



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-2674; Fax: (207) 287-2675
TTY Users: Dial 711 (Maine Relay)

DATE: October 27, 2015
TO: Interested Parties
FROM: Stefanie Nadeau, Director, MaineCare Services
SUBJECT: Emergency Rule: MaineCare Benefits Manual, Chapter's II & III, Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities

This letter gives notice of an emergency rule: MaineCare Benefits Manual, Chapters II & III, Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities.

Effective July 1, 2015, the state's biennial budget, Public Law 2015, Chapter 267 (702 – L.D. 109), increased the reimbursement rate for providers of Attendant Care Services and Personal Care Services in the MaineCare Benefits Manual, Chapter III Section 19, Home and Community Based Benefits for the Elderly and for Adults with Disabilities. In Chapter III, Section 19 the Department also proposed to increase – in Chapter II, Section 19, the monthly limits for members' Section 19 services from \$4,200/month to \$4,603/month. The Maine State Legislature approved of these increases when it enacted the budget. On June 30, 2015, the Legislature voted to override the Governor's veto of the budget, which became effective on July 1, 2015.

Section 19 services are governed by a Section 1915(c) waiver approved by the Centers for Medicare and Medicaid Services (CMS). Pursuant to 5 M.R.S.A. §8054, the Department makes these reimbursement changes in Section 19 through emergency rule making. Pursuant to PART UU Sec. UU-1 of the budget, the Legislature provided that the Department need not demonstrate emergency findings in support of this emergency rulemaking.

In Chapter III, Section 19, these emergency rule changes allow MaineCare to increase:(1) Attendant Care Services (Personal Care Services, Participant Directed Option), billing code S5125, from \$2.93 per quarter hour to \$3.21 per quarter hour; and (2) Personal Care Services (Agency PSS), billing code T1019 from \$3.75 per quarter hour to \$4.10 per quarter hour.

Because the Department is increasing reimbursement for services in Chapter III of Section 19, it also seeks to increase the monthly program cap for MaineCare members, so that they are not adversely affected by the reimbursement changes. As such, these emergency rule changes in Chapter II Section 19 increase the limitation in Sec. 19.06(A) from \$4,200 per member per month to \$4,603 per member per month.

Given that the budget was effective July 1, 2015, the Department seeks to make these changes retroactive to July 1, 2015. The Department has authority for the retroactive effective date under 22 M.R.S.A. §42(8), because these changes increase reimbursement for providers, ensure that members have access to medically necessary covered services, and otherwise have no adverse impact on either MaineCare providers or members.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare Services website at <http://www.maine.gov/dhhs/oms/rules/index.shtml> or for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

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

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 Chapter 101, MaineCare Benefits Manual, Emergency Rule, Chapters II & III, Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities

ADOPTED RULE NUMBER:

CONCISE SUMMARY: Effective July 1, 2015, the state's biennial budget, Public Law 2015, Chapter 267 (702 – L.D. 109), increased the reimbursement rate for providers of Attendant Care Services and Personal Care Services in the MaineCare Benefits Manual, Chapter III Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities. The Department also proposed to increase – in Chapter II, Section 19, the monthly limits for members' Section 19 services from \$4,200/month to \$4,603/month.

Section 19 services are governed by a Section 1915(c) waiver approved by the Centers for Medicare and Medicaid Services (CMS). Pursuant to 5 M.R.S.A. §8054, the Department makes these reimbursement changes in Section 19 through emergency rule making. Pursuant to PART UU Sec. UU-1 of the budget, the Legislature provided that the Department need not demonstrate emergency findings in support of this emergency rulemaking.

In Chapter III, Section 19, these emergency rule changes allow MaineCare to increase: (1) Attendant Care Services (Personal Care Services, Participant Directed Option), billing code S5125, from \$2.93 per quarter hour to \$3.21 per quarter hour; and (2) Personal Care Services (Agency PSS), billing code T1019 from \$3.75 per quarter hour to \$4.10 per quarter hour.

Because the Department is increasing reimbursement for services in Chapter III of Section 19, it also seeks to increase the monthly program cap for MaineCare members, so that they are not adversely affected by the reimbursement changes. As such, these emergency rule changes in Chapter II, Section 19 increase the limitation in Sec. 19.06(A) from \$4,200 per member, per month to \$4,603 per member, per month.

Given that the budget was effective July 1, 2015, the Department seeks to make these changes retroactive to July 1, 2015. The Department has authority for the retroactive effective date under 22 M.R.S.A. §42(8), because these changes increase reimbursement for providers, ensure that members have access to medically necessary covered services, and otherwise have no adverse impact on either MaineCare providers or members.

[HTTP://WWW.MAINE.GOV/DHHS/OMS/RULES/INDEX.SHTML](http://www.maine.gov/dhhs/oms/rules/index.shtml) for rules and related rulemaking documents.

EFFECTIVE DATE: July 1, 2015

AGENCY CONTACT PERSON: Andrew Hardy, Comprehensive Health Planner
AGENCY NAME: MaineCare Services, Division of Policy
ADDRESS: 242 State Street, 11 State House Station
Augusta, Maine 04333-0011
andrew.hardy@maine.gov

TELEPHONE: (207)-624-4058 FAX: (207) 287-1864
TTY users call Maine relay 711

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Home and Community Benefits for the Elderly and for Adults with Disabilities (HCB) are in-home care and other services, designed as a package, to assist eligible Members to remain in their homes, or other residential community settings, and thereby avoid or delay institutional nursing facility care. Medical eligibility for these HCB services is established by a medical eligibility determination (MED) assessment, which is conducted by the Department, or its Authorized Entity, the Assessing Services Agency (ASA). All services covered under this Section require prior approval by the Department, or the ASA, and shall be delivered according to the Member's Authorized Plan of Care. Services include: Care Coordination, Adult Day Health, Assistive Technology, Attendant Services, Home Health Services, Financial Management Services, Personal Care Services, Personal Emergency Response Systems, Respite Care, Transportation services, and Environmental Modifications. These services are provided in accordance with Title XIX, §1915(c) of the *Social Security Act* (42 U.S.C. §1396n(c)). Transportation services are provided under a section 1915(c) waiver and also under and in conjunction with a section 1915(b) waiver.

19.01 DEFINITIONS

- 19.01-1 **Activities of Daily Living** (ADLs) are basic activities of self-care performed by individuals on a daily or frequent basis necessary for independent living and may include activities such as: bed mobility, transfer, locomotion, eating, toilet use, bathing, and dressing. The specific ADL requirements for eligibility and covered services are set forth elsewhere in this section.

- 19.01-2 **Acute/Emergency Episode** is the unforeseen occurrence of an acute health episode that requires a change in the Member's Authorized Plan of Care, or the unforeseen circumstance where the availability of the Member's caregiver or informal support system is compromised.

- 19.01-3 **Adult Day Health Services** are health and social services provided to promote the optimal functioning of the Member. Services are delivered according to an individual plan of care at an adult day health site which has in effect a current license pursuant to the Department's "Regulations Governing the Licensing and Functioning of Adult Day Services Programs."

- 19.01-4 **Adult Family Care Home** (AFCH) is a residential style home which has in effect a current license from the Division of Licensing and Regulatory Services in accordance with Section 2 of the *MaineCare Benefits Manual*. Adult family care services are personal care services.

- 19.01-5 **Assessing Services Agency (ASA)** is an Authorized Entity providing services to the Department for medical eligibility determinations, plan of care development and prior authorization of covered services under this Section. The ASA conducts face-to-face assessments, using the Department's Medical Eligibility Determination (MED) form. A Member's medical eligibility is based upon a Member's assessment outcome. If medical eligibility is determined for this Section, the ASA develops the plan of care and specifies all services to be provided under this Section, including type of services and number of hours for all provider types.

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19.01 DEFINITIONS (cont.)

- 19.01-6 **Assistive Technology** means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of Members to perform Activities of Daily Living or Instrumental Activities of Daily Living. Assistive Technology service means a service that directly assists a Member in the selection, acquisition, or use of an Assistive Technology device.
- 19.01-7 **Assistive Technology-Remote Monitoring** means real time remote support monitoring of the participant with electronic devices to assist them to remain safely in their homes. Remote monitoring services may include a range of technological options including in-home computers, sensors, and video camera linked to a provider that enables 24/7 monitoring and/or contact as necessary.
- 19.01-8 **Assistive Technology –Transmission** means transmission of data for use of the Assistive Technology device via internet or cable utility that supports remote monitoring.
- 19.01-9 **Attendant** is an individual who meets the qualifications required in Section 19.08-4(B)(5). The Attendant provides services as authorized in the plan of care to a Member utilizing the Participant Directed Option.
- 19.01-10 **Attendant Services** means assistance with covered ADL and IADL tasks, including Health Maintenance Activities, that are delivered by an Attendant in accordance with an Authorized Plan of Care under the Participant Directed Option.
- 19.01-11 **Authorized Entity** is an independent entity providing services to the Department to perform specified functions under a valid contract or other approved signed agreement.
- 19.01-12 **Authorized Plan of Care** is a plan of care which is authorized by the Assessing Services Agency, or the Department, and which specifies all services to be delivered to a Member under this Section, including the number of hours for each covered service, and the provider type to deliver each service. The Authorized Plan of Care shall be based upon the Member's assessment outcome scores recorded in the Department's MED form, utilizing the time frames contained therein, and the professional clinical judgment of the assessor. The Authorized Plan of Care shall reflect the needs identified by the assessment, taking into account the Member's living arrangement, informal caregiving supports provided by family and friends, and services provided by other public and private funding sources. MaineCare shall not cover any service under this benefit that duplicates another service, regardless of payor or provider, including services such as Medicare and MaineCare hospice services, Private Non-Medical Institution (PNMI) services, and assisted housing services (see 22 MRSA §7852). All authorized, covered services provided under this Section must be listed in the Care Plan Summary on the MED form.

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19.01 DEFINITIONS (cont.)

- 19.01-13 **Back Up Plan** is a part of the service plan that addresses contingencies such as emergencies, including the failure of a worker to appear as scheduled, when the absence of the service presents a risk to the Member's health and welfare.
- 19.01-14 **Care Coordination Services** are those covered services provided by a care coordinator who is employed, or contracted, by a Service Coordination Agency to help the Member access the services in the plan of care as authorized by the Department or its Authorized Entity. The purpose of Care Coordination Services is to assist Members in receiving appropriate, effective and efficient services, which allow them to retain or achieve the maximum amount of independence possible and desired. Care Coordination Services are designed to assist the Member with identifying immediate and long-term needs, and ensure that the Member is offered choices in service delivery based on his/her needs, preferences, and goals. These services assist with locating service providers, overseeing the appropriateness of the plan of care by regularly obtaining Member feedback, and monitoring the Member's health status. Care Coordination Services are provided to Members who utilize the Participant Directed Option as well as Members receiving services through Direct Care Providers.
- 19.01-15 **Care Plan Summary** is a section of the MED form that describes all medical and other services, regardless of funding source, to be provided to the Member, the frequency, and the type of provider who delivers each service. The Care Plan Summary shall include, but is not limited to, the HCB authorized by the Department or the ASA.
- 19.01-16 **Choice Letter** is a document signed by the Member or legal agent of the Member indicating the Member's decision to select either home and community benefits or institutional services.
- 19.01-17 **Cost of Care** is the monthly dollar amount a Member is responsible for paying to the State each month toward the cost of the Member's HCB services, as determined by the Office for Family Independence, Department of Health and Human Services.
- 19.01-18 **Cueing** is any spoken instruction or physical guidance that serves as a signal to do something. Cueing is typically used when caring for Members who are cognitively impaired.
- 19.01-19 **Direct Care Provider** is a MaineCare provider that directly provides Adult Day, Personal Care, Home Health or in-home Respite services under this Section.

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19.01 DEFINITIONS (cont.)

- 19.01-20 **Environmental Modifications** are in-home physical modifications to the Member's residence, authorized in the Member's plan of care, which are necessary to ensure the health and welfare of the Member, or which enable the Member to function with greater independence in the home, and are not covered or available under any other funding source. Modifications include, but are not limited to: ramps, lifts, modifications to bathrooms and kitchens, and specialized modifications such as door widening. This does not include major re-modeling or construction. The Department does not cover modification of motor vehicles.
- 19.01-21 **Extensive Assistance** means although the individual performed part of the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:
- Weight-bearing support three (3) or more times, or
 - Full staff performance of activity (three (3) or more times) during part (but not all) of the last seven (7) days.
- 19.01-22 **Financial Management Services (FMS)** provide administrative and payroll services for Members utilizing the Participant Directed Option. FMS services include, but are not limited to, preparing payroll and withholding taxes, making payments to suppliers of goods and services, and assisting with compliance with State and Federal tax and labor regulations and the requirements under this Section. The FMS acts as an agent of the employer in accordance with Federal Internal Revenue Service Codes and Procedures.
- 19.01-23 **Health and Welfare Tool** is an evaluation completed by the Service Coordination Agency to assess risks and unmet needs of Members as required by the Department.
- 19.01-24 **Health Maintenance Activities** are activities to assist the Member with Activities of Daily Living and Instrumental Activities of Daily Living, and additional activities specified in this definition. These activities are performed by a designated caregiver for an individual who would otherwise perform the activities if he or she were physically or cognitively able to do so, and enable the Member to live in his or her home and community. These additional activities include, but are not limited to catheterization, ostomy care, preparation of food and tube feedings, bowel treatments, administration of medications, care of skin with damaged integrity, and occupational and physical therapy activities such as assistance with prescribed exercise regimes.
- 19.01-25 **Home Health Services** are nursing services, physical therapy, occupational therapy, speech therapy, home health aide (HHA) services, and medical social services, delivered at the Member's place of residence, under physician orders and authorized by the ASA.

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19.01 DEFINITIONS (cont.)

- 19.01-26 **Instrumental Activities of Daily Living (IADL)** are tasks necessary for maintaining a person's immediate environment, such as preparing and serving meals, washing dishes, dusting, making bed, pick-up living space, sweeping, vacuuming and washing floors, cleaning toilet, tub and sink, appliance care, changing linens, refuse removal, shopping for groceries and prepared foods, storage of purchased groceries, and laundry, either within the residence or at an outside laundry facility. The specific IADL requirements for eligibility and covered services are set forth elsewhere in this Section.
- 19.01-27 **Limited Assistance** is a term used to describe an individual's self-care performance in Activities of Daily Living, as defined by the Minimum Data Set (MDS) assessment process. It means that although the individual was highly involved in the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:
- physical help in guided maneuvering of limbs or other non-weight-bearing assistance three (3) or more times, or
 - Limited Assistance three (3) or more times, plus more help with weight-bearing support provided only one (1) or two (2) times.
- 19.01-28 **MeCare** is a computerized long-term care medical eligibility system facilitating the entire medical assessment process, from intake through information dissemination.
- 19.01-29 **Medical Eligibility Determination (MED) Form** is the Department's approved form for determining a Member's medical eligibility for services under this Section. The MED form's definitions, scoring mechanisms and time frames provide the basis for including services in the Authorized Plan of Care. The Department, or the ASA, shall conduct the MED assessment on a face-to-face basis. Based upon the Member's outcome scores, an Authorized Plan of Care is then developed, which specifies the services, numbers of hours, and provider types. The Care Plan Summary section of the MED form documents the Authorized Plan of Care, and identifies any other non-HCB services the Member may be receiving, regardless of payor.
- 19.01-30 **Member** is an individual who meets the eligibility requirements of this Section and is authorized to receive services. For purposes of making health care decisions, a Member may be represented by his or her "guardian," "agent" or "surrogate," as these terms are defined in 18-A MRS Sec. 5-801.
- 19.01-31 **Nursing Facility Services** are described in Chapter II, Section 67, "Nursing Facility Services", of this Manual. They primarily include professional nursing care or rehabilitative services for individuals who are injured, disabled, or sick which are needed on a daily basis and, as a practical matter, can only be provided in a nursing facility, ordered by and provided under the direction of a physician, and less intensive than hospital inpatient services.

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19.01 DEFINITIONS (cont.)

- 19.01-32 **One-person Physical Assist** requires one (1) person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting. This does not include Cueing.
- 19.01-33 **Participant Directed Option** means a service provision option that allows a Member or a Member's Representative to manage Attendant Services. Specifically, the Member or the Member's Representative hires, discharges, trains, schedules and supervises the Attendant(s) providing services to the Member and directs the provision of those Attendant Services. If the Member is directing his or her own services, the Member's ability to self-direct must be documented on the MED Form as defined in this Section.
- 19.01-34 **Participant Directed Rate** means the reimbursement for Attendant Services under the Participant Directed Option which consists of two components: the Attendant provider wage and the employer expense component:
- (1) Attendant portion of the rate that is designated as the Attendant's gross hourly wage for authorized care provided;
 - (2) Participant Directed Option expense component that is the portion of the participant directed provider rate for any mandated employer's share of social security, federal and state unemployment taxes, Medicare, and worker's compensation insurance premiums.
- 19.01-35 **Personal Emergency Response System (PERS)** is an electronic device that enables certain high-risk Members to secure help in the event of an emergency. The Member may also wear a portable "help" button to allow for mobility. The system is connected to a Member's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.
- 19.01-36 **Personal Care Services**, are those covered ADLs, IADLs and Health Maintenance Activities provided in a Member's residence by an individual employed by an agency qualified to work as a home health aide, certified nursing assistant (CNA) or Personal Support Specialist, as appropriate, in accordance with an Authorized Plan of Care.
- 19.01-37 **Personal Support Specialist (PSS)**, also known as personal care assistant, is a person who provides Personal Care Services and has completed a Department approved training course of at least fifty (50) hours, unless otherwise exempt under this Section, which includes, but is not limited to, instruction in basic personal support procedures, first aid, handling of emergencies, and review of the mandatory reporting requirement under the *Adult Protective Services Act*. PSSs are unlicensed assistive personnel as defined in Title 22 MRSA §1717(1)(D).

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19.01 DEFINITIONS (cont.)

- 19.01-38 **Representative** means an individual responsible for managing Attendant Services on behalf of a Member using the Participant Directed Option. The Representative must meet the qualifications and requirements as described in Section 19.08-4(B)(7).
- 19.01-39 **Respite Care** is provided to a Member who is unable to care for him or herself, and who requires care on a short-term basis due to the temporary absence of, or to provide relief for, the caregiver who normally provides the care.
- 19.01-40 **Risk Assessment** is an evaluation to assess potential risks to Members and the development of strategies to mitigate such risks that are integral to enabling Members to live in the community while ensuring their health and welfare.
- 19.01-41 **Service Coordination Agency** (SCA) is an organization that has the statewide capacity to provide Care Coordination and Skills Training to eligible Members under this Section, and has met the MaineCare provider enrollment requirements of the Department. In addition to Care Coordination and Skills Training, the Service Coordination Agency is responsible for administrative functions, including but not limited to, maintaining Member records, submitting claims, conducting internal utilization and quality assurance activities, and meeting the reporting requirements of the Department. The Service Coordination Agency shall refer to the Department's contracted Waiver Service Provider when a Member is determined eligible for any of the following services: Assistive Technology (including devices, remote monitoring and transmissions), PERS, Environmental Modifications and Respite Care delivered in an institution. In order to prevent a potential conflict of interest, the Service Coordination Agency providing Care Coordination Services to a Member may not be a provider of direct care services.
- 19.01-42 **Service Order** means the document used by the Service Coordination Agency to engage and provide information to the Direct Care Provider specifying the tasks authorized by the Assessing Services Agency on the Care Plan Summary of the MED form. The Service Order is provided by the Service Coordination Agency to the Direct Care Provider and includes information on type, amount and frequency of services to be provided.
- 19.01-43 **Signature** of the Registered Nurse (RN) assessor from the Assessing Services Agency and the care coordinator from the Service Coordination Agency equates with the "login" onto the MeCare eligibility determination computer system.
- 19.01-44 **Significant Service Change** is defined as a major change in the Member's status that is not self-limiting, impacts on more than one (1) area of his or her health status, and requires multidisciplinary review or revision of the Authorized Plan of Care and is expected to result in a change in eligibility outcome or a change to the Member's current service plan.

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19.01 DEFINITIONS (cont.)

- 19.01-45 **Skills Training** is a service that provides Members and Representatives with the information and skills necessary to carry out their responsibilities when choosing to participate in the Participant Directed Option. This is a required service for Members utilizing the Participant Directed Option.
- 19.01-46 **Total Dependence** means full staff performance of the activity during the entire last seven (7) day period, i.e., complete non-participation by the Member in all aspects of the ADLs.
- 19.01-47 **Transportation** are those services needed to provide the Member access to Adult Day Health Services and any other waiver services covered and authorized under this Section.
- 19.01-48 **Unstable Medical Condition** exists when the Member's condition is fluctuating in an irregular way and/or is deteriorating and affects the Member's ability to function independently. The fluctuations are to such a degree that medical treatment and professional nursing observation, assessment and management at least once every eight (8) hours is required. An Unstable Medical Condition requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record. Not included in this definition is the loss of function resulting from a temporary disability from which full recovery is expected.
- 19.01-49 **Waiver Services Provider** is an agency that holds a contract with the Department's Office of Aging and Disability Services. This provider is responsible for coordinating the following services that have been authorized as part of the plan of care: Assistive Technology (including devices, remote monitoring and transmissions), PERS, Environmental Modifications and Respite Care delivered in an institution. This provider enters into agreements with subcontractors and ensures that these services are delivered according to the Authorized Plan of Care; oversees and assures compliance with policy requirements, and conducts required internal and external utilization review activities with regard to these services. This provider is responsible to bill the Department and reimburse the subcontractors for delivering these services.

19.02 ELIGIBILITY FOR CARE

19.02-1 **General and specific requirements**

To be eligible for services under this section, a Member must be eighteen (18) years or older and meet the general MaineCare eligibility requirements found in Chapter 332, *MaineCare Eligibility Manual*, medical requirements, and other specific requirements for Home and Community Benefits for the Elderly and Adults with Disabilities.

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19.02 ELIGIBILITY FOR CARE (cont.)

Even if a Member meets all criteria for eligibility for services under this section, the provision of these services is subject to available funding for this program, individual cost limitations as set forth in this Section and aggregate cost neutrality assurances required by 42 CFR §441.302. Some Members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the Service Coordination Agency to verify a Member's eligibility for MaineCare, as described in Chapter I, prior to coordinating the provision of services authorized by the ASA.

19.02-2 Medical requirements

A person meets the medical eligibility requirements for this Section if he or she meets the medical eligibility requirements specified in Chapter II, Section 67.02, Nursing Facility Services, of this Manual. The Department, or its Assessing Services Agency, using the Medical Eligibility Determination Form must complete a face-to-face assessment. The clinical judgment of the ASA shall be determinative of the scores given on the MED assessment.

19.02-3 Other specific requirements

A Member meets the requirements of this Section when all of the additional following conditions are met:

- A. The projected cost of services under this Section needed by the Member on a monthly basis must be established within the limits set forth in Section 19.06; and
- B. A Member or applicant who meets the eligibility criteria for nursing facility level of care has been informed of, and offered the choice of available, appropriate and cost effective, home and community benefits; and
- C. The Member selected home and community benefits as documented by a signed Choice Letter; and
- D. The health and welfare of the applicant/Member would not be endangered receiving services at home or in the community; and
- E. The particular services needed by the Member are available in the geographic area and a willing provider is available; and
- F. The Member must make themselves available for any eligibility assessment and participate to the extent needed for the assessment to be completed; and

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19.02 ELIGIBILITY FOR CARE (cont.)

- G. The Member must have a permanent or chronic disability or functional impairment which interfere with his/her own capacity to provide self-care and daily living skills without assistance as verified by the Member's physician; and
- H. Members will be accepted into the program on a first-come, first-served basis, based upon the availability of funding. The wait list will be maintained by the Office of Aging and Disability Services. A portion of the Member capacity of this Section is reserved for Members eligible and participating in Maine's Money Follows the Person (Homeward Bound) program as approved by Centers for Medicare and Medicaid Services.

19.02-4 **Additional requirements for accessing the Participant Directed Option:**

For a Member to direct his or her own services under the Participant Directed Option without the use of a Representative, the Member must have cognitive capacity, as assessed on the MED form, to be able to self-direct his or her Attendant(s). The ASA will assess cognitive capacity as part of each Member's eligibility determination using the MED findings. Minimum MED form scores are:

- a) decision making skills; a score of 0 or 1;
- b) making self-understood: score of 0, 1 or 2;
- c) ability to understand others: score of 0, 1 or 2;
- d) self-performance of managing finances; a score of 0, 1, or 2; and
- e) support for managing finances: a score of 0, 1, 2 or 3.

A Member not meeting the specific scores detailed above during his or her eligibility determination will be presumed not able to self-direct without the use of a Representative under this Section.

19.03 DURATION OF CARE

Each Member receiving services under this Section is eligible for as many covered services as are authorized in the Member's plan of care by the Department or the ASA. Services are authorized to meet the needs identified in the Member's most recent assessment, based on the outcome scores, time frames and definitions of the MED form, and subject to the limits specified elsewhere in this Section.

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19.03 DURATION OF CARE (cont.)

MaineCare coverage of services under this Section requires prior approval from the Department, or its Assessing Services Agency. Beginning and end dates of a Member's medical eligibility period correspond to the beginning and end dates for MaineCare coverage of the services in the Authorized Plan of Care. The Department reserves the right to request additional information to evaluate medical necessity. Coverage will be denied if the services provided are not included in the Authorized Plan of Care, except as allowed for an acute/emergency episode as described in Section 19.04-5(A)(13).

- 19.03-1 HCB shall be reduced, denied, suspended or terminated by the Assessing Services Agency, Service Coordination Agency or the Department, as appropriate, if any of the following situations occur:
- A. The Member does not meet the eligibility requirements of Section 19.02;
 - B. The Member declines personal care, Attendant or nursing services;
 - C. A plan of care to maintain or delay significant deterioration in the health and welfare of the Member at home, or in the community, can no longer be developed and implemented;
 - D. The Member receives services under Chapter II, Section 96, Private Duty Nursing and Personal Support Services; Chapter II, Section 12, Personal Care Attendant Services; Chapter II, Section 22, Home and Community Benefits for Adults with Physical Disabilities; or Section 40, Home Health Services. Only care management services may be provided under this Section to a Member who receives services under Chapter II, Section 96, Private Duty Nursing and Personal Support Services, or Section 40, Home Health Services, until home and community benefits are in place for the Member and a transition can be made;
 - E. The Member does not meet the medical eligibility criteria for nursing facility level services as set forth in Chapter II, Section 67.02 of this Manual, as determined by the Assessing Services Agency;
 - F. The Member is accessing another waiver pursuant to Title XIX, §1915 (c) of the *Social Security Act*, including any of the following Sections: Section 18: "Home and Community Based Services for Adults with Brain Injury", Section 20: "Home and Community Based Services for Adults with Other Related Conditions", Section 21: "Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder", and Section 29: "Support Services for Adults with Intellectual Disabilities or Autistic Disorder";

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19.03 DURATION OF CARE (cont.)

- G. The Member is not financially eligible to receive MaineCare benefits;
- H. The Member does not comply with the Authorized Plan of Care for services;
- I. When the Member's most recent MED assessment, and the clinical judgment of the ASA, determines that the Authorized Plan of Care must be changed or reduced to match the Member's needs as identified in the reassessment and subject to the limitations of the cap. Even though the Member's medical eligibility for home and community benefits may not be affected, the plan of care may be modified by the ASA to reflect the change in needs or any change in policy that affects all Members;
- J. The Member becomes an inpatient of a hospital, a resident of a nursing facility (NF), or resident of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID);
- K. The Member becomes a resident in an assisted living setting or in an Adult Family Care Home (as defined in the MBM, Chapter II, Section 2) or other residential care setting including a private non-medical institution (as defined in the MBM, Chapter II, Section 97), sometimes referred to as a residential care facility or supported living, regardless of payment source (i.e. private or MaineCare).
- L. The cost of services exceeds the program cap and limits set forth in the Section;
- M. The Member has provided fraudulent or repeatedly inaccurate information in connection with eligibility or services;
- N. The federally-approved Waiver under which these rules were promulgated terminates, expires or a future amendment is not approved;
- O. The Department, the SCA or the ASA documents that the Member, or other person living or visiting the Member's residence, harasses, threatens or endangers the safety of individuals delivering services or the health and safety of individuals providing services is otherwise endangered; or
- P. The Member does not permit the ASA, SCA or Direct Care Provider access to information from the Member's physician or to access other health information necessary to meeting the needs of the Member; or

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19.03 DURATION OF CARE (cont.)

- Q. The Member does not provide a letter from his or her physician as required by Section 19.02-3(G) to the SCA within (60) sixty days of the referral to the SCA for services.

19.03-2 **Denial of Participant Direction**-In addition to the above, the ASA, SCA or Department, as appropriate, may deny or terminate the ability of a Member to receive participant-directed services for any of the reasons set forth below. Prior to and as part of denying or terminating services specific to the Participant Directed Option, the SCA will work to transition the Member to another Representative or to agency services, as appropriate:

- a) The Representative provides fraudulent or repeatedly inaccurate information to the Department, ASA, SCA or FMS in connection with obtaining or receiving services, including the submission of time sheets that are not accurate of the services provided;
- b) The Department, the SCA or the ASA documents that the Representative harasses, threatens or endangers the safety of the Member or individuals delivering services;
- c) The SCA documents that the Member or the Representative fails to hire or manage an Attendant consistent with the requirements of this Section, including directing an Attendant to provide services that are inconsistent or not covered by the Authorized Plan of Care or hiring an Attendant who does not have the ability to provide Attendant Services as authorized by the plan of care;
- d) The Member or the Representative fails to successfully complete the initial Skills Training within the required time frame from the date of the referral for Skills Training;
- e) The Member or the Representative a) fails to hire an Attendant within sixty (60) days from the completion of Skills Training or b) has not employed an Attendant for a consecutive (60) day period, not counting days where services may have been suspended; or
- f) A Member no longer has Cognitive Capacity and there is no willing and appropriate person meeting the requirements of this Section to act as Representative.

19.03-3 **Suspension**-Services may be suspended for up to sixty (60) days. If such circumstances extend beyond 60 days, the Member's service coverage under this Section will be terminated and the Member will need to be reassessed to determine medical eligibility for these services.

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19.03 DURATION OF CARE (cont.)

If a Member enters a hospital or nursing facility, the SCA may provide Care Coordination services to that Member provided it is within sixty (60) days of discharge from the institution. However, these services may not be billed and cannot be reimbursed until the Member is home under this Section.

- 19.03-4 **Out of State Services:** Personal care or Attendant Services provided to a Member while the Member is out of state must be approved by the Service Coordination Agency and may not exceed fourteen (14) consecutive days. The SCA will review the plan of care and determine if all ADL and IADL services are needed by the Member while out of state. The Member is allowed thirty (30) days total of out of state services per fiscal year. This section applies only when the service is being provided by an agency licensed or registered in Maine or provided by an Attendant reimbursed under the Participant Directed Option. The Member must continue to meet all other program requirements. All out of state services are also governed by Chapter I of the *MaineCare Benefits Manual*.

19.04 COVERED SERVICES

Covered services are available for Members meeting the eligibility requirements set forth in Section 19.02. Covered services must be required in order to maintain the Member's current health status, or prevent or delay deterioration of a Member and/or avoid long-term institutional care. Services under this Section require prior approval by the Department, or its Assessing Services Agency, and are included in the calculation of the Member's program cap. Services shall not be reimbursed until both medical and financial MaineCare eligibility have been approved. Members who meet the eligibility requirements for services under this Section are eligible for the following services, as included by the ASA in the Authorized Plan of Care:

- 19.04-1 **Adult Day Health** Services are delivered four (4) or more hours per day, on a regularly scheduled basis, up to seven (7) days a week. The hours spent in Adult Day Health Services shall count as personal care services. If a Member's plan of care specifies that a particular covered personal care service is needed, such as a bath, it must be provided. Based upon Member needs the Adult Day Health Services may include:
- monitoring of health care
 - supervision, assistance with Activities of Daily Living
 - nursing
 - personal support services
 - rehabilitation
 - health promotion activities
 - exercise groups
 - counseling

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19.04 COVERED SERVICES (cont.)

Noon meals and snacks are provided as a part of Adult Day Health Services reimbursement. There must be a regular, ongoing schedule of group and individual activities planned with the participants and based on the assessment of a Member participant's needs and interests.

19.04-2 **Assistive Technology Device and Services** includes:

- (A) services consisting of purchasing, leasing, or otherwise providing for the acquisition of Assistive Technology devices for participants; and
- (B) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing Assistive Technology device.

This service will only be authorized when the requested equipment and supplies are medically necessary, improve or maintain the Member's level of independence, ability to access needed supports and services in the community or if required to ensure a Member's health and welfare. All other reimbursement of Assistive Technology must be explored and utilized, including all Medicaid State Plan services, prior to reimbursement of Assistive Technology services under this Section. Documentation must describe how the Member's expected use, purpose and intended place of use have been matched to features of the products requested in order to achieve the desired outcome in an efficient and cost effective manner.

Examples of items that may be covered are voice-activated, motion-activated and electronic devices, communication devices and mobility devices.

Vehicle modifications are excluded under this Section. Examples of other items that are excluded are recreation or quality of life items, such as televisions, microwave ovens and other general household appliances.

This need may be identified by the ASA at the time of assessment or upon a service need referral by the SCA, subject to the service limits of this Section. The SCA will make a referral to the Waiver Services Provider, who will be responsible for the coordination, implementation and oversight of the service. A thorough evaluation of all Assistive Technology will be completed prior to service delivery by the Waiver Services Provider and Assistive Technology consultants, if appropriate.

19.04-3 **Assistive Technology-Remote Monitoring** means real time remote support monitoring of the participant with electronic devices to assist them to remain safely in their homes. Remote monitoring services may include a range of technological options including in-home computers, sensors, and video camera linked to a provider that enables 24/7 monitoring and/or contact as necessary.

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19.04 COVERED SERVICES (cont.)

Final approval for remote monitoring must be made by the Department, Office of Aging and Disability Services upon a recommendation by the ASA or SCA. In making such a recommendation the ASA or the SCA must consider and document the following information:

- a) number of hospitalizations in the past year;
- b) use of emergency room in the past year;
- c) history of falls in the last six months resulting from injury;
- d) Member lives alone or is home alone for significant periods of time;
- e) service access challenges and reasons for those challenges;
- f) history of behavior indicating that a Member's cognitive abilities put them at a significant risk of wandering ; and
- g) other relevant information for the request.

A thorough evaluation of all Assistive Technology will be completed prior to service delivery by the Waiver Services Provider and appropriate Assistive Technology consultants. The Member's record must document the Member's consent and commitment to the Assistive Technology plan elements including all assistive communication, environmental control and safety components. Provider will comply with all federal, state and local regulations that apply to its business including but not limited to "*Electronic Communications Privacy Act of 1986*". Any services that use networked services must comply with *Health Insurance Portability and Accountability Act* requirements.

Use of remote monitoring requires sufficient Back Op Plans and the SCA will be responsible for ensuring that the Member has at least two adequate back-up plans prior to making a referral to the WSP for this service

19.04-4 **Assistive Technology-Transmission** means transmission of data for use of the Assistive technology device via internet or cable utility that supports remote monitoring.

19.04-5 **Care Coordination Services** are provided to all Members who receive Home and Community-Based Benefits, and activities are guided by the Member's Authorized Plan of Care. Care Coordination is provided through in-person contact in the Member's residence, or through telephone and other methods with the Member, his/her family and other responsible parties, providers of service, and others relevant to addressing the Member's service needs.

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19.04 COVERED SERVICES (cont.)

For Members who are using the Participant Directed Option, Care Coordination includes assisting the Member in coordinating access to Skills Training and Financial Management Services as defined in this section.

A. Responsibilities

1. Making initial contact with the Member or the responsible party, by telephone or other appropriate method, within two (2) business days of notification of authorization by the ASA of Care Coordination Services to discuss service delivery options, choice of provider(s), preferred frequency of service delivery based on the Member's needs consistent with the timeframe of the service authorization (i.e. weekly/monthly), clarify issues, and answer questions;
2. Ensuring implementation of the Authorized Plan of Care and coordinating service providers who are responsible for delivering services, by making referrals and providing Service Orders to qualified service provider(s) the Member chooses; or if the Member chooses the Participant Directed Option providing access to Skills Training;
3. Visiting the Member at his/her residence no later than thirty (30) days of receipt of notification of authorization by the ASA of Care Coordination Services to review the needs and goals of the Member; develop and document the Member's back-up plan; complete a Risk Assessment and complete the Health and Welfare Tool approved by the Office of Aging and Disability Services;
4. For Members receiving Personal Care Services through an agency, conducting face-to-face monitoring with the Member at least annually to monitor the Member's overall health status by completing the Health and Welfare Tool and following up on identified needs and issues;
5. For Members receiving Attendant Services through the Participant Directed Option, conducting face-to-face monitoring with the Member at least every six (6) months to monitor the Member's overall health status by completing the Health and Welfare Tool and following up on identified needs and issues;
6. Assessing the Member/provider relationship, including whether PSS or Attendant duties are being performed satisfactorily;
7. Monitoring the overall health status of the Member;

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19.04 COVERED SERVICES (cont.)

8. Documenting receipt, investigation and resolution of all complaints from any party related to services under this Section;
9. Making contacts with family Members, designated representatives, guardians, providers of services or supports, the Assessing Services Agency, and the Department to ensure continuity of care and coordination of services;
10. Monitoring the Member's receipt of services and reviewing the plan of care by contacting the Member at least once per month. Monitoring calls may be reduced to a lesser frequency but not less than quarterly if the Member requests less frequent calls and there is documentation in the record to support this choice.

Monitoring may be done by telephone unless an in-person visit is needed to be effective as determined by the SCA or the Department;
11. Responding timely to assist the Member with resolving problems and other concerns;
12. Advocating on behalf of the Member for appropriate community resources and services by providing information, making referrals and otherwise facilitating access to these supports;
13. Modifying the Authorized Plan of Care in the event a Member experiences an emergency or acute episode as defined in this section. The care coordinator may adjust the Authorized Plan of Care up to fifteen (15) percent of the monthly authorized amount, not to exceed the monthly program cap. Services added or changed due to the emergency or acute episode may not continue beyond fourteen (14) days.
14. Making referrals for reassessments prior to the end of the eligibility period, and based upon a Significant Service Change in the Member's condition;
15. Issuing notices of intent to suspend, reduce or terminate, as appropriate, when the Member is ineligible for such services or the level of services are reduced. The care coordinator may not issue a notice to reduce or terminate services based on medical eligibility;
16. Other activities include, but are not limited to:

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19.04 COVERED SERVICES (cont.)

- a) Complying with the Department's protocols for submitting provider service authorizations through MeCare in the Department's MaineCare claims system,
- b) Maintaining Member records,
- c) Providing information as required by the Department,
- d) Following requirements regarding mandated reporting.

19.04-6 **Environmental Modifications** include the following medically necessary modifications to the Member's residence:

- A. Ramps;
- B. Lifts, such as porch or stair lifts and hydraulic, manual or other electronic lifts;
- C. Modifications to bathroom facilities such as: roll-in showers, sink, bathtub, toilet and plumbing modifications, water faucet controls, floor urinal and bidet adaptations and turn-around space adaptations;
- D. Modifications to kitchen facilities such as: sink modifications, sink cut-outs, and water faucet controls, turn-around space adaptations, surface adjustments/additions and cabinetry adjustments/additions; and
- E. Specialized accessibility/safety adaptations such as: door-widening, electrical wiring, grab bars and handrails, automatic door openers/doorbells, voice activated, light activated, motion activated and electronic devices, fire safety adaptations, medically necessary air filtering devices, low-pile carpeting, and smooth or non-skid flooring needed to assure safe ambulation or wheelchair mobility. Adaptations under this Section must require a physical modification to the home and shall not be duplicative of services covered by this or other sections of the *MaineCare Benefits Manual*.

All requests for, and repairs to, Environmental Modifications must be authorized in advance by the Department, or the ASA. The Department, or the ASA, shall make the determination of medical necessity for Environmental Modifications. Reimbursement shall not be provided for general house repairs or re-modeling. Modification of motor vehicles is not covered under this Section.

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19.04 COVERED SERVICES (cont.)

All Environmental Modifications must be provided in accordance with applicable Federal, State or local building codes and, if applicable, performed by or supervised by State licensed/certified professionals. The Waiver Services Provider shall maintain documentation in support of services billed to the Department.

Reimbursement for Environmental Modifications under this Section shall be provided only when payment for these services may not be made under any other Section of this Manual.

19.04-7 **Financial Management Services (FMS)** will be covered only for those Members who are electing the Participant Directed Option. FMS related duties and tasks include:

- A. Assisting Members in verifying support worker citizenship status;
- B. Collecting and processing timesheets of Attendants and disbursing Attendant payments;
- C. Processing payroll, withholdings, filings and payment of applicable Federal, state and local employment-related taxes and insurances;
- D. Establishing and maintaining Member files in accordance with this section; and
- E. Conducting required background checks, including checks of the Certified Nursing Assistant (CNA) Registry, Office of Inspector General (OIG) Exclusions list, and any required criminal background checks.

19.04-8 **Home Health Services** are provided in fifteen (15) minute increments or on a “visit” basis. However, only home health agencies that are Medicare certified and licensed in the State of Maine may bill on a “visit” basis. The type and frequency of each covered home health service must be authorized by the ASA in the plan of care. The home health provider shall develop a nursing plan of care, which shall include the personal support and nursing services authorized by the ASA or the Department, and the medical treatment plan which shall be reviewed and signed by the Member’s physician. This plan shall be provided to the SCA at no additional cost.

Home Health Services under this Section include the following, which may be provided by an independent contractor with the exception of LPN, MSW and home health aide/ CNA services:

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19.04 COVERED SERVICES (cont.)

Registered nurse supervisory visits made for the sole purpose of supervising other home health staff are not billable as a visit and are, therefore, not reimbursable as a HCB service. If nursing services are delivered as part of the visit, those nursing services may be covered.

- A. **Registered Nurse** services, include:
1. Initiating a plan of nursing treatment and revising it as necessary. Copies of the nursing treatment plan, regardless of the reimbursement source shall be made available to the SCA;
 2. Skilled nursing services not reimbursable by Medicare or another third party;
 3. Informing the physician, the care coordinator and other parties, as appropriate, of changes in the Member's condition and needs;
 4. Teaching the Member and family about meeting nursing and related needs;
 5. Performing all other duties and responsibilities within the scope of the nursing license.
- B. **Licensed Practical Nurse** services include all duties and responsibilities within the scope of the nursing license.
- C. **Physical Therapy** services are those restorative services provided in accordance with physician orders, by a physical therapist, or by a physical therapist assistant working under the direct supervision of a licensed physical therapist, licensed in Maine in which services are provided, and acting within the scope of that license.
- In order for pool therapy to be covered under this Section, physician orders are required and pool therapy must be specified in the Authorized Plan of Care. Physical therapy services delivered in a pool setting must be provided by a licensed physical therapist. No additional reimbursement will be provided for pool fees.
- D. **Occupational Therapy** services are those restorative services provided in accordance with physician orders, by an Occupational Therapist, Registered (OTR), or by a Certified Occupational Therapist Assistant (COTA) under the direct supervision of an OTR, licensed in Maine, and acting within the scope of that license. These services include:

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19.04 COVERED SERVICES (cont.)

1. Task-oriented activities such as treatment to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the Member;
 2. Evaluation of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance and assessment of living areas for the disability; and
 3. Specific occupational therapy techniques such as assistance with Activities of Daily Living skills, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance, and treatment techniques to improve physical capabilities for activities. The occupational therapist assists the physician in evaluating level of function, helps develop and revise a plan of treatment, and prepares clinical and progress notes.
- E. **Speech-Language Therapy** services are those services which are provided by an individual licensed in Maine, and acting within the scope of that license as a Speech-Language Pathologist, which include speech, voice and language evaluation, diagnosis and plan of care, speech, voice and language therapy and/or aural rehabilitation, speech pathology, collateral services, speech and language periodic re-evaluation, speech pathology diagnostic services, hearing screening, and speech, voice and/or language screening. The speech language pathologist assists the physician in evaluating level of function, helps develop the plan of treatment and prepares clinical and progress notes.
- F. **Home Health Aide/Certified Nursing Assistant Services** are delegated and overseen by a registered nurse. Written instructions for Member's care are prepared by a registered nurse or therapist as appropriate. Duties include:
1. the performance of simple procedures as an extension of therapy services;
 2. assistance with ADLs and IADLs as authorized in the plan of care;
 3. assistance with medications that are allowed under the scope of practice;
 4. reporting changes in the Member's condition and needs to the nurse; and

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19.04 COVERED SERVICES (cont.)

5. completing appropriate records.

G. **Medical Social Services** are provided by an individual with a Masters of Social Work (MSW) who is licensed in Maine, and acts within the scope of that license. The social worker:

1. assists the physician and other team members in understanding the significant social and emotional factors related to the health problems;
2. participates in the development of the medical treatment plan;
3. educates the family regarding the Member's health status and plan of care;
4. Performs all other duties and responsibilities within the scope of social work licensure.

19.04-9 **Personal Care Services (also known as Personal Support Services)**, include Personal Care Services delivered by an agency related to a Member's physical requirements for assistance with ADLs, including assistance with Health Maintenance Activities. Health Maintenance Activities must be activities that would otherwise be performed by the Member, if the Member were physically or cognitively able to do so. Additionally, when authorized in the plan of care, Personal Care Services may include IADLs. Personal Care Services will not be authorized for the sole purposes of providing assistance with IADLs.

The ASA will use the allowances in Appendix A to determine the time necessary to complete authorized ADL and IADL tasks. If these times are not sufficient when considered in light of a Member's unique circumstances as identified and documented by the ASA, the ASA may make an appropriate adjustment subject to the limits in this Section.

ADL tasks include assistance with:

1. Bed mobility, transfer, and locomotion activities to get in and out of bed, wheelchair or motor vehicle;
2. Using the toilet and maintaining continence;
3. Health Maintenance Activities as defined in Section 19.01-24;
4. Bathing, including transfer;

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19.04 COVERED SERVICES (cont.)

5. Personal hygiene which may include combing hair, brushing teeth, shaving, washing and drying face, hands, and perineum;
6. Dressing; and
7. Eating, and clean up.

IADL services must be authorized and specified in the Authorized Plan of Care. IADL tasks include assistance with:

1. grocery and prepared food shopping, assistance with obtaining medication, to meet the Member's health and nutritional needs;
2. routine housework, including sweeping, washing and/or vacuuming of floors, cleaning of plumbing fixtures (toilet, tub, sink), appliance care, changing of linens, refuse removal;
3. laundry done within the residence or outside of the home at a laundry facility; and
4. meal preparation and clean up.

19.04-10 **Attendant Services** are services related to a Member's physical requirements for assistance with ADLs for a Member utilizing the Participant Directed Option, including assistance with Health Maintenance Activities. Health Maintenance Activities must be activities that would otherwise be performed by the Member, if the Member were physically or cognitively able to do so. Additionally, when authorized in the plan of care, Attendant Services may include IADLs. Attendant Services will not be authorized for the sole purpose of providing assistance with IADLs. The ASA will use the allowances in Appendix A to determine the time necessary to complete authorized ADL and IADL tasks. If these times are not sufficient when considered in light of a Member's unique circumstances as identified and documented by the ASA, the ASA may make an appropriate adjustment subject to the limits in this Section.

ADL tasks include assistance with:

1. Bed mobility, transfer, and locomotion activities to get in and out of bed, wheelchair or motor vehicle;
2. Using the toilet and maintaining continence;
3. Health Maintenance Activities as defined in Section 19.01-24;
4. Bathing, including transfer;

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19.04 COVERED SERVICES (cont.)

5. Personal hygiene which may include combing hair, brushing teeth, shaving, washing and drying face, hands, and perineum;
6. Dressing;
7. Eating, and clean up; and
8. Assistance with administration of medications as directed by the Member for the Member.

IADL services must be authorized and specified in the Authorized Plan of Care. IADL tasks include assistance with:

1. grocery and prepared food shopping, assistance with obtaining medication, to meet the Member's health and nutritional needs;
2. routine housework, including sweeping, washing and/or vacuuming of floors, cleaning of plumbing fixtures (toilet, tub, sink), appliance care, changing of linens, refuse removal;
3. laundry done within the residence or outside of the home at a laundry facility;
4. meal preparation and clean up; and
5. money management as directed by the Member for the Member.

19.04-11 **Personal Emergency Response Systems (PERS)** are covered only for those Members who live alone, or who are alone for significant parts of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision. PERS can serve as a backup plan to assure access to emergency assistance. Reimbursement is limited to the installation fee and the monthly phone charge for the emergency response system and the home unit communicator.

19.04-12 **Transportation Services** are offered in order to enable Members to gain access to Section 19 services, as specified by the plan of care. Transportation services for Section 19 services are provided under the *MaineCare Benefits Manual*, Section 113 (Non-Emergency Transportation services).

19.04-13 **Respite Services** shall be provided in the Member's home, or it shall be provided in a licensed nursing facility. Federal financial participation shall not be claimed for room and board except when provided as part of Respite Care in a licensed nursing facility. A facility must bill the Waiver Services Provider for reimbursement of respite services provided in an institution.

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19.04 COVERED SERVICES (cont.)

For respite services delivered in the Member's home, the appropriate staff for meeting the Member's needs (i.e., RN, HHA/CNA or PSS) can be utilized and reimbursement shall be at that worker's regular rate. All respite services must be billed using the appropriate respite procedure code and rate (home: number of hours per RN or HHA/CNA or PSS; or nursing facility service component only).

- 19.04-14 **Skills Training** services instruct the Member in the management of Attendant Services under the Participant Directed Option. Instruction in management of Attendant Services includes instruction in recruiting, interviewing, selecting, training, scheduling, discharging, and directing a competent Attendant in the activities in the Authorized Plan of Care and requirements under this Section. Skills Training must include information on how to report suspected abuse, neglect and exploitation to Adult Protective Services.

Skills Training must occur prior to the start of services. Initial Skills Training must occur within thirty (30) calendar days of referral for Skills Training. The SCA may extend the thirty (30) day timeframe for good cause (e.g. hospitalization of the Member or Representative). A competency-based assessment may be performed in lieu of Skills Training for Members who have previously completed such training.

19.05 NON-COVERED SERVICES

The following services are non-covered services:

- A. Services that are not in the Authorized Plan of Care according to Section 19.04, except as allowed under an acute/emergency episode (see Section 19.04-5 (A)(13));
- B. Services that are described as non-covered services in Chapter I of the *MaineCare Benefits Manual* including but not limited to recreational, custodial and leisure activities;
- C. Household tasks, except included as IADL services in the Authorized Plan of Care, according to Section 19.04;
- D. Personal Care Services or Attendant Services provided by a spouse of the Member, or by the parents or stepparents of a minor child who is a Member;
- E. Services provided by anyone prohibited from employment due to criminal background checks or annotations on the Maine Registry of Certified Nursing Assistants and Direct Care Workers as set forth in this Section;
- F. Custodial care or supervision;

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19.04 COVERED SERVICES (cont.)

- G. Personal care services delivered in a licensed or unlicensed assisted housing setting, including a residential care facility;
- H. Room and board and food (except when allowed as part of Adult Day Services or as part of respite services delivered in the NF setting);
- I. Services provided not in the presence of the Member unless in the provision of covered IADLs, such as grocery shopping or laundry while the Member remains at home;
- J. Services provided when the Member is in the hospital, nursing facility, PNMI, or ICF- IID;
- K. Supervisory visits for HHAs, CNAs, and PSSs;
- L. Effective as of January 1, 2015, services in excess of forty (40) hours per week provided by an individual worker to any individual Member or household;
- M. Services provided out of state except as otherwise specifically allowed under this Section or as authorized under Chapter I of the MaineCare Benefits Manual; and
- N. Personal care or Attendant Services provided to a Member receiving respite in an institutional setting because personal care is the responsibility of that provider.

19.06 LIMITS

Effective Retroactive
to Date 7/1/2015

- A. Except as otherwise provided in this Section, effective retroactive to July 1, 2015, the program cap established by the Department is \$4,603 per Member per month.
- B. Skills Training Services shall not exceed 14.25 hours per annual eligibility period including the hours needed for initial instruction. These costs will not be included as part of the Member's monthly program cap.
- C. FMS and services are not included as part of the monthly program cap.
- D. Care Coordination Services received by a Member shall not exceed twenty-four (24) hours (96 units) per annual eligibility period with the following exceptions: if the Department determines that exceptional circumstances exist such that the health or welfare of a Member cannot be met under this limit, the Department may authorize additional units of care coordination service. These costs will not be included as part of the Member's monthly program cap.

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19.05 LIMITS (cont.)

- E. Environmental Modifications may not exceed \$3000 per annual eligibility period per Member. These costs will not be included as part of the Member's monthly program cap.
- E. Assistive Technology Devices and Services may not exceed \$1000 per Member per annual eligibility period. These costs are included as part of the Member's monthly program cap.
- F. Assistive Technology-Transmission: These services may not exceed \$600 per Member per annual eligibility period. These costs are included as part of the Member's monthly program cap.
- G. Assistive Technology- Remote Monitoring: These services may not exceed \$6000 per Member per annual eligibility period. These costs are included as part of the Member's monthly program cap.
- H. Respite- Expenditures for Respite Care shall not exceed the allowed maximum, which is based on the cost of thirty (30) days of Nursing Facility Services at the rate as established in Chapter III, per Member per annual eligibility period. These costs are included as part of the Member's monthly program cap.
- J. Personal Care or Attendant Services: The monthly program cap may be exceeded by no more than 20% for personal care or Attendant Services for Members who meet either of the following qualifications, provided that in no case shall a Member receive more than eighty-six and a quarter (86.25) hours per week of personal care and/or Attendant Services:
 - 1. The Member needs Extensive Assistance (defined in 19.01-6) with the following Activities of Daily Living:
 - a. **Bed Mobility:** how person moves to and from lying position, turns side to side, and positions body while in bed;
 - b. **Transfer:** how person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet and dressing);
 - c. **Locomotion:** how person moves between locations on the same floor, in room and other areas. If in wheelchair, self-sufficiency once in chair;
 - d. **Eating:** how person eats and drinks (regardless of skill); and

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19.05 LIMITS (cont.)

- e. **Toilet Use:** how person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes;

OR

2. The Department or the Department's Authorized Entity determines based on medical necessity that the Member faces significant risk to health, welfare and safety; is at imminent risk of institutionalization; and there is no ability to meet the Member's needs through other resources or supports such that extraordinary measures are warranted.

19.07 GENERAL ELIGIBILITY PROCEDURES

The procedure for determining eligibility, in accordance with the criteria outlined in §19.02 above, for HCB is as follows:

- A. **Medical eligibility:** A complete, standardized referral, or verbal/written request by the Member, or designated representative, for a medical eligibility assessment shall be submitted to the Department or the ASA. The ASA shall conduct a medical eligibility assessment within five (5) calendar days of receipt of a request, except when the Member is receiving acute level of care services. In such cases, the assessment is delayed until twenty-four (24) hours before discharge, or when continued acute level services are denied.

The Department or its Authorized Entity shall conduct a face-to-face medical eligibility assessment at the Member's residence using the MED assessment form. The individual conducting the assessment shall be a registered nurse and will be trained in conducting assessments and developing an Authorized Plan of Care using the Department's approved tool. The RN assessor's findings and scores recorded in the MED form shall be determinative in establishing eligibility for services and the Authorized Plan of Care. Applicants who meet the eligibility criteria set forth in Section 19.02, or their guardian, agent or surrogate as appropriate, shall receive an Authorized Plan of Care based upon the scores, time frames and findings recorded in the MED assessment and level of care for which they are eligible. The covered services to be provided in accordance with the Authorized Plan of Care shall: 1) not exceed the established financial caps; 2) be subject to prior approval by the Department or the ASA; and 3) the nursing or therapy treatment plan shall be under the direction of the Member's physician, when applicable.

The ASA shall be responsible to:

1. Offer the applicant at the time of assessment a choice of available Service Coordination Agencies from the list of enrolled MaineCare providers for this service.

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19.07 GENERAL ELIGIBILITY PROCEDURES (cont.)

2. Inform the applicant (guardian, agent, or surrogate) of the options stated in the Choice Letter. The applicant (guardian, agent, or surrogate) will need to indicate his or her choice of either Nursing Facility Services or home and community benefits on the Choice Letter and state his or her wish to initiate services by signing the Choice Letter. The Choice Letter must be signed annually.
 3. If the applicant or Member chooses nursing facility care, the individual shall be placed in accordance with existing placement procedures as set forth in this Manual, Chapter II, Section 67. In the event a nursing facility bed is not available, the Member may choose home and community benefits within ninety (90) days of the assessment date unless otherwise specified in the assessment. A new Choice Letter must be signed.
 4. If the financial eligibility process has not been initiated, the ASA assessor will provide an application for financial eligibility determination and refer the applicant to the Office for Family Independence (OFI).
 5. The ASA assessor shall approve an initial eligibility period for up to one (1) year, based upon the scores and needs identified in the MED assessment. A shorter eligibility period may be authorized for an individual Member when supported by documented clinical judgment of the assessor.
 6. The ASA shall forward the completed assessment packet to the Department's service order
 7. within two business days of the medical eligibility determination and development of the Authorized Plan of Care.
 8. When the Member is placed on a wait list under this Section, the ASA will discuss other funding service options during the assessment process. The ASA will initiate any necessary referrals on the Member's behalf to access home care options. The Member will be informed that his or her name has been referred to the HCB wait list, when applicable.
- B. **Financial Eligibility:** Financial eligibility is determined by the local office of the Office for Family Independence (OFI) as outlined in the *MaineCare Eligibility Manual*. The ASA's pre-screen intake process may instruct the applicant and/or designated representative to initiate the financial eligibility process at the local OFI office. For SSI Members, no financial determination process is necessary. The RN assessor will verify SSI status.
- C. **Implementation of the authorized plan:** On receipt of the eligibility packet the Service Coordination Agency shall:

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19.07 **GENERAL ELIGIBILITY PROCEDURES** (cont.)

1. contact the Member within two (2) business days;
2. assist the Member with locating providers and obtaining authorized services or making appropriate referrals for Skills Training and Fiscal Management Services;
3. implement and coordinate services with the Direct Care Provider using Service Orders;
4. monitor service utilization and assure compliance with this policy; and
5. send a copy of the Authorized Plan of Care to the attending physician, with a cover letter inviting the physician to participate and comment on the plan of care.

In addition to the above, the SCA shall be responsible for submitting provider service authorizations through MeCare to the Department's MaineCare claims system according to Department procedures. When the services are terminated the SCA will be responsible for entering service end-dates by the next business day.

D. Redetermination of Eligibility

1. For all Members receiving services under this Section, in order for the reimbursement of services to continue uninterrupted beyond the approved eligibility period, a reassessment and prior approval of services is required and must be conducted no earlier than twenty-one (21) days prior to and no later than the eligibility end-date. The SCA is responsible for making these referrals to the ASA 21 days prior to the end of the eligibility end date.
2. The Service Coordination Agency will provide relevant information to the ASA, prior to the reassessment due date. The information shall be shared with the ASA as part of the referral for re-determination of medical eligibility and development of the Authorized Plan of Care.
3. The SCA shall make referrals for reassessments based upon a Significant Service Change in the Member's health status or service needs.
4. If a service plan is under appeal and services are being maintained during that process, a Member will not be reassessed while the appeal process is ongoing except as authorized by the Office of Aging and Disability Services for reasons of health and welfare.

19.08 POLICIES AND PROCEDURES

19.08-1 Member Complaint Logs

The ASA, SCA, FMS and Waiver Services Provider shall each be responsible for maintaining a log of Member complaints regarding home and community benefits. This shall include all verbal and written complaints.

There shall be documentation regarding the Member, date and nature of the complaint and how each complaint was addressed or resolved. The Member complaint log shall be made available to the Department upon request.

19.08-2 Member Surveys - The ASA, SCA and FMS shall be responsible for conducting annual Member surveys as approved by the Department.

19.08-3 Reports and Monitoring

The SCA shall submit monthly reports to the Department detailing the current program census and the number of new admissions and discharges. The SCA shall submit quarterly health and welfare reports.

The FMS shall submit monthly reports on active Members in the Participant Directed Option served by their agency. This report will include number of background checks conducted by FMS on Attendants, number of participants served and number of Attendants reimbursed within a given month.

The ASA shall submit reports to the Department as specified in the contract between the Department and the ASA.

Ongoing monitoring shall be conducted by the Department of Health and Human Services, Office of Aging and Disability Services, which will include on-site visits to the Service Coordination Agency, the Assessing Services Agency and visits to a sample of Members. The Department will monitor compliance with the waiver document and regulations.

19.08-4 Professional and Other Qualified Staff

If registered professional nurses, physical therapists, occupational therapists and speech-language pathologists are acting as independent contractors, they must be enrolled as a MaineCare provider in order to provide services under this Section. Services shall be provided by the following staff:

19.08 POLICIES AND PROCEDURES (cont.)

A. Professional Staff

The following professional staff must be fully licensed, which license must be documented by written evidence from the appropriate governing body. All professional staff must provide services only to the extent permitted by licensure and approval to practice conditions. If the professional is not acting as an independent contractor he/she must be employed directly by or through a contractual relationship with a MaineCare provider.

1. **Registered Professional Nurse:** A registered professional nurse may provide nursing services within the scope of his or her licensure.
2. **Practical Nurse:** A licensed practical nurse may provide nursing services within the scope of his or her licensure provided they are supervised by a registered professional nurse.
3. **Master's Social Worker:** A social worker must hold a Master's Degree from a school of social work accredited by the Council on Social Work Education.
4. **Physical Therapist:** A physical therapist who meets the requirements and the qualifications set forth in the *MaineCare Benefits Manual (MBM)*, Chapter II, Section 85-Physical Therapy Services, may provide physical therapy services.
5. **Occupational Therapist:** A registered occupational therapist who meets the requirements and the qualifications set forth in the *MaineCare Benefits Manual (MBM)*, Chapter II, Section 68-“Occupational Therapy Services”, may provide occupational therapy services.
6. **Speech-Language Pathologist:** A speech-language pathologist meeting the requirements and qualifications set forth in the *MaineCare Benefits Manual (MBM)*, Chapter II, Section 109-

Speech and Hearing Services, may provide speech and language therapy services.

B. Other Qualified Staff

Other qualified staff Members, other than professional staff defined above, must have appropriate education, training, certification, and experience, as verified by the employing agency that is enrolled as a MaineCare provider.

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19.08 POLICIES AND PROCEDURES (cont.)

1. Care Coordinator

In order to provide Care Coordination Services under this section, the care coordinator must be:

- a) a licensed social service or health professional: or
- b) possess four years of education in the health or social services field and one year of community experience: or
- c) a registered occupational therapist who is licensed to practice occupational therapy in the State of Maine; or
- d) a certified occupational therapy assistant who is licensed to practice occupational therapy in the State of Maine under the documented supervision of a licensed occupational therapist.

2. Home Health Aide

A home health aide must be listed on the Maine Registry of Certified Nursing Assistants and Direct Care Workers and must not be prohibited from employment under Title 22 MRSA §1812(G). Home health aides employed by a home health agency must be in compliance with the Regulations Governing the Licensing and Functioning of Home Health Care Services. A home health aide shall work under the direct supervision of a registered nurse.

3. Certified Nursing Assistant

A CNA must be listed on the Maine Registry of Certified Nursing Assistants or Direct Care Workers and must not be prohibited from employment under Title 22 MRSA §1812(G). A CNA shall work under the direct supervision of an RN.

4. Personal Support Specialist

A PSS must be employed by, or acting under a contractual relationship with, a licensed home health agency or by a registered personal care agency. A family Member who meets the requirements of this Section may be a PSS and receive reimbursement for delivering personal support services, with the exception of the MaineCare Member's spouse, or the parent (including stepparent) of a minor child who is a MaineCare Member.

- a. All individuals employed as a PSS must:

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19.08 POLICIES AND PROCEDURES (cont.)

- i. Undergo criminal background on the Maine Registry of Certified Nursing Assistants and Direct Care Workers. PSSs may not be employed by the provider agency if they are prohibited from employment under Title 22 MRSA §1717.
- ii. Meet one (1) of the training and examination requirements below. An individual without the required training may be hired and reimbursed for delivering personal support services as long as the individual enrolls in a certified training program within sixty (60) days of hire and completes training and examination requirements within nine (9) months of employment and meets all other requirements. If the individual fails to pass the examination within nine (9) months, reimbursement for his or her services must stop until such time as the training and examination requirements are met. A PSS must meet one (1) of the following:
 - aa. Hold a valid certificate of training for Certified Nursing Assistants and be listed on the Maine Registry of Certified Nursing Assistants; or
 - bb. Hold a valid certificate of training, issued within the past three (3) years, for nurse's aide or home health aide training that meets the standards of the Maine State Board of Nursing nursing assistant training program; or
 - cc. If a CNA's status on the Maine Registry of Certified Nursing Assistants has become inactive, or an individual holds a valid certificate of training meeting the standards of the Maine State Board of Nursing nursing assistant program issued more than three (3) years ago, the individual must pass the competency-based examination of didactic and demonstrated skills from the Department's approved Personal Support Specialist curriculum. A certificate of training as a personal care assistant/Personal Support Specialist will be awarded upon passing this examination; or

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19.08 POLICIES AND PROCEDURES (cont.)

- dd. Hold a valid certificate of training as a Personal Support Specialist issued as a result of completing the Department approved Personal Support Specialist training curriculum and passing the competency-based examination of didactic and demonstrated skills. The training course must include at least fifty (50) hours of formal classroom instruction, demonstration, return demonstration, and examination. Tasks covered under this Section must be covered in the training; or
 - ee. Be a Personal Support Specialist who successfully completed a Department-approved curriculum prior to September 1, 2003. Such individuals will be grandfathered as a qualified PSS.
- b. New employee orientation must be provided as follows:
- i. A PSS, newly hired to an agency, who meets the Department's PSS training requirements, must receive an agency orientation. The training and certification documents must be on file in the PSS's personnel file.
 - ii. A newly hired PSS who does not yet meet the Department's training and examination requirements must undergo an eight (8) hour orientation that reviews the role, responsibilities and tasks of the PSS. To meet the required eight hours for orientation an agency may choose to use job shadowing for a maximum of two (2) hours of the 8 hour time requirement. The orientation must be completed by the PSS prior to the start of delivering services. The PSS must demonstrate competency to the employing agency in all required tasks prior to being assigned to a Member's home, with the exception of Health Maintenance Activities, whereby a PSS can demonstrate competency via on the job training once being assigned to a Member's home.
- c. Provider agency responsibilities include, but are not limited to the following:

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19.08 POLICIES AND PROCEDURES (cont.)

- i. Assuring that a PSS meets the training, competency, and other requirements of this Section, and maintaining documentation of how each requirement is met in the PSS's personnel file, including: evidence of orientation when applicable, check of the CNA and Direct Care Worker Registry, criminal background check, and the verification of credentials including the certificate of training and/or verification of competency.
- ii. **Supervisory visits**
 - aa. **Initial visit.** A provider agency supervisor must make an initial visit to a Member's home prior to the start of PSS services to develop and review with the Member the plan of care as authorized by the ASA on the Care Plan Summary and as ordered by the care coordinator.
 - bb. **Scheduled supervisory visits.** A PSS employed by a provider agency must receive on-site supervision of the implementation of the Member's Authorized Plan of Care by the agency employer at least quarterly to verify competency and Member satisfaction with the PSS performance of the tasks in the plan of care. More frequent or additional on-site supervision visits of the PSS occur at the discretion of the provider agency as governed by its personnel policies and procedures.
 - cc. A provider agency must develop and implement written policies and procedures that ensure a smoke-free environment. PSSs are not allowed to smoke, consume alcohol, or use controlled substances in the Member's home or vehicle during work hours.
 - dd. A provider agency must develop and implement written policies and procedures that address abuse, neglect or misappropriation of a Member's property and that includes information on mandated reporting requirements.

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19.08 POLICIES AND PROCEDURES (cont.)

- d. The Department has the authority to recover funds for services provided if the provider agency does not provide required documentation to support qualifications of the agency or staff or services billed.
- e. The Office of MaineCare Services and the Office of Aging and Disability Services have the responsibility of ensuring the quality of services and the authority to determine whether a PSS agency has the capacity to comply with all service requirements. Failure to meet standards may result in non-approval, a plan of correction, or termination of the provider enrollment agreement.
- f. An agency must provide documentation demonstrating compliance with these requirements upon request by the Department, including the Office of Aging and Disability Services.

5. Attendants.

An Attendant must be at least eighteen (18) years old, except for an individual who was employed and being reimbursed to provide services to a Member under this Section or *MaineCare Benefits Manual* Section 22, "Home and Community Benefits for the Physically Disabled", as of the effective date of these rules.

The following individuals may not be reimbursed as Attendants under this Section:

- a. A Member's guardian or conservator;
- b. A Member's Representative;
- c. An individual who has an annotation of abuse, neglect or misappropriation of property on the Maine Registry of Certified Nursing Assistants and Direct Care Workers;
- d. An individual hired after the effective date of these rules who has a criminal conviction which would prohibit that individual from being hired by an agency under 22 MRSA §1717.
- e. An individual who receives Attendant or Personal Care Services as a Member under this Section or other MaineCare or State funded long term care program.

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19.08 POLICIES AND PROCEDURES (cont.)

After the completion of Skills Training instruction, the Member or Representative shall train the Attendant on the job. Within a twenty-one (21) day probation period, the Member or Representative will determine the competency of the Attendant on the job. At a minimum, based upon the Attendant's job performance, the Member or Representative will certify competence in the following areas:

- ability to follow oral or signed and written instructions and carry out tasks as directed by the Member or Representative;
- disability awareness;
- use of adaptive and mobility equipment;
- transfers and mobility; and
- ability to assist with Health Maintenance Activities.

Satisfactory performance in the areas above will result in a statement of Attendant competency for each Attendant. This statement must be completed on a Department-approved form signed by the Member, submitted to the Service Coordination Agency, with a copy kept in the Member's record. The SCA may require that the Member or the Representative provide additional information or verification regarding the competency of an Attendant before or after hiring.

6. Skills Trainer

Skills Trainer must have a high school degree or equivalent, be an employee of the Service Coordination Agency, and have the ability to teach the skills required for a Member to successfully utilize the Participant Directed Option including information on: recruiting, interviewing, selecting, training, scheduling and supervising a competent Attendant. Requisite skills which must be documented by the SCA include the ability to effectively communicate with participants or representatives, their families and other support staff; knowledge of program regulations and the principles of participant direction; and knowledge of community resources.

7. Representative

A Representative may manage Attendant Services for a Member under the Participant Directed Option and shall not be compensated for the services provided under this Section.

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19.08 POLICIES AND PROCEDURES (cont.)

The Representative must be able to manage and direct program Attendant Services for the Member in accordance with their preferences and meet all program requirements. The Representative may not actively manage the care for more than two Members participating in the Participant Directed Option under this Section or another MaineCare or state funded long term care program. Specifically, the Representative must:

1. Be at least 18 years of age
2. Have the ability to understand and perform tasks required to manage an Attendant as determined by the Service Coordination Agency.
3. Have the ability to communicate effectively with the Service Coordination Agency, Fiscal Management Services and Attendant(s) in performing the tasks required to employ an Attendant.
4. Effective January 1, 2015, agrees to visit the Member in person at least once a month and contact the Member in person, by phone or other means at least weekly.
5. Not be an Attendant reimbursed for providing care to the Member.

8. Other Workers

The Waiver Services Provider may contract with other workers qualified by training and/or experience, to perform specific services including Assistive Technology Services (devices, remote monitoring, and transmission). Qualified and experienced contractors are required to build Environmental Modifications.

19.08-5 Member's Record

- A. SCA, FMS and Direct Care Provider responsibilities.** The SCA, FMS and Direct Care Providers are responsible for maintaining a specific record for each Member, which shall include, but is not limited to the Member's name, address, birth date, MaineCare ID, pertinent medical history, and diagnosis.

All Member records shall be kept current in accordance with the rules outlined under Chapter I, Section 1, General Administrative Policies and Procedures and available to the Department as documentation of services included on invoices.

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19.08 POLICIES AND PROCEDURES (cont.)

Records shall be retained for a period of not less than five (5) years from the date of service delivery, with the exception that, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and a cost settlement has been finalized.

- B. **SCA responsibilities.** In addition to the requirements elsewhere in this Section, the SCA shall maintain all notes, progress notes and documentation related to its responsibilities and requirements.
- C. **Provider agency responsibilities.** Direct Care Provider must maintain documentation of the dates, type, amount and duration of services provided, progress notes, discharge summary, release of information authorization, and service approval issued by the SCA. A provider of Home Health Services must maintain the nursing plan of care signed by the physician.

Written progress notes shall contain:

- 1. Identification of the service provided, date, total hours, and by whom. Exclude travel time unless provided as a service as described in Sections 19.01 and 19.04;
- 2. Progress toward the achievement of long and short-range goals. Include explanation when goals are not achieved as expected;
- 3. Signature of the service provider; and
- 4. Full account of any unusual condition or unexpected event, dated and documented.

All entries shall be signed by the individual who performed the service.

- D. **FMS responsibilities**
In addition to the requirements set forth elsewhere in this Section, the FMS shall maintain:
 - 1. Attendant payroll records and employment forms;
 - 2. Timesheets submitted by the Member or the Member's Representative; and
 - 3. Evidence of all required background checks.

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19.08 POLICIES AND PROCEDURES (cont.)

E. **Representative responsibilities**

In addition to the requirements set forth elsewhere in this Section, the Representative must maintain and provide documentation to the SCA, as requested, of monthly in person contact and other required contact with the Member.

19.08-6 Member Appeals

A Member or applicant has the right to appeal as set forth in Chapter I of this Manual. An appeal for Members must be requested in writing or verbally to:

Director
Office of Aging and Disability Services
c/o Hearings
11 State House Station
Augusta, ME 04333-0011

19.08-7 Program Integrity

All providers are subject to the Department's Program Integrity activities. Refer to Chapter I, General Administrative Policies and Procedures for rules governing these functions.

Ongoing monitoring shall be conducted by the Department of Health and Human Services, Office of Aging and Disability Services, which will include on-site visits to the ASA, and the SCA and visits to a sample of Members. The Department will monitor the ASA's and SCA's compliance with the Waiver document, regulations and contract performance.

19.09 CONFIDENTIALITY

The disclosure of information regarding MaineCare Members is strictly limited to purposes directly connected with the administration of the MaineCare program. Providers shall maintain the confidentiality of information regarding MaineCare Members in accordance with 42 CFR 431 Subpart F of the federal regulations.

19.10 REIMBURSEMENT

Reimbursement for covered services shall be the lowest of:

- A. The amount listed in Chapter III, Section 19, Allowances for Home and Community Benefits for the Elderly and Adults with Disabilities for Members authorized for these services;

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19.10 **REIMBURSEMENT** (cont.)

- B. The servicing provider's usual and customary charge; or
- C. The fee negotiated between the Waiver Services Provider and providers contracted for Environmental Modifications.

In accordance with Chapter I, it is the responsibility of the provider to seek payment from any other resources (private or group insurance benefits, Workers' Compensation, Medicare, etc.) that are available for payment of a rendered service prior to billing MaineCare. Therefore, a service provider under these HCB is expected to seek payment from sources other than MaineCare that may be available to the Member.

Providers should document all efforts to collect from a third party.

19.11 **BILLING INSTRUCTIONS**

Billing must be accomplished in accordance with the Billing Instructions and procedure codes in Chapter III.

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APPENDIX I: Task Time Allowances

ADL=Activities of Daily Living			
Activity	Definitions	Time Estimates	Considerations
Bed Mobility	How person moves to and from lying position, turns side to side position while still in bed.	5 – 10 Minutes	Position Supports, cognition, pain, disability level
Transfer	How person moves between surfaces to/from: bed, chair, wheelchair, standing position (exclude to/from bath/toilet)	5 – 10 minutes up to 15 minutes	Use of slide board, gait belt, swivel aid, supervision needed, positioning after transfer, cognition Mechanical lift transfer
Locomotion	How person moves between locations in his/her room and other areas on same floor. If in wheelchair, self-sufficiency once in chair	5 - 15 minutes (Document time and number of times done in POC)	Disability level, type of aids used, cognition, pain
Dressing & Undressing	How person puts on, fastens and takes off all items of street clothing, including donning/removing prosthesis	20 - 45 minutes	Supervision, disability, cognition, pain, type of clothing, type of prosthesis
Eating	How person eats and drinks (regardless of skill)	5 minutes 30 minutes 30 minutes	Set up, cut food and place utensils Individual is fed Supervision of activity due to swallowing, chewing, cognition issues
Toilet Use	How person uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter and adjusts clothes	5 -15 minutes/use	Bowel, bladder program, ostomy regimen, catheter regimen, cognition

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Personal Hygiene	How person maintains personal hygiene (exclude baths and showers)	20 min/day Washing face, hands, perineum, combing hair, shaving and brushing teeth 20 min/week Shampoo (only if done separately) 15 min up to 3 times/week Nail Care 20 min/week	Disability level, pain, cognition, adaptive equipment
Walking	a. How person walks for exercise only b. How person walks around own room c. How person walks within home d. How person walks outside	Document time and number of times in POC, and level of assistance needed	Disability, cognition, pain, mode of ambulation (cane), prosthesis needed for walking
Bathing	How person takes full-body bath/shower, sponge bath (exclude washing of back, hair), and transfers in/out oftub/shower	15 - 30 minutes	If shower used and shampoo done then consider as part of activity, cognition

IADL = Instrumental Activities of Daily Living			
Activity	Definitions	Time Estimates	Considerations
Light Meal, Lunch & Snacks	Preparation and clean up	5 – 20 minutes	Member participation; type of food preparation; number of meals in POC and preparation for more than one meal
Main Meal Preparation	Preparation and cleanup of main meal	20 - 40 minutes	Is Meals on Wheels being used? Preparation time for more than one meal and Member participation

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Light Housework/ Routine Housework	Dusting, picking up living space Kitchen housework- put the groceries away, general cleaning Making/changing beds Total floor care all rooms and bathrooms Garbage/trash disposal Non-routine tasks, outside chores, seasonal	30 min – 1.5 hr./week	Size of environment, Member needs and participation, others in household
Grocery Shopping	Preparation of list and purchasing of goods	45 min – 2 hours/week	Other errands included: bills, banking and pharmacy. Distance from home
Laundry	Sort laundry, wash, dry, fold and put away	In-home 30 minutes/load 2 loads/week	Other activities which can be done if laundry is done in the house or apartment
		Out of home 2 hours/week	

Task time allowances are used for the authorization of covered services under this Section. Refer to Section 19.04.

These allowances reflect the time normally allowed to accomplish the listed tasks. The Authorized Entity will use these allowances when authorizing a Member's plan of care for covered services. If these times are not sufficient when considered in light of a Member's extraordinary unique circumstances as identified by the Authorized Entity, the Authorized Entity may make an appropriate adjustment as long as the authorized hours do not increase.

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SECTION 19

Effective
 Retroactive
 to 7/1/2015

PROCEDURE CODE	DESCRIPTION	UNIT	RATE
H2014	Skills Training and Development (Participant Directed Option)	15 minutes	\$14.03
T2040U7	Financial Management, self-directed, waiver (Participant Directed Option)	Monthly	\$85.09
S5125	Attendant Care Services (Personal Care Services, Participant Directed Option)	15 minutes	\$3.21
T1019 0589	Personal Care Services (Agency PSS)	15 minutes	\$4.10
T1016	Care Coordination	15 minutes	\$17.00
S5160	Personal Emergency Response System, Installation and Testing	1 unit	Customary Charge, Not to Exceed \$45.00
S5161	Personal Emergency Response System, Service Fee	Monthly	Customary Charge, Not To Exceed \$35.00
H0045	Respite Care Services, not in the home	Per Diem	\$142.72
T1005	Respite Care Services, in the home	15 minutes	Actual Cost Not to Exceed Cap
T1005 U7	Respite Care Services, in the home-Participant Directed Option	15 minutes	Actual Cost Not to

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PROCEDURE CODE	DESCRIPTION	UNIT	RATE
			Exceed Cap
S5165	Environmental Modifications	Per Service	By report
S5100	Adult Day Health Services	15 Minutes	\$2.34
A9279	Assistive Technology-(Monitoring feature/device, stand alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified)	1 unit	Per device
A9279 QC	Assistive Technology-Remote Monitoring-Monthly fee	Monthly	Up to \$ 500.00
T2035	Assistive Technology-Transmission (Utility Services)	Monthly	Up to \$ 50.00
T1005	Respite Care, in the home by CNA/Home Health Aide	15 minutes	\$4.30
0669)		
0551	Skilled Nursing Visit (RN)	Per visit	\$84.10
0559	Other Nursing (LPN)	Per visit	\$58.88
0421	Physical Therapy Visit	Per visit	\$92.94
0431	Occupational Therapy Visit	Per visit	\$98.76
G0151 TF	Certified Physical Therapy Assistant- Home Health Services	Per visit	\$65.72
0421	Visit Charge		

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G0152 TF	Occupational Therapy Assistant- Home Health Services	Per visit	\$69.83
0431	Visit Charge		
0441	Speech Therapy Visit- Home Health Services	Per visit	\$97.34
PROCEDURE CODE	DESCRIPTION	UNIT	RATE
0571	Home Health Aide Visit- Home Health Services	Per visit	\$39.84
0561	Medical Social Services Visit- Home Health Services	Per visit	\$84.10
G0154 TD	Skilled Nursing Visit (RN) (Non Medicare Certified Home Health Agency) - Home Health Services	15 minutes	\$11.06
0559			
G0154 TE	Nursing Visit (LPN) (Non Medicare Certified Home Health Agency) - Home Health Services	15 minutes	\$6.32
0559			
G0151	Physical Therapy Visit- Home Health Services	15 minutes	\$12.36
0421			
G0152	Occupational Therapy Visit- Home Health Services	15 minutes	\$12.87
0431			
G0153	Speech Therapy Visit- Home Health Services	15 minutes	\$12.87
0441			
T1004	Certified Nurses Aide- Home Health Services	15 minutes	\$4.30
0581			
G0156	Home Health Aide- Home Health Services	15 minutes	\$4.30

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0571			
G0155	Medical Social Services Visit- Home Health Services	15 minutes	\$11.48
0561			

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INDEPENDENT PRACTITIONERS ONLY			
PROCEDURE CODE	DESCRIPTION	UNIT	RATE
G0154 TD	Skilled Nursing Visit (R.N.) - Home Health Services	15 minutes	\$8.17
G0151	Physical Therapy Visit- Home Health Services	15 minutes	\$10.80
G0152	Occupational Therapy Visit- Home Health Services	15 minutes	\$10.60
G0153	Speech Therapy Visit- Home Health Services	15 minutes	\$11.75