and to evaluate the member's satisfaction with the change.

21.05 COVERED SERVICES

21.05-1 Assistive Technology- Assistive technology device means a Department approved 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;
- 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.
21.05 COVERED SERVICES (cont.)

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.

21.05-2 Career Planning is a person-centered, comprehensive direct support. 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 sixty (60) hours annually, to be delivered in a six-month period. No two six-month periods may be provided consecutively. In order to receive Career Planning services, the member’s Personal Plan must identify the need to explore work, identify a career direction, 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.
21.05 COVERED SERVICES (cont.)

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

21.05-3 Communication Aids are devices or services necessary to assist members with hearing, speech, or vision impairments to effectively communicate.

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. Augmented communication. Providers must submit a written plan for DHHS’s approval defining the augmented communication services that will be offered to the member.

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.

21.05-4 Community Support is provided by a Direct Support Professional employed by an OADS approved provider, in order to increase or maintain a member’s ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on community inclusion, personal development, and support in areas of daily living skills if necessary. Community Support is intended to be flexible, responsive and provided to members as defined by the member’s choice and needs as documented in the member’s Personal Plan. The location of the service and staffing level may vary, allowing for a mix of individualized and group services.

Community Support allows 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
21.05 COVERED SERVICES (cont.)

conditions, such as workplace policies and safety, necessary for the member to achieve and maintain successful employment.

A member may not receive Community Support while enrolled in high school. Community Support cannot be 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 21.07.1

- The average staff to member ratio for Community Support for each program location must not exceed 1:3.
- 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 $26,640.19 annually.

Within the scope of Community Support, there may be activities that require that the service be provided in the member's home; this will involve the origination or termination 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.

21.05-5 Counseling is a direct service to assist the member in the resolution of the member’s behavioral, social, mental health or 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), or equivalent conditional license. Counseling is limited to 16.25 hours annually.

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
21.05 COVERED SERVICES (cont.)

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 assisting individuals primarily responsible for carrying out the member’s Personal Plan in the member's home or in other community sites as appropriate, to make necessary adjustments; and

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

Consultation is available in the following specialties: Occupational Therapy, Physical Therapy, Speech Therapy, Behavioral and Psychological services. The provider of this service must be a Licensed Occupational Therapist (OT/L) 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.

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 member need, other team members may include a physician, occupational, physical or speech therapist.
21.05 COVERED SERVICES (cont.)

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 must be authorized by a primary designated DHHS representative without the Personal Plan documentation this is permitted 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 DHHS 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 or contracted by an approved provider enrolled in MaineCare.

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 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 provider but must have completed the approved Employment Specialist training as outlined by DHHS in order to provide Employment Specialist Services. The need for
21.05 COVERED SERVICES (cont.)

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.

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

On Behalf Of will continue as 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 ten (10) 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.

21.05-10 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 his or her 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 or other appropriate professional 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);
21.05 COVERED SERVICES (cont.)

- 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 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.

Home Accessibility

Adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

The limit for adaptations is ten thousand dollars ($10,000) in a five (5) year period, with an additional annual allowance up to three hundred dollars ($300) for repairs and replacement per year. All items in excess of five hundred dollars ($500) require documentation from a physician or other appropriate professionals such as OT, PT or Speech therapists that the purchase is appropriate and medically necessary to meet the member’s need. Medically necessary home modifications that cannot be obtained 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 provided at the provider’s managed service location 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. Agency Home Support is constant daily support that includes personal care, protective oversight, and supervision in accordance with the member’s Personal Plan, 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.
The Department is seeking and anticipates receiving CMS approval for this Section.
Pending approval, Covered Services will be provided as follows:

21.05 COVERED SERVICES (cont.)

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.

On Behalf Of is a component of Home Support and is included in the established authorization and is not a separate billable activity. The cost of transportation related to the provision of Home Support is a component of the rate paid for the service and is not separately billable.

21.05-12 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.

On Behalf Of is a component of Home Support and is included in the established authorization and is not a separate billable activity.
21.05 COVERED SERVICES (cont.)

An increased level of support may be available for members in Family Centered Support based on the documented needs of the member as reviewed and approved by the CRT. 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 21.10-5, DHHS is discontinuing Family-Centered Support.

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.

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.

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 Department is seeking and anticipates receiving CMS approval for this Section.
Pending approval, Covered Services will be provided as follows:

21.05 COVERED SERVICES (cont.)

The Remote Support provider has staff available 24 hours per day 7 days per week to deliver direct 1:1 support 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 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 Planning Team will ensure the appropriateness of the identified assistive technology.

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 that monitor 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.

21.05-15 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.
21.05 COVERED SERVICES (cont.)

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 a Licensed Occupational Therapist, (OT/L) for Occupational Therapy Maintenance or a Licensed Occupational Therapy Assistant (OTA/L) under the supervision of a Licensed Occupational Therapist.

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 three (3) members at once. When the service is provided to a group, the appropriate group rate must be billed.

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...
21.05 COVERED SERVICES (cont.)

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.

For this Service, respite is a component of the rate paid to the Administrative Oversight Agency and therefore is not a separate billable service. The record must accurately reflect the member’s location 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, as reviewed and approved by the CRT. When the member requires an increased level of staffing it must be documented in the member’s Personal Plan. See Appendix I for additional requirements.

21.05-21 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 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;
B. control switches/pneumatic switches and devices such as sip and puff controls, and adaptive switches or devices that increase the member’s ability to perform activities of daily living;
C. environmental control units such as locks, electronic control units and safety restraints; and
D. other devices necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment that are not otherwise covered for reimbursement in the MaineCare Benefits Manual.

21.05 COVERED SERVICES (cont.)

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.

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 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.
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.05 COVERED SERVICES (cont.)

No more than six (6) members at a time 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.

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.

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 $26,640.19 annually.

21.05-24 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.
The Department is seeking and anticipates receiving CMS approval for this Section.
Pending approval, Covered Services will be provided as follows:

21.05 COVERED SERVICES (cont.)

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.).

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.

On Behalf of is a component of Work Support-Individual and is included in the established authorization, and is not a separate billable activity. The maximum annual allowance is $26,640.19 annually.

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

21.06 NON-COVERED SERVICES

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

21.06.1 Duplicative Services A member receiving services under this Section 21, may not receive duplicative MaineCare services at the same time under any other sections of the MaineCare Benefits Manual, including: 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 Autism Spectrum 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.

21.06-2 Services not identified by the Personal Plan;

21.06-3 Services to any MaineCare member who receives services under any other federally approved MaineCare Home and Community based waiver program;
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.06 NON-COVERED SERVICES (cont.)

21.06-4 Services to any member who is a nursing facility resident, state psychiatric hospital or ICF/IID resident;

21.06-5 Services that are reimbursable under any other sections of the MaineCare Benefits Manual;

21.06-6 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;

21.06-7 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;

21.06-8 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;

21.06-9 Work Support-Individual, Work Support-Group or Employment Specialist Services when the member is not engaged in employment.

21.06-10 Specialized Medical Equipment and Supplies, Communication Aids, or Home Accessibility Adaptations unless the service has been determined non-reimbursable under Medical Supplies and Durable Equipment, Section 60 or other sections of the MaineCare Benefits Manual.

21.07 LIMITS

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

21.07-2 When 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 $26,640.19 annually.
21.07 LIMITS (cont.)

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

21.07-5 **Specialized Medical Equipment and Supplies** costing more than five hundred dollars ($500), the member must obtain documentation from a physician or other appropriate professional such as an OT, PT or Speech therapist assuring that the purchase is appropriate to meet the member’s need and is medically necessary.

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

21.07-6 **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) assuring that the purchase is appropriate to meet the member’s need and assures the medical necessity of the devices or services. Only communication aids that cannot be obtained as a covered service under other sections of the MaineCare Benefits Manual will be reimbursed under this Section.

21.07-7 **Consultation Services** are limited to those providers not already reimbursed for consultation as part of another service. Personnel who provide services under targeted case management may not be reimbursed for consultation services. Consultation is limited to sixteen and a half (16.5) hours annually, per type of consultation (Occupational Therapy, Physical Therapy, Speech, Behavioral and Psychological). Non-traditional communication is limited to sixty (60) hours annually.

21.07-8 **Crisis Intervention Services** that have not been included on the Personal Plan are limited to a period not to exceed two weeks and must be authorized by the DHHS 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.

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

21.07-10 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 an Occupational Therapist Assistant/Licensed (OTA/L) is limited to forty (40) quarter hour units per year. When a OTA/L is providing Occupational Therapy (Maintenance), it must be under the supervision of an OTR.

21.07-11 Enrollment in High School A member may not receive Community Support while enrolled in high school.

21.07-12 Place of Employment A member may not receive Community Support or Home Support at his or her place of employment.

21.07-13 Family-Centered Support Providers No additional Family-Centered Support providers will be approved and enrolled after 12/20/2007.

21.07-14 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 to continue holding the funded opening.

After six (6) continuous months in a nursing facility or hospital, if the member does not resume waiver services, the member will be terminated from the waiver.

21.07-15 Work Support-Individual services are limited to one DSP per member at a time.

21.07-16 Home Support- Agency Per Diem As of December 24, 2012, Home Support-Agency Per Diem placements will only be approved at provider operated homes where a minimum of two (2) members reside.

21.07-17 Home Support Quarter Hour may not exceed three hundred and thirty six (336) quarter hour units or eighty four (84) hours a week.

21.07-18 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).

21.07-19 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 is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.07 LIMITS (cont.)

21.07-20 **Assistive Technology Services** are not covered under this rule if they are available under another MaineCare rule.

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.

21.07-21 **Career Planning** is limited to sixty (60) hours to be delivered in a six-month period. No two six month periods may be provided consecutively.

21.07-22 **Counseling** is limited to sixteen and a quarter (16.25) hours annually.

21.07-23 **Employment Specialist Services** are provided on an intermittent basis with a maximum of ten hours each month.

21.07-24 **Home Support-Remote Support** is limited to forty-eight (48) units (12 hours) per day. This can be in addition to Home Support-Quarter Hour, as long as this is not duplicative.

21.08 DURATION OF CARE

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

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

A. The member is determined to be financially or medically ineligible for this benefit or MaineCare;
B. The member is determined to be a nursing facility resident, ICF/IID, psychiatric hospital, or hospital resident for six months;
C. The member is 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;
21.08 DURATION OF CARE (cont.)

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 waiver 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 DHHS.

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

21.09 MEMBER RECORDS

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

In addition, the member’s records must contain:

21.09-1 The member's name, address, birth date, MaineCare identification number, guardian contacts, if applicable, and emergency contacts;

21.09-2 The member’s social and medical history, including any allergies, 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.
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.09 MEMBER RECORDS (cont.)

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. 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 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.

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.

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. Any intervention must be consistent with the DHHS’s rule governing Behavioral Support, Modification and Management for people with intellectual disabilities or Autism (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.

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

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
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

from the Maine College of Direct Support within six (6) months of date of hire.

Prior to providing services to a member alone, a DSP must have completed the following four modules from the College of Direct Support, including computer based and live sessions:

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

Documentation of completion must be retained in the personnel record.

B. Completed the following Department-approved trainings, within the first six (6) months from date of hire and thereafter every thirty six (36) months;

C.

a. the Regulations Regarding Reportable Events, Adult Protective Investigations and Substantiation Hearings (14-197, Ch. 12)
b. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5)
c. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)
d. Grievance Training (must be completed before working with members).

D. Has a background check consistent with Section 21.10-10;
E. Has an adult protective and child protective record check;
F. Is at least eighteen (18) years of age;
G. Graduated from high school or acquired a GED;
H. Prior to administering medication, a DSP is legally authorized to assist with the administration of medication if the DSP is certified as a Certified Nursing Assistant-Medications (CNA-M); as a Certified Residential Medication Aide (CRMA), or 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.
I. 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.)

J. A DSP who also provides Career Planning must have completed the additional employment modules in the Maine College of Direct Support and an additional twelve (12) hours of Career Planning and Discovery training provided through Maine’s Workforce Development System and 6 hours continuing education annually.

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.

A DSP can supervise another DSP.

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. Certificate Requirements

1. Direct support staff must be a certified DSP and be certified as a Rehabilitation Engineering Technologist (RET) or;
2. Assistive Technology Professionally (ATP) from the Rehabilitation Engineering and Assistive Technology Society of North American (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 21.10-13; 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 twelve (12) hours of Career Planning and Discovery provided through Maine’s Workforce Development System and six (6) hours of Department approved continued education every twelve (12) months.

21.10-5 Phase-Out of Family-Centered Support

DHHS is discontinuing the Family-Centered Support service. If a bed becomes vacant in a Family-Centered Support home, that vacancy may be filled.
21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

Existing Family-Centered Support providers must meet all the requirements of a Direct Support Professional as set forth in these rules.

Effective with this rule, 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. DHHS will not authorize Family-Centered Support services under a new license.

21.10-6 Residential Vacancies in Two-Person Homes

A. On the next business day, from the time of vacancy, the provider shall provide notice of the vacancy to the responsible Resource Coordinator in the OADS and the case managers for both the departing and remaining members.

B. No later than three (3) 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 (30) 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 (30) discharge notice to the hospitalized member, his or her guardian, and 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 DHHS within five (5) business days of the vacancy (or, where the 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 DHHS 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
21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

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 (30) 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 (30) calendar days from the mailing of the ninety-Day Letter, the provider shall issue a thirty-day (30) discharge notice to the member, his or her guardian, where applicable, and DHHS. The provider shall cooperate with the member’s planning team in developing a transition plan for the member to move to other housing, whether permanent or interim, within thirty (30) days.

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

21.10-7 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 and supervision. The Shared Living Home Provider is required to:

A. Attend to the member’s physical health and emotional well-being.
B. Participate as a part of the member’s Person-Centered Planning Team and maintain open communication with the Case Manager, Administrative Oversight Agency, guardian and Person-Centered Planning Team.
C. Assist in transition, admission, or discharge plans.
D. Include the member in family and community life, assisting the member to develop healthy relationships and increased community independence.
E. Provide community access to services and activities desired by the member but not limited to; religious affiliation (if desired), physical activities, shopping, volunteering, etc.
F. Maintain professional daily documentation in accordance with MaineCare requirements.
G. Maintain daily documentation of all medication administered to the member or by self-administration.
H. Report any unusual incidents to the member’s team (Case Manager, Administrative Oversight Agency and guardian) and, when required, through the Reportable Events Reporting System.
I. Reports to the member’s team all changes in household members or legal status of household members.
21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

J. Maintain current homeowner’s or renter’s insurance at all times.
K. Provide the transportation to appointments and activities.
L. Maintain a valid Maine driver’s license and a properly registered, inspected, insured and maintained vehicle.
M. Enter into a contract for professional support with the Administrative Oversight Agency.

21.10-8 Background Check Criteria

The provider must conduct background checks every two (2) years on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who maybe providing direct support services under this Section. A background check is required for any adult who may be providing direct or indirect services where the member receives Shared Living or Family-Centered Support. Background checks are required for any adult residing in a Family-Centered or Shared Living Home. Background checks on persons professionally licensed by the State of Maine will include a confirmation that the licensee is in good standing with the appropriate licensing board or entity. The provider shall not hire or retain in any capacity any person who may directly provide services to a member under this Section if that person has a record of:

A. any criminal conviction that involves abuse, neglect or exploitation;
B. any criminal conviction in connection to intentional or knowing conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person;
C. any criminal conviction resulting from a sexual act, contact, touching or solicitation in connection to any victim; or
D. any other criminal conviction, classified as Class A, B or C or the equivalent of any of these, or any reckless conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person within the preceding two (2) years or;
E. a habitual offender status under 29-A, M.R.S. § 2551-A.

The provider shall contact child and adult protective services (including OADS and the Office of Child and Family 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. Within sixty (60) days of the effective date of this rule, all staff and all adults residing with a member
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

must have all background checks completed. All background checks must be completed every twenty-four (24) months thereafter. Costs for background checks are the provider’s responsibility.

21.10-9 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.

21.10-10 Informed Consent Policy

Providers must put in place and implement an informed consent policy approved by the DHHS. For the purposes of this requirement, informed consent means consent obtained in writing from a person or the person's legally authorized representative for a specific treatment, intervention or service, following disclosure of information adequate to assist the person in making the consent. Such information may include the diagnosis, the nature and purpose of the procedure(s) or service(s) for which consent is sought, all material risks and consequences of the procedure(s) or service(s), an assessment of the likelihood that the procedure(s) or service(s) will accomplish the desired objective(s), any reasonably feasible alternatives for treatment, with the same supporting information as is required regarding the proposed procedure(s) or service(s), and the prognosis if no treatment is provided. At a minimum, a provider’s informed consent policy 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.

21.10-11 Reportable Events & Behavioral Treatment

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 Spectrum Disorder 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 six (6) months of being hired and every thirty-six (36) months thereafter. All staff must receive the following Department sponsored training on the following regulations:

a. Regulations Regarding Reportable Events, Adult Protective Investigations and Substantiation Hearings Regarding Persons with Intellectual Disability or Autism (14-197, Ch. 12)
21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS (cont.)

b. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197, Ch. 5)
c. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (Title 34-B §5605)

Completion of trainings must occur before staff begin work with members or within six (6) months of the date of hire and every thirty-six (36) months thereafter. All staff, regardless of length of employment must have documentation of training completion in their personnel file.

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.
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

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. Increased level of support is not to be used for respite or in substitute for the Shared Living Provider. It is to be used in addition to the Shared Living Provider to ensure the member’s safety. 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. The Clinical Review Team (CRT) reviews all increased level of support requests. The CRT will use the following criteria to determine when this increased level of reimbursement to support the additional staff is utilized.

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

1) **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 offenses, 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, less than three months old, from a Physician, Physician Assistant, 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;
4) The anticipated frequency of the increased support on a daily, weekly, or monthly basis and
The Department is seeking and anticipates receiving CMS approval for this Section.
Pending approval, Covered Services will be provided as follows:

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

5) Whether the setting where the member is served is appropriate to carry out the physician’s recommended treatment or intervention.

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.

The CRT will review the information submitted with the request, the personal plan, information in the electronic records, such as reportable events, crisis notes and case management notes as well as any applicable assessments or evaluations of the member. Increased support that is anticipated to be needed for an extended or indefinite period of time must be reviewed and approved at least annually by the clinical review team.

The CRT 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 by the CRT. Upon receipt of the additional information, the CRT will approve or deny the request in writing within ten (10) working days.
The purpose of this Appendix is to detail guidelines for the Office of Aging and Disability Services 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 DHHS’ established published rate for Home Support, Community Support, Employment Specialist Services and Work Support Services-Individual.

The Clinical Review Team (CRT) is the entity within OADS that is responsible for review and approval, of all Medical Add-On rate increases for services under this section.

The rate supports members with intermittent or longer duration medical conditions; changes or needs that may support Medical Add-On include but are not limited to: 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. Conditions related to surgeries, procedures, injuries and other short term conditions are also considered for the Medical Add-On rate increase.

The following standards and practices must be demonstrated in order for the CRT to approve a Medical Add-On:

A. Physician Order

1. There must be a written physician’s or physician assistant order, less than three (3) months old, 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:
      I. The approximate length of time required for each episode of the treatment or intervention and
      II. 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.
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

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

B. Planning Team

1. The team must meet or otherwise confer for the following purposes:
   a. To review and complete the request for Medical Add-On and any additional documentation required for submission to the CRT.
   b. To determine whether the setting where the member is served is appropriate to carry out the physician or physician assistant’s recommended treatment or intervention;
   c. 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.

C. Provider Requirements

1. The provider must be an enrolled MaineCare provider.
2. For any physician or physician assistant 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 CRT will review the information submitted with the request, the Personal Plan, information in the electronic record, such as reportable events, crisis notes, as well as any applicable assessments or evaluations in the member’s record.
2. The CRT 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 the CRT will approve or deny the request within ten (10) working days.

3. Approvals will include a specification of the duration of the Medical Add-On, as well as authorized daily or weekly units of service which require the Medical Add-On.
4. Treatments or interventions that are anticipated to be needed for an extended or indefinite period of time must be reviewed annually or more frequently as determined necessary by the CRT. Verification of this continued need must be provided to the CRT within a year of the original approval, in order for the Medical Add-On to continue.
21.16 APPENDIX III- On Behalf of Covered Activities

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

Examples of acceptable activities include:

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

Services, activities and time that are directly related to a member that are associated with that member’s Personal Plan, medical plan or behavioral plan including in-service training specific to a member’s plan of support, consultations with supervisors, therapist, clinicians, member’s employer and or medical staff; activities relating to a member’s parent, guardian or Maine Developmental Services Oversight and Advisory Board (MDSOAB) 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 his or her parents, guardian, or friends home for visits, returning a member to his or her 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 Department is seeking and anticipates receiving CMS approval for this Section.
Pending approval, Covered Services will be provided as follows:

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.
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

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 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 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 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.


The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.18 APPENDIX V- Additional Requirements for Section 21 Providers of Home Support Services, Shared Living, 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) shall be subjected 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. The 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 associations or similar bodies are appropriately qualified, certified, and/or licensed.
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

21.18 APPENDIX V- Additional Requirements for Section 21 Providers of Home Support Services, Shared Living, 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. 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 organizational chart, 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 as 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 be 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 personnel policies that include a description of the education, experience, and training required for Direct Support Professionals, Supervisors, and Program Directors.

      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, and 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 is not limited to the following:

1. Person Centered Planning Process as outlined in 42 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 Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine, (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.

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’ rule governing Behavioral Support, Modification and Management for people with intellectual disabilities or Autism. (14-197 CMR Ch. 12, Regulations Regarding Reportable Events, Adult Protective Investigations and 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
The Department is seeking and anticipates receiving CMS approval for this Section.
Pending approval, Covered Services will be provided as follows:

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

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 Events, Rights and Basic Protections and Reporting of Abuse, Neglect and Exploitation.

v. Duration of Care. The provider shall maintain policies that outline the 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. The provider shall have 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 program 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 ongoing, year-round, regular activities to measure goal achievement.
d. include a component describing the system to monitor compliance with federal and state laws and regulation

i. Evaluation. The findings of the quality management process shall be reviewed at least annually by the provider.

ii. Plan of Correction. A 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.

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.
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

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

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 insure and maintain a record of all homes in which home support services are provided and have adequate homeowner/rental liability insurance and all 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. The provider shall ensure that:

      i. furnishings and equipment are appropriate to the member’s age and physical conditions,
      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) are 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 that shall provide secure space used for the proper storage of potentially harmful materials (i.e. chemicals, medications, and firearms).

d. 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:
The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, Covered Services will be provided as follows:

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

i. be one of choice and based on the needs of the individual as indicated in the member’s Personal Plan;
ii. ensure a member’s rights of privacy, dignity and respect and freedom from coercion and restraint;
iii. support opportunities to promote competitive, integrated employment,
iv. support opportunities to seek employment in competitive integrated settings, engage in community life, control personal resources and optimize autonomy; and support their choice in activities and schedules, facilitate choice of services and providers, and access to services in the community.

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 sanctions or penalties allowed under the MaineCare Benefits Manual or other state or federal law.