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**DATE:** August 23, 2016  
**TO:** Interested Parties  
**FROM:** Stefanie Nadeau, Director, MaineCare Services  
**SUBJECT:** **Emergency Adoption:** 10-144, C.M.R. ch. 101, MaineCare Benefits Manual, Chapter II & III, Section 17, Community Support Services

This letter gives notice of an emergency rule: MaineCare Benefits Manual, Section 17, Community Support Services

Following various changes to Ch. II Section 17 Community Support Services adopted by the Department on March 22, 2016, certain members no longer met clinical criteria for Community Support Services. This prompted a legislative review of the Section 17 rule changes, after which the legislature enacted Resolves 2016, ch. 82 (eff. Apr. 26, 2016). This Resolve requires the Department to extend the authorized service period for certain individuals who no longer meet clinical criteria for Section 17 services after the rule changes adopted on March 22, 2016. For members affected by the March 22<sup>nd</sup> rule change, the Department shall authorize a 120 day extension for the member's Section 17 services. Additionally, 90-day extensions may be granted, provided the member is able to reasonably demonstrate to the Department, or Authorized Entity, that he or she has attempted to and has been unable to access medically necessary covered services under any other section of the MaineCare Benefits Manual. The Ch. II changes shall be effective retroactive to April 26, 2016. The temporary transition period shall end on June 30, 2017.

Separately, the legislature enacted *An Act to Increase Payments to MaineCare Providers that are Subject to Maine's Service Provider Tax*, P.L. 2016, ch. 477 (eff. Apr. 15, 2016). Certain MaineCare providers subject to the service provider tax have experienced an increase in the tax to 6% since January 1, 2016. The legislature thus provided additional appropriations to certain MaineCare providers, including Section 17 providers, in an effort to offset the increase in the provider tax. The Department is seeking and anticipates CMS approval of the reimbursement changes for Section 17 providers. Pending approval, the Department will reimburse providers under the new increased rates retroactively to July 1, 2016 pursuant to P.L. 2016, ch. 477 (eff. Apr. 15, 2016).

Each of the new laws were enacted by the Legislature on an emergency basis. Given that each law provides benefits to the regulated community, and the time-sensitive, limited nature of the extension in eligibility, the Department is authorized to enact these changes to Section 17 on an emergency basis, without the findings required by 5 M.R.S. § 8054(2). These emergency rule changes shall be effective for ninety (90) days. The Department shall engage in proposed routine technical rulemaking to permanently adopt these Section 17 rule changes.

Finally, the Department notes that on April 29, 2016, the legislature overrode the Governor's veto of LD 1696, Resolve, *To Establish a Moratorium on Rate Changes Related to Rule Chapter 101: MaineCare Benefits Manual, Sections 13, 17, 28 and 65* (Resolves 2016, ch. 88). That law imposes a moratorium on rulemaking to change reimbursement rates, including Section 17, until after a rate study has been completed and presented to the Legislature. The Department consulted with the Office of Attorney General and the Office of the Attorney General determined and has advised the Department that Resolves 2016, ch. 88 does not prevent the instant rule changes because (1) the separate law, P.L. 2016, ch. 477, is more specific in regard to changing reimbursement for providers impacted by the Service Provider Tax increase; and (2) these are reimbursement rate increases, thus providing a benefit to MaineCare providers.

Rules and related rulemaking documents may be reviewed at and printed from 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.

If you have any questions regarding the policy, please contact Provider Services at 1-866-690-5585 or TTY users call Maine relay 711.

## Notice of Agency Rule-making Adoption

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

**CHAPTER NUMBER AND TITLE:** 10-144 C.M.R. Chapter 101, MaineCare Benefits Manual, Chapters II & III, 101, Section 17, Community Support Services and Allowances for Community Support Services

**ADOPTED RULE NUMBER:**

**CONCISE SUMMARY:** The Department adopts this emergency rule to effectuate the following changes:

1. Following various changes to Ch. II Section 17 Community Support Services adopted by the Department on March 22, 2016, certain members no longer met clinical criteria for Community Support Services. This prompted a legislative review of the Section 17 rule changes, after which the legislature enacted Resolves 2016, ch. 82 (eff. Apr. 26, 2016). This Resolve requires the Department to extend the authorized service period for certain individuals who no longer meet clinical criteria for Section 17 services after the rule changes adopted on March 22, 2016. For members affected by the March 22<sup>nd</sup> rule change, the Department shall authorize a 120 day extension for the member's Section 17 services. Additionally, 90-day extensions may be granted, provided the member is able to reasonably demonstrate to the Department, or Authorized Entity, that he or she has attempted to and has been unable to access medically necessary covered services under any other section of the MaineCare Benefits Manual. The Ch. II changes shall be effective retroactive to April 26, 2016. The temporary transition period shall end on June 30, 2017.
2. Separately, the legislature enacted *An Act to Increase Payments to MaineCare Providers that are Subject to Maine's Service Provider Tax*, P.L. 2016, ch. 477 (eff. Apr. 15, 2016). Certain MaineCare providers subject to the service provider tax have experienced an increase in the tax to 6% since January 1, 2016. The legislature thus provided additional appropriations to certain MaineCare providers, including Section 17 providers, in an effort to offset the increase in the provider tax. The Department is seeking and anticipates CMS approval of the reimbursement changes for Section 17 providers. Pending approval, the Department will reimburse providers under the new increased rates retroactively to July 1, 2016 pursuant to P.L. 2016, ch. 477 (eff. Apr. 15, 2016).
3. Each of the new laws were enacted by the Legislature on an emergency basis. Given that each law provides benefits to the regulated community, and the time-sensitive, limited nature of the extension in eligibility, the Department is authorized to enact these changes to Section 17 on an emergency basis, without the findings required by 5 M.R.S. § 8054(2). These emergency rule changes shall be effective for ninety (90) days. The Department shall engage in proposed routine technical rulemaking to permanently adopt these Section 17 rule changes.
4. Finally, the Department notes that on April 29, 2016, the legislature overrode the Governor's veto of LD 1696, Resolve, *To Establish a Moratorium on Rate Changes Related to Rule Chapter 101: MaineCare Benefits Manual, Sections 13, 17, 28 and 65* (Resolves 2016, ch. 88). That law imposes a moratorium on rulemaking to change reimbursement rates, including Section 17, until after a rate study has been completed and presented to the Legislature. The Department consulted with the Office of Attorney General and the Office of the Attorney General determined and has

advised the Department that Resolves 2016, ch. 88 does not prevent the instant rule changes because (1) the separate law, P.L. 2016, ch. 477, is more specific in regard to changing reimbursement for providers impacted by the Service Provider Tax increase; and (2) these are reimbursement rate increases, thus providing a benefit to MaineCare providers.

See <http://www.maine.gov/dhhs/oms/rules/index.shtml> for rules and related rulemaking documents.

**EFFECTIVE DATE:** September 2, 2016  
**AGENCY CONTACT PERSON:** Dean Bugaj, Comprehensive Health Planner  
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10-144 Chapter 101  
 MAINECARE BENEFITS MANUAL  
 CHAPTER II

---

Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
------------	--	--

---

**TABLE OF CONTENTS**

17.01	<b>DEFINITIONS</b> .....	1
	17.01-1 Authorized Entity .....	1
	17.01-2 Certified Employment Specialist.....	1
	17.01-3 Certified Intentional Peer Support Specialist .....	1
	17.01-4 Certified Rehabilitation Counselor.....	1
	17.01-5 Clinician .....	1
	17.01-6 Community Support Service .....	1
	17.01-7 Community Support Provider .....	1
	17.01-8 Covered Service .....	1
	17.01-9 CRMA .....	2
	17.01-10 Homeless Person .....	2
	17.01-11 Individual Support Plan.....	2
	17.01-12 Level of Care Utilization System (LOCUS) .....	2
	17.01-13 LOCUS Certified Assessor .....	2
	17.01-14 MHRT-1 .....	2
	17.01-15 MHRT/C.....	2
	17.01-16 Natural Supports.....	2
	17.01-17 Peer.....	2
	17.01-18 Primary Diagnosis .....	3
	17.01-19 Prior Authorization .....	3
	17.01-20 Substance Abuse Counselor .....	3
	17.01-21 Utilization Review.....	3
17.02	<b>ELIGIBILITY FOR CARE</b> .....	3
	17.02-1 Requirements for Eligibility.....	3
	17.02-2 General Requirements.....	3
	17.02-3 Specific Requirements.....	4
	17.02-4 Determination of Eligibility.....	5
17.03	<b>TIMELINESS AND DURATION OF CARE</b> .....	6
	17.03-1 Temporary Transition Period .....	6
17.04	<b>COVERED SERVICES</b> .....	7
	17.04-1 Community Integration Services.....	7
	17.04-2 Community Rehabilitation Services.....	9
	17.04-3 Assertive Community Treatment .....	9
	17.04-4 Daily Living Support Services .....	12
	17.04-5 Skills Development Services.....	13
	17.04-6 Day Supports Services.....	14
	17.04-7 Specialized Group Services.....	14

Effective  
9/2/16

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

---

Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
------------	--	--

---

**TABLE OF CONTENTS (cont.)**

17.04-8	Interpreter Services.....	15
17.05	<b>LIMITATIONS</b> .....	16
17.05-1	Reimbursement.....	16
17.05-2	Multiple Providers.....	16
17.05-3	Concurrent Provision of Services.....	16
17.05-4	Location.....	17
17.05-5	Private Non-Medical Institutions .....	17
17.05-6	Utilization Review.....	18
17.05-7	Exclusivity of Billing .....	18
17.06	<b>NON-COVERED SERVICES</b> .....	18
17.07	<b>PROFESSIONAL AND OTHER QUALIFIED STAFF</b> .....	19
17.07-1	Mental Health Professionals .....	19
17.07-2	Other Qualified Individuals .....	20
17.08	<b>POLICIES AND PROCEDURES</b> .....	21
17.08-1	Assessments .....	21
17.08-2	Individual Support Plan.....	22
17.08-3	Records .....	23
17.08-4	Member Appeals .....	23
17.09	<b>PROGRAM INTEGRITY AND QUALITY ASSURANCE</b> .....	23
17.09-1	Role of Department of Health and Human .....	23
17.09-2	Waiver Criteria.....	23
17.10	<b>REIMBURSEMENT</b> .....	24
17.10-1	Rates.....	24
17.10-2	Services Provided in a Group.....	24
17.10-3	Reimbursement Allowances.....	25
17.10-4	Exemption From Rounding.....	25
17.11	<b>CONFIDENTIALITY</b> .....	25
17.12	<b>BILLING INSTRUCTIONS</b> .....	25

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

---

Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
------------	--	--

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**17.01 DEFINITIONS**

For purposes of Section 17, the following words have the following meanings:

- 17.01-1 **Authorized Entity** means an entity authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.
  
- 17.01-2 **Certified Employment Specialist** means an individual who has completed an Association of Community Rehabilitation Educators (ACRE) approved course- - or other employment specialist training approved by DHHS and maintains certification.
  
- 17.01-3 **Certified Intentional Peer Support Specialist (CIPSS)** means an individual who has completed the DHHS Office of Substance Abuse and - Mental Health Services (SAMHS) curriculum for CIPSS and receives and maintains certification.
  
- 17.01-4 **Certified Rehabilitation Counselor** means an individual certified by the Commission on Rehabilitation Counselor Certification.
  
- 17.01-5 **Clinician** is an individual appropriately licensed or certified in the state or province in which he or she practices, practicing within the scope of that licensure or certification, and qualified to deliver treatment under this Section. A clinician includes the following: Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-conditional (LCPC-conditional); Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker-conditional (LMSW-conditional clinical); physician, psychiatrist; Advance Practice Registered Nurse Psychiatric and Mental Health Practitioner (APRN-PMH-NP); Advanced Practice Registered Nurse Psychiatric and Mental Health Clinical Nurse Specialists (APRN-PMH-CNS); Physician Assistant (PA); or licensed psychologist.
  
- 17.01-6 **Community Support Service** means a rehabilitative service that is provided in the context of a supportive relationship, pursuant to an individual support plan that promotes a person’s recovery, and integration of the person into the community, and sustains the person in his or her current living situation or another living situation of his or her choice.
  
- 17.01-7 **Community Support Provider** means an agency that is licensed by DHHS, holds a valid contract with DHHS, and has received a rate-setting letter from DHHS to provide Community Support Services to members eligible for covered services under Section 17.02. Please refer to Section 17.05-2 for detail on multiple providers of Community Support Services. DHHS will contract with all agencies that are willing and able to meet the standard DHHS requirements for providing community support services and the standard contract requirements.
  
- 17.01-8 **Covered Service** means a Community Support Service for which Community

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

---

Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
------------	--	--

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17.01 **DEFINITIONS** (cont.)

Support Providers can be reimbursed under the MaineCare Program.

- 17.01-9 **Certified Residential Medications Aide (CRMA)** means an individual who holds a current certification from DHHS as a Certified Residential Medication Aide.
- 17.01-10 **Homeless person** means a person sleeping in places not meant for human habitation, such as cars, parks, sidewalks, and abandoned or condemned buildings, or is sleeping in homeless shelters.
- 17.01-11 **Individual Support Plan (ISP)** is developed for and with a member receiving Community Support Services by a Community Support Provider. An Individual Support Plan (ISP):
- A. Reflects the strengths and needs of the member;
  - B. Reflects services that follow the member’s goals; and
  - C. Reflects the resources that will meet the member’s goals in the community, including the natural supports available or in need of being created.
- 17.01-12 **Level of Care Utilization System (LOCUS)** is Level of Care Utilization System for Psychiatric and Addiction Services, of the American Association of Community Psychiatrists.
- 17.01-13 **LOCUS Certified Assessor** is an individual certified for LOCUS assessment by DHHS upon successful completion of prescribed LOCUS training.
- 17.01-14 **MHRT-1** means an individual who has received Mental Health Rehabilitation Technician-1 certification from DHHS to provide service under Section 17.04-4 or Section 97, “Private Non-Medical Institutions”, MaineCare Benefits Manual.
- 17.01-15 **MHRT/C** means an individual who has received Mental Health Rehabilitation Technician/Community certification from DHHS.
- 17.01-16 **Natural Supports** means personal associations and relationships typically developed in the community that enhance the quality and security of life for people. Natural Supports include, but are not limited to: family relationships; friendships reflecting the diversity of the neighborhood and the community; association with fellow students or employees in regular classrooms or work places; and associations developed through participation in clubs, organizations, and other civic associations.
- 17.01-17 **Peer** means an individual who is receiving or who has received services related to the diagnosis of a major mental illness and is willing to self-identify with peers on this

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

---

Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
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17.01 **DEFINITIONS** (cont.)

basis in the community.

17.01-18 **Primary Diagnosis** for the purposes of this policy, primary diagnosis shall mean the diagnosis that results in qualifying functional deficits.

17.01-19 **Prior Authorization (PA)** means the process of obtaining DHHS prior approval based on eligibility and medical necessity for a service. All services in this Section except Specialized Group Services require prior authorization by the Department or an Authorized Entity. After submitting a PA request, the provider will receive prior authorization with a description of the type, duration and costs of the services authorized. The provider is responsible for providing services in accordance with the prior authorization and the requirements in this section. The prior authorization number is required on the CMS 1500 claim form. All extensions of services beyond the original authorization must be prior authorized by this same procedure.

17.01-20 **Substance Abuse Counselor** means an individual who is licensed by the Maine State Board of Alcohol and Drug Counselors as a Certified Alcohol and Drug Counselor (CADC), Licensed Alcohol and Drug Counselor (LADC); or an Advanced Practice Registered Nurse (APRN), Licensed Physician (MD or DO), Physician Assistant (PA), Licensed Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC), or Licensed Marriage and Family Therapist (LMFT) who has at a minimum one (1) year of clinical experience providing substance abuse treatment.

17.01-21 **Utilization Review** means a formal assessment of the medical necessity, efficiency and appropriateness of services and treatment plans on a prospective, concurrent or retrospective basis. The provider is required to notify the DHHS or an Authorized Entity prior to initiation of services in order for the Department or an Authorized Entity to begin utilization review.

17.02 **ELIGIBILITY FOR CARE**

17.02-1 **Requirements for Eligibility.** A person is eligible to receive covered services if he or she meets both general MaineCare eligibility requirements and specific eligibility requirements for Community Support Services. Eligibility for services under the *MaineCare Benefits Manual*, Chapter II, Section 13, Targeted Case Management Services, - Section 65, Behavioral Health Services, Section 91, Health Home Services and Section 92, Behavioral Health Home Services may not preclude eligibility for covered services under this Section. However, services must be coordinated and not duplicated.

17.02-2 **General Requirements.** Individuals must meet the eligibility criteria as set forth in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

17.02 **ELIGIBILITY FOR CARE** (cont.)

and amount of services they are eligible to receive.

17.02-3 **Specific Requirements.** A member meets the specific eligibility requirements for covered services under this section if:

- A. The person is age eighteen (18) or older or is an emancipated minor with:
1. A primary diagnosis of Schizophrenia or Schizoaffective disorder in accordance with the DSM 5 criteria; or
  2. Another primary DSM 5 diagnosis or DSM 4 equivalent diagnosis with the exception of Neurocognitive Disorders, Neurodevelopmental Disorders, Antisocial Personality Disorder and Substance Use Disorders who:
    - a) has a written opinion from a clinician, based on documented or reported history, stating that he/she is likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in or have significant risk factors of homelessness, criminal justice involvement or require a mental health inpatient treatment greater than 72 hours, or residential treatment unless community support program services are provided; based on documented or reported history; for the purposes of this section, reported history shall mean an oral or written history obtained from the member, a provider, or a caregiver; or
    - b) has received treatment in a state psychiatric hospital, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
    - c) has been discharged from a mental health residential facility, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
    - d) has had two or more episodes of inpatient treatment for mental illness, for greater than 72 hours per episode, within the past 24 months, for a non-excluded DSM 5 diagnosis; or
    - e) has been committed by a civil court for psychiatric treatment as an adult; or
    - f) until the age of 21, the recipient was eligible as a child with severe emotional disturbance, and the recipient has a written opinion from a clinician, in the last 12 months, stating that the recipient had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided.

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

17.02 **ELIGIBILITY FOR CARE** (cont.)

AND

- B. Has significant impairment or limitation in adaptive behavior or functioning directly related to the primary diagnosis and defined by the LOCUS or other acceptable standardized assessment tools approved by the Department. If using the LOCUS, the member must have a LOCUS score, as determined by a LOCUS Certified Assessor, of seventeen (17) (Level III) or greater, except that to be eligible for Community Rehabilitation Services (17.04-2) and ACT (17.04-3), the member must have a LOCUS score of twenty (20) (Level IV) or greater.
- C. Eligible members who are eighteen (18) to twenty-one (21) years of age shall elect to receive services as an adult or as a child. Those members electing services as an adult are eligible for services under this Section. Those electing services as a child may be eligible for services under Chapter II, Section 65, Behavioral Health Services or Section 13 or both.
- D. The LOCUS or other approved tools must be administered, at least annually, or more frequently, if DHHS or an Authorized Entity requires it.

17.02-4 **Determination of Eligibility.** For each member seeking Community Support Services, a Community Support Provider will:

- A. Verify the member's eligibility for MaineCare; and
- B. Determine the member's eligibility, initially and annually, for Community Support Services. The annual eligibility verification must include a recent diagnosis that is supported by evidence provided of symptoms as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders, completed within the past year, as documented by an appropriately licensed clinician.
- C. For Community Integration Services only, verify that a member meets specific Eligibility Requirements under 17.02-3 within thirty (30) days of the start date of services. If eligibility verification is not submitted by close of business on day thirty (30), MaineCare will cease payment for services under this section on day thirty one (31).

Requests for a waiver of 17.02-3 Specific Requirements for eligibility must be made in accordance with 17.09-2(A).

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

17.03 **TIMELINESS AND DURATION OF CARE**

For Community Integration Services, providers must conduct an initial face-to-face intake or initial assessment visit within seven (7) calendar days of referral, regardless of source of referral. Except as expressly provided in Section 17.04, a member is eligible for the covered services specified in Section 17.04 for as long as he or she meets the criteria for eligibility specified in Section 17.02, subject to prior authorization and/or utilization review. Utilization review (Continuing stay reviews) consider the member's complete clinical situation and what the progress has been throughout treatment, in conjunction with the LOCUS score or functional impairment criteria as evidenced by other approved standardized assessment tools. An improvement in functioning level or adaptive behaviors - will not in and of itself necessarily mean ineligibility for services.

17.03-1 **Temporary Transition Period.** This section pertains only to members who, following the routine technical rulemaking adopted March 22, 2016, no longer meet clinical eligibility criteria for Section 17 Community Support Services.

Effective retroactive to March 23, 2016, a member shall be eligible for an extension of eligibility not to exceed 120 days after his or her current authorization period expiration if:

- (a) The member was eligible for and received Section 17 covered services as of March 22, 2016; and
- (b) After March 22, 2016, the member became clinically ineligible for such services.

Effective  
9/2/16

Any temporary extension shall be effective only until the member accesses medically necessary covered services under another section of the MaineCare Benefits Manual. Should a member be unable to access other medically necessary covered services within the initial 120 day extension of eligibility, and can demonstrate reasonable efforts to access such services, the Department may authorize additional 90 day extensions of Section 17 covered services.

**This temporary transition period shall end effective June 30, 2017.**

In the event of Section 17 service denial, the member's current Community Supports Services provider will actively engage with the member in seeking medically necessary covered service alternatives, and will document all correspondence (verbal and/or written) in attempting to secure covered service alternatives. The current Community Support Services provider will facilitate the member's transition to an alternative covered service, which may include coordinating with an alternative provider to ensure the transition is successful.

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

**17.04 COVERED SERVICES**

The following are covered services reimbursable under MaineCare. All services delivered will ensure that member voice and choice are reflected in all Plan development:

17.04-1 **Community Integration Services.** Community Integration Services, involve biopsychological - assessment of the member, evaluation of community services and natural supports needed by the member who satisfies the eligibility requirements of Section 17.02, and rapport building through assertive engagement and linking to necessary natural supports and community services while providing ongoing assessment of the efficacy of those services.- -

Community Integration Services involve active participation by the member or guardian. The services also involve active participation by the member's family or significant other, unless their participation is not feasible or is contrary to the wishes of the member or guardian. These services are provided - -as indicated on the ISP. These services may not be provided in a group.

A Community Support Provider furnishing Community Integration Services must employ a certified MHRT/C who performs the following:

- A. Identifies the medical, social, residential, educational, vocational, emotional, and other related needs of the member;
- B. Performs a psychosocial assessment, including history of trauma and abuse, history of substance abuse, general health, medication needs, self-care potential, general capabilities, available support systems, living situation, employment status and skills, training needs, and other relevant capabilities and needs;
- C. Facilitate formal and informal opportunities for career exploration during service delivery time for working-age and transition age youth participants;
- D. Provides assertive, persistent engagement to build rapport and trust with individuals who may be reluctant to accept those services necessary to meet their individual goals;
- E. Develops an ISP that is based on the results of the assessment in Section 17.04-1(B), which includes:
  - 1. Statements of the member's desired goals and related treatment and rehabilitation goal(s);
  - 2. A description of the service(s) and natural support(s) needed by the member to address the goal(s);

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

**17.04 COVERED SERVICES (cont.)**

3. A statement for each goal of the frequency and duration of the needed service(s) and support(s);
  4. The identification of providers of the needed service(s) and natural support(s);
  5. The identification and documentation of the member's unmet needs; and
  6. A review of the plan at least every ninety (90) days to determine the efficacy of the services and natural supports and to formulate changes in the plan as necessary.
- F. Coordinates referrals, and advocates access by the member to the service(s) and natural support(s) identified in his or her Individual Support Plan;
- G. Participates in ensuring the delivery of crisis intervention and resolution services, providing follow-up services to ensure that a crisis is resolved and assistance in the development and implementation of crisis management plans;
- H. Assists in the exploration of less restrictive alternatives to hospitalization;
- I. Makes face-to-face contact with other professionals, caregivers, or individuals included in the treatment plan in order to achieve continuity of care, coordination of services, and the most appropriate - services for the member per their ISP;
- J. Contacts the member's guardian, family, significant other, and providers of services or natural supports to ensure the continuity of care and coordination of services between inpatient and community settings;
- K. Evaluates service provision to determine whether the member's ISP needs to be revised, whether a new plan is needed, or whether services should be terminated;
- L. Provides information and consultation with the member receiving Community Support Services, to the member, his or her family, or his or her immediate support system, in order to assist the member to manage the symptoms or impairments of his or her illness with a focus on independence; and
- M. Assists the member in restoring and improving - communication skills needed to request assistance or clarification from supervisors and co-workers when needed and in -enhancing skills and employing strategies to overcome

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

---

Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
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17.04 **COVERED SERVICES** (cont.)

or address psychiatric symptoms that interfere with seeking, obtaining, and maintaining a job.

17.04-2 **Community Rehabilitation Services.** Community Rehabilitation Services support the development of the necessary skills for living in the community, and promote recovery, and community inclusion. Services include individualized combinations of the following, and are delivered by a team, with primary case management for each member assigned to one team member.

- Community Integration Services as defined in Section 17.04-1 of the *MaineCare Benefits Manual*
- Daily Living Support Services as defined in Section 17.04-4 of the *MaineCare Benefits Manual*
- Skills Development Services as defined in Section 17.04-5 of the *MaineCare Benefits Manual*

Services must be available twenty-four (24) hours a day, seven (7) days a week. Staff must be at a work site twelve (12) hours per day and on call the remainder.

A minimum of one (1) face-to-face contact per day, seven (7) days per week must be provided.

The team providing services must be provided by a team made up of MHRT/1's and MHRT/C's, delivering services within the scope of their certifications. The minimum staffing ratio for the team is one (1) staff person to six (6) members. Replacement staff and supervisors are excluded from calculation of the staffing ratio.

Services must be prior authorized by the Department or an Authorized Entity and be appropriate to meet the clinical and rehabilitation needs of the member.

17.04-3 **Assertive Community Treatment.** Assertive Community Treatment (ACT) provides individualized intensive integrated services that are delivered by a multi-disciplinary team of practitioners and are available twenty-four (24) hours a day, every day, three hundred and sixty five (365) days a year. ACT services are delivered primarily in the community and not in an office based setting. Assertive interventions, including street outreach, are employed by the team as appropriate. ACT teams must provide at least on average, per member, three (3) face-to-face contacts with the member per week. There may be exceptions to the three (3) face-to-face contact requirements and the member's record must clearly document why the contacts did not occur, such exceptions may include;

1. All attempts to reach and meet with the member, including if the

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

---

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

---

**17.04 COVERED SERVICES (cont.)**

member was unavailable or the contact occurred through a closed door.

2. Contacts to transition the member to another level of care.
3. Variations in the number of weekly face-to-face contacts i.e. two (2) contacts in one week and four (4) the next.

If the member is seen as not tolerating or benefitting from the level of intensity of ACT services, the member should be re-evaluated for a different service or level of care.

ACT teams must assume clinical responsibility for all members on the team and must offer all of the following services and support:

- Individual assessment and individual support plan development;
- Development and implementation of a comprehensive crisis management plan and provision of follow-up services, including emergency face-to-face contact, if necessary, to assure services are delivered and the crisis is resolved;
- Use and promotion of informal and natural supports to assist the member with integration in the community;
- Contacts with the member's parent, guardian, other family members, and providers of services or natural supports, as appropriate, to ensure continuity of care and coordination of services within and between inpatient and community settings;
- Individual, group and family outpatient therapy, supportive counseling or problem-solving activities in order to maintain and support the member's
- recovery and provide the support necessary to help the member manage the
- symptoms of the member's illness and co-occurring substance abuse;
- Linking and evaluating the efficacy of services and natural supports, and formulating changes to the individual support plan as necessary;
- Medication services, including medication management and administration, which minimally includes:
  - 1) one (1) face-to-face contact per month with the psychiatrist; or a psychiatric and mental health nurse practitioner (NP);

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

17.04 **COVERED SERVICES** (cont.)

- 2) capacity to administer medications daily in a member's home or community by an appropriately licensed or certified ACT team professional.
- Employment assistance including facilitating formal and informal opportunities for career exploration and assisting the member in obtaining and maintaining competitive employment; and
  - Housing assistance.
- A. The minimum overall staffing ratio for an ACT team is one (1) staff person to ten (10) members. Administrative staff are excluded from calculation of the staffing ratio. ACT team staff must include;
1. a Team Leader, who may be one of the staff listed below but must be an independently licensed professional. The team leader must spend at least twenty five percent (25%) of his or her work hours providing direct service to the members. The team leader must be at least one (1.0) FTE (full time equivalent);
  2. a psychiatrist or a psychiatric and mental health clinical nurse specialist (CNS), or a psychiatric and mental health nurse practitioner (NP), who is at least one-half (.5) FTE for every fifty (50) members and provides clinical leadership to the team in conjunction with the Team Leader;
  3. a registered nurse, who is at least one (1.0) FTE for every fifty (50) members;
  4. a certified rehabilitation counselor or employment specialist, who spends at least ninety percent (90%) of his or her time on employment related activities and who is at least one (1.0) FTE for every fifty (50) members;
  5. a Certified Intentional Peer Support Specialist (CIPSS), who is at least one (1) FTE, except that this requirement become effective one (1) year following CMS approval of a state plan amendment requiring peer participation on ACT teams; and
  6. a substance abuse counselor who is at least one-half (.5) FTE for every fifty (50) members.
- B. Multidisciplinary teams **may also** include any of the following;
1. a licensed occupational therapist,

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

---

Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
------------	--	--

---

17.04 **COVERED SERVICES** (cont.)

2. an MHRT/C,
3. a licensed psychologist, or
4. a licensed clinical social worker or a licensed clinical professional counselor.

17.04-4 **Daily Living Support Services.** Daily Living Support Services are designed to assist a member to maintain the highest level of independence possible. The services provide personal supervision and therapeutic support to assist members to develop and maintain the skills of daily living. The services help members remain oriented, healthy, and safe. Without these supportive services, members likely would not be able to retain community tenure and would require crisis intervention or hospitalization. These services are provided to members in or from their homes or temporary living quarters in accordance with an individual support plan. Support methods include modeling, cueing, and coaching. The services do not include specialized crisis support services as described in the *MaineCare Benefits Manual, Chapter II, Section 65, Behavioral Health Services, subsection 65.06-1, Crisis Resolution*. Daily Living Support Services are provided by an MHRT-1, except that when Daily Living Support Services includes administration and supervision of medication, a CRMA must provide that portion of the services.

Daily Living Support Services do not include:

- A. Programs, services or components of services that are primarily opportunities for socialization and activities that are solely recreational in nature (such as picnics, dances, ball games, parties, field trips, religious activities, social clubs, camp and companionship activities).
- B. Programs, services or components of services the basic nature of which is to maintain or supplement housekeeping, homemaking or basic services for the convenience of a person receiving services (including housekeeping, shopping, child care and laundry services).

A Community Support Provider who furnishes services to a member under Sections 17.04-1 or 17.04-3 may also contract with DHHS to furnish Daily Living Support Services to the member concurrently. Requests for these concurrent services must be approved by DHHS or an - Authorized Entity -, in accordance with Section 17.09-2(B). If approved, the provider shall review the member's ISP, developed pursuant to 17.04-1(E) at least every ninety (90) days to determine whether the Daily Living Support Services should be continued. DHHS or an Authorized Entity must determine at least every ninety (90) days whether to authorize continuation of the services upon request in accordance with Section 17.09-2(B).

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

---

Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
------------	--	--

---

17.04 **COVERED SERVICES** (cont.)

A Community Support Provider may furnish Daily Living Support Service to a member, even though the provider is not concurrently furnishing services to the member under Sections 17.04-1 or 17.04-3 or Section 92. In that event, another Community Support Provider who is under contract with DHHS to provide services under Sections 17.04-1 or 17.04-3 or Section 92 must review the member's ISP, developed pursuant to 17.04-1(E) or Section 92 at least every ninety (90) days and determine whether the Daily Living Support Services should be continued. DHHS or an Authorized Entity- must determine at least every ninety (90) days whether to authorize continuation of the services, upon request in accordance with Section 17.09-2(B). Daily Living Support Services may not be provided concurrently to the member under Section 17.04-5, Skills Development Services.

17.04-5 **Skills Development Services.** Skills Development Services involve face-to-face contact with the member with or without family or non-professional caregivers that restore and improve the member's skills and abilities essential to independent living (i.e. self-care and daily life management). Services may be provided to an individual or in a group setting and are targeted to enhance access to community resources, with natural supports, increase independence to promote successful community integration. Skill enhancement is provided through structured interventions for attaining goals identified in the ISP. Progress on goals will be reviewed at least every ninety (90) days to determine the efficacy of the services and natural supports and to formulate changes in the plan as necessary.

Skills Development Services are provided - by an MHRT/C and when Skills Development includes administration and supervision of medication, a CRMA must provide that portion of the services.

When Skills Development Services are related to supporting -employment for a member, they must be billed with the code for "Ongoing Support to Maintain Employment." Such services are focused on managing behaviors or symptoms that interfere with an individual's ability to obtain or retain employment. Services include instruction in dress, grooming and socially acceptable behaviors in the workplace, supportive contacts on or off the job, instruction and skill development on how to request workplace accommodation, how to solve problems and resolve coworker conflict.

When Skills Development Services are provided to a member for ten (10) or fewer hours per week, continuation of the services beyond one (1) year requires, upon request, prior authorization by DHHS or an Authorized Entity -, in accordance with Section 17.09-2(B). When services are provided for more than ten (10) hours per week, DHHS or an Authorized Entity must review continuation of the services every ninety (90) days in accordance with Section 17.09-2(B). Skills Development may be provided in a group when facilitated by qualified staff and

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

---

Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
------------	--	--

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17.04 **COVERED SERVICES** (cont.)

comply with 17.10-2. Skills Development Services may not be provided concurrently to the member with Section 17.04-4.

17.04-6 **Day Supports Services.** Day Supports Services, formerly known as “day treatment,” focus on training designed to assist the member in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills. These services take place in an agency environment. They are offered most often in a group setting and are provided by certified MHRT/Cs under the supervision of, or are co-facilitated by, a mental health professional as defined in 17.07-1. Day Supports Services are covered for one (1) year from the start date of the services unless, upon request of the provider, DHHS or an Authorized Entity - approves continuation of the services in accordance with Section 17.09-2(B).

17.04-7 **Specialized Group Services.** Specialized Group Services consist of education, peer, and family support, provided in a group setting, to assist the members to focus on recovery, wellness, meaningful activity, and community tenure. When co-facilitated by two non-licensed mental health professionals, including Other Qualified Individuals, a licensed mental health professional must supervise the co facilitators.

Specialized Group Services fall into the following four (4) groups:

- A. **Wellness Recovery Action Planning (WRAP).** Wellness Recovery Action Planning is a curriculum-based self-management and recovery system developed, trademarked, and maintained by the Copeland Center for Wellness and Recovery. WRAP explores the foundational concepts of recovery and wellness, including hope, personal responsibility, and education; increases the understanding of personal experiences; encourages the use of natural supports; and helps individuals develop a personal plan that promotes an improved quality of life focusing on relapse prevention, personal growth and recovery. The group meets for a maximum of twelve (12) sessions of two (2) hours each.

WRAP services are co-facilitated by peers who are CIPSS certified and, who must have successfully completed the Copeland Center's "Mental Health Recovery WRAP: Facilitator Certification" program or any equivalent successor Copeland Center program for certifying WRAP facilitators. More information about WRAP training and certification is available by calling the Office of Substance Abuse and - Mental Health Services toll-free at (800) 499-0027 or (207) 287-4243 or (207) 287-4250 (Maine Relay 711) or by contacting the Copeland Center directly at:

Copeland Center for Wellness & Recovery  
P. O. Box 6471 -  
Brattleboro, VT 05302 -  
Phone: (802) 254-5335 -

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

17.04 **COVERED SERVICES** (cont.)

<http://www.copelandcenter.com>

- B. **Recovery Workbook Group.** Recovery Workbook Group is a co-facilitated, curriculum-based recovery group designed to increase awareness and understanding of the recovery process. This service includes the development of coping and empowerment strategies, skills for rebuilding connections with self or others, and skills needed to strengthen and maintain the recovery process and to create opportunities for living fuller lives. The group meets for a maximum of thirty (30) weekly two (2) hour sessions for a total of sixty (60) hours covering seven (7)- sessions. The service is facilitated by individuals who have received a certificate for successful completion of the course “PDP 703-REC: Facilitating a Recovery Workshop” through the Boston University Center for Psychiatric Rehabilitation. The Recovery Workbook Group is co-facilitated and requires at least one peer facilitator who is CIPSS certified. The second co- facilitator may be a peer, mental health professional, or other qualified individual.
- C. **Trauma Recovery and Empowerment Group (TREM).** Trauma Recovery and Empowerment Group utilizes a skills-based group treatment approach to address issues of sexual, physical, and emotional abuse. The co-facilitated group meets for a maximum of thirty-three (33) sessions offered over a nine (9) month period for trauma survivors -. Thirty (30) sessions focus on empowerment, trauma recovery, and advanced trauma recovery issues. The remaining three (3) sessions serve as the conclusion, or termination, for the group. Each session is seventy-five (75) minutes long and includes a combination of discussion and experiential exercises. Format for the group is based upon “*Trauma Recovery and Empowerment – A Clinician’s Guide for Working with Women in Groups*” authored by Maxine Harris, Ph.D. and The Community Connections Trauma Work Group and may include utilization of the workbook entitled “*Healing the Trauma of Abuse*” co-authored by Mary Ellen Copeland. M.A., M.S., and Maxine Harris, Ph.D.
- D. **Dialectical Behavior Therapy (DBT).** Dialectical Behavior Therapy is a skills training group conducted in a psychoeducational format. The co-facilitated group focuses on the acquisition and strengthening of skills. Skills training consists of four (4) modules: mindfulness, distress tolerance, interpersonal effectiveness in conflict situations, and emotional regulation. Groups meet weekly for two (2) to two and a half (2 1/2) hour sessions for up to one (1) year, but may meet more frequently for a shorter duration. Format for the group is based upon “*Skills Training Manual for Treating Border-Line Personality Disorder*” authored by Marsha M. Linehan.

17.04-8 **Interpreter Services.** Interpreter Services for MaineCare members who are hearing impaired or who do not speak English may be reimbursed in accordance with Chapter I, Section 1.06-3, of the *MaineCare Benefits Manual*.

10-144 Chapter 101  
 MAINECARE BENEFITS MANUAL  
 CHAPTER II

Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
------------	--	--

**17.05 LIMITATIONS**

17.05-1 **Reimbursement.** MaineCare will reimburse only for covered services provided by agencies and individuals pursuant to Section 17.07-2.

17.05-2 **Multiple Provider.** Only a single Community Support Provider may be reimbursed at the same time for services to any one member under this Section for Community Integration Services, Community Rehabilitation Services, or Assertive Community Treatment. Other Community Support Services are reimbursable under this Section to more than one Community Support Provider at a time. Requests for a waiver of the limitation on multiple providers may be approved by DHHS or an Authorized Entity, upon request and in accordance with Section 17.09-2(C).

Every Service under this Section must have an ISP as defined in 17.01-12. Coordination between all Section 17 providers is required and must be documented in the ISP. The Community Support Provider who delivers 17.04-1 (Community Integration), 17.04-2 (Community Rehabilitation Services), or 17.04-3 (Assertive Community Treatment-ACT) services must develop an Individual Support Plan (ISP) pursuant to 17.04-1(E). If a member receives one of these four (4) services as well as 17.04-4 (Daily Living Support), 17.04-5 (Skills Development), 17.04-6 (Day Support), or 17.04-7 (Specialized Group) services, provided by the same agency, each service must also be added to the member’s ISP developed pursuant to 17.04-1(E). If 17.04-4 (Daily Living Support), 17.04-5 (Skills Development), 17.04-6 (Day Support), or 17.04-7 (Specialized Group) services are provided by a different Community Support Provider, the provider of the additional service is responsible for ensuring that the service is authorized, integrated and added in writing into the ISP developed by the Community Support Provider delivering 17.04-1, 17.04-2, 17.04-3 services.

17.05-3 **Concurrent Provision of Services.** The following chart reflects covered services that may, and may not, be concurrently provided to a member:

<b>A. Type of Service</b>	<b>B. Additional Services that May be Provided Concurrently with the Service Listed in Column A</b>	<b>C. Services that may not be Provided Concurrently with the Service Listed in Column A</b>
Community Integration Services	1. Daily Living Support Services <i>or</i> Skills Development Services <i>or</i> Day Supports Services; and 2. Specialized Group Services, unless otherwise specified; and 3. Interpreter Services	1. Assertive Community Treatment 2. Community Rehabilitation Services 3. Section 92, Behavioral Health Home 4. Section 13, Targeted Case Management

10-144 Chapter 101  
 MAINECARE BENEFITS MANUAL  
 CHAPTER II

Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
------------	--	--

17.05 **LIMITATIONS** (cont.)

Community Rehabilitation Services	<ol style="list-style-type: none"> <li>1. Day Supports Services</li> <li>2. Specialized Group Services, unless otherwise specified; and</li> <li>3. Interpreter Services</li> </ol>	<ol style="list-style-type: none"> <li>1. Community Integration Services</li> <li>2. Assertive Community Treatment</li> <li>3. Daily Living Support Services</li> <li>4. Skills Development Services</li> </ol>
Assertive Community Treatment	<ol style="list-style-type: none"> <li>1. Daily Living Support Services or Skills Development Services or Day Supports Services; and</li> <li>2. Specialized Group Services, unless otherwise specified; and</li> <li>3. Interpreter Services</li> </ol>	<ol style="list-style-type: none"> <li>1. Community Integration Services</li> <li>2. Community Rehabilitation Services</li> </ol>
Daily Living Support Services	<ol style="list-style-type: none"> <li>1. Community Integration Services</li> <li>2. Day Support Services</li> <li>3. Assertive Community Treatment</li> <li>4. Specialized Group Services, unless otherwise specified</li> <li>5. Interpreter Services</li> </ol>	<ol style="list-style-type: none"> <li>1. Skills Development Services</li> </ol>
Skills Development Services	<ol style="list-style-type: none"> <li>1. Community Integration Services</li> <li>2. Day Supports Services</li> <li>3. Assertive Community Treatment</li> <li>4. Specialized Group Services, unless Otherwise specified</li> <li>5. Interpreter Services</li> </ol>	<ol style="list-style-type: none"> <li>1. Daily Living Supports</li> </ol>

Requests to provide concurrent services, such as any two services listed in Column B, Number 1 within each subcategory of the chart, to assist in a member's transition from one service to another, may be requested from DHHS or an Authorized Entity in accordance with 17.09-2(C).

17.05-4 **Location.** Except as may be expressly provided in Section 17.04 or by federal or state statute or regulation, covered services may be provided in any community location.

17.05-5 **Private Non-Medical Institutions.** Community Support Services specified in Sections 17.04-2 and 17.04-3 cannot be provided in a Private Non-Medical Institution, as defined in the *MaineCare Benefits Manual* Chapters II & III Section 97, without written authorization from DHHS or an Authorized Entity in accordance with Section 17-09-2(C). In order to avoid duplication of services, providers furnishing services under Section 17.04-3 as part of

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

17.05 **LIMITATIONS** (cont.)

treatment in a Private Non-Medical Institution must coordinate and not duplicate services with providers of services outside the residential setting, including but not limited to services provided in *MaineCare Benefits Manual*, Chapter II, Section 13 and 97.

17.05-6 **Utilization Review.** DHHS or an - Authorized Entity - reserves the right to Review continuation of any covered services as described in this Section, applying the standards established by this Section for eligibility and for continuation of a service.

17.05-7 **Exclusivity of Billing.** If a service may be billed under either this Section or Section 65, a Community Support Provider may bill the service under only one of those sections for a single member.

17.06 **NON-COVERED SERVICES**

**Services Not MaineCare Reimbursable.** The following services are not MaineCare reimbursable under this Section and as referenced in Chapter I, Section 1.06-5:

- A. Programs, services, or components of services that are primarily opportunities for socialization and activities that are solely recreational in nature (such as picnics, dances, ball games, parties, field trips, religious activities, social clubs, camps, and companionship activities);
- B. Programs, services, or components of services the basic nature of which is to maintain or supplement housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry service).
- C. Substance Abuse treatment services which do not meet the criteria cited in Subsection 17.02-3 (A).
- D. Psychotherapy, as defined in Chapter II, Section 65, except for Assertive Community Treatment.
- E. Costs for paperwork, internal meetings, or appointment reminders associated with the delivery of covered services are built into the rates and are not reimbursable as separate services.
- F. Refer to the *MaineCare Benefits Manual*, Chapter I for additional listings of non-covered services.
- G. Transportation Services. Costs related to transportation are built into the rates for services provided under this Section. Therefore, separate billings for travel time are not reimbursable.

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

**17.07 PROFESSIONAL AND OTHER QUALIFIED STAFF**

- 17.07-1 **Mental Health Professionals:** All professional staff must provide services only to the extent permitted by licensure and approval to practice conditions. As used in this Section, “Mental Health Professionals” means the following professionals:
- A. A psychiatrist who has current and valid licensure as a physician by the Maine Board of Licensure in Medicine or by the state or province where services are provided, and who:
    - 1. Is certified by the American Board of Psychiatry and Neurology; or
    - 2. Is eligible for examination by that Board as documented by written evidence from that Board; or
    - 3. Has completed three years of post-graduate training in psychiatry approved by the Education Council or the American Medical Association and submits written evidence of the training.
  - B. A psychologist who is a licensed psychologist by the Maine Board of Examiners of Psychologists or by the state or province where services are provided, as documented by written evidence from that Board.
  - C. A social worker who holds a master's degree from a school of social work accredited by the Council on Social Work Education, and who has written documentation from the state or province where services are provided that he or she is:
    - 1. Licensed by the state or province as a licensed clinical social worker, or licensed master social worker clinical-conditional.
  - D. A psychiatric nurse is licensed as a registered professional nurse by the state or province where services are provided and certified by the American Nurses Credentialing Center (ANCC) as a psychiatric and mental health nurse.
  - E. An Advanced practice psychiatric and mental health registered nurse is licensed as a nurse practitioner or clinical nurse specialist by the state or province where services are provided, has graduated from a child and adolescent or adult psychiatric and mental health nurse practitioner or clinical nurse specialist program, is certified by the appropriate national certifying body.
  - F. A licensed clinical professional counselor (LCPC) or a licensed clinical professional counselor conditional (LCPC-C) who is licensed by the state or province where

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

17.07 **PROFESSIONAL AND OTHER QUALIFIED STAFF** (cont.)

services are provided as documented by written evidence.

- G. A certified rehabilitation counselor who holds a national certification from the Commission on Rehabilitation Counselor Certification.
- H. A professional with training in co-occurring mental health and substance abuse disorders:
  - 1. Is a psychiatrist who has the qualifications specified in Section 17.07-1(A) and also has national certification as an addiction specialist; or
  - 2. Is a mental health professional with the qualifications specified in Sections 17.07-1(B), (C), (D), (E), (F) and (L) and is licensed by the state or province as documented by written evidence.
- I. An advanced practice registered nurse is a registered professional nurse who is a graduate of an accredited nursing program, who on the basis of specialized training and experience is authorized to practice expanded professional health care as an advanced practice registered nurse by the Board of Nursing in the state or province in which the services are provided.
- J. A registered nurse, under the direction of a psychiatrist, who is a graduate of an accredited nursing program and holds a valid license to practice in the state or province in which services are to be provided.
- K. A physician assistant, under the direct supervision of a psychiatrist, who is authorized to practice by the Board of Maine Licensure in Medicine, the Maine Board of Osteopathic Licensure, or the state or province in which services are provided.
- L. An Occupational Therapist registered who is licensed as an occupational therapist by the Maine Board of Occupational Therapy Practice, as documented by written evidence from such Board or who is licensed in accordance with the laws of the state or province in which services are provided.
- M. A substance abuse counselor as described in 17.01-20.

17.07-2 **Other Qualified Individuals.** As used in this Section, “Other Qualified Individuals means individuals who have had appropriate education, training, and experience, as defined by DHHS to provide Community Support Services as follows;

- 1. Possess a certification from DHHS as an MHRT at the level appropriate for the service being delivered; or

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

17.07 **PROFESSIONAL AND OTHER QUALIFIED STAFF** (cont.)

2. Possess a certification as a CIPSS as described in 17.01-4; or
3. Employment Specialist who has completed a DHHS approved Employment Specialist Training; or
4. Possess a CRMA certification (40 hour approved course) for the administration and supervision of medication; or ;

A Community Support Provider, as part of licensure, must document that supervision by a licensed professional exists for all Other Qualified Individuals as defined above, and meets the licensing standard. When the supervisor of Other Qualified Individual(s) is not employed by the licensed agency the supervision of that individual is subject to approval by DHHS or an Authorized Entity in accordance with 17.09 -2(D).

17.08 **POLICIES AND PROCEDURES**

17.08-1 **Assessments.** The following policies and procedures apply to covered services related to the assessment of a member, as described in Section 17.08-1(B):

- A. If the member seeking Community Support Services is in a crisis/outreach situation, it may not be necessary or possible for the assessment to cover all of the areas generally covered in an assessment. An exception to the scope of the assessment may be made by a supervisory mental health professional and recorded in the member's record. A complete Community Support Services assessment must be developed as soon as clinically feasible, but no later than thirty (30) days.
- B. The clinical components of an assessment will be:
  1. Performed by the appropriate mental health professionals acting within the scope of their license;
  2. Coordinated by a Community Support Provider.
- C. The member or guardian seeking Community Support Services will be an integral part of the assessment and will provide essential information. The member's family or significant other also may be involved, unless such involvement is not feasible or contrary to the wishes of the member or guardian.
- D. A Community Support Provider shall develop a comprehensive ISP as defined in 17.04-1(E) within thirty (30) days of application of a member for covered services 17.04-1 (Community Integration), 17.04-2 (Community

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

**17.08 POLICIES AND PROCEDURES (cont.)**

Rehabilitation Services), 17.04-3 (Assertive Community Treatment-ACT). For all other Section 17 Covered Services, an ISP as specified in 17.01-12 must be developed within thirty (30) days of acceptance. These timeframes must be met unless there is documentation in the member's file that supports a clinical reason why the assessment was not done within thirty (30) days. In these cases, the assessment and the ISP or treatment plan must be developed as soon as clinically feasible.

- E. Assessments must indicate the member's diagnosis and the name and credentials of the clinician who determined the diagnosis.

17.08-2 **Individual Support Plan (ISP).** The following apply to covered services related to a member's individual support plan described in 17.04-1.C and 17.01-12:

- A. The ISP must be based on the results of the assessment;
- B. All identified clinical services indicated in the ISP must be approved by a Mental Health Professional;
- C. To help the member achieve the objectives of his or her ISP, the Community Support Provider shall provide information and support to the member or guardian and, unless not feasible or contrary to the wishes of the member or guardian, to his or her family or significant other;
- D. To ensure that the member has access to specific services, supports, and resources identified in his or her ISP, the Community Support Provider shall provide coordination and advocacy and by working directly with providers, advocates, and informal support systems;
- E. To ensure that the ISP is being followed and is appropriate to a member's needs, the Community Support Provider shall:
  - 1. Review ISP to determine efficacy of the services and natural supports and to formulate changes in the plan as necessary; and
  - 2. Evaluate the effectiveness of the ISP with the member or guardian and, unless not feasible or contrary to the wishes of the member or guardian, with other providers and the member's family or significant other; and
- F. The ISP as defined in 17.04-1(E) must be reviewed and approved in writing by a mental health professional within the first thirty (30) calendar days of application of the member for those services and every ninety (90) calendar days thereafter, or more frequently as indicated in the ISP. An ISP related to 17.04-4 (Daily Living Support Services), 17.04-5 (Skills Development

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

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Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
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17.08 **POLICIES AND PROCEDURES** (cont.)

Services), 17.04-6 (Day Support Services), or 17.04-7 (Specialized Group Services) must be reviewed and approved in writing by a Mental Health Professional within the first thirty (30) days of acceptance.

- 17.08-3 **Records.** The Community Support Provider shall maintain an individual record for each member receiving covered services. The record must minimally include:
- A. Name, birthdate, and MaineCare identification number;
  - B. Pertinent available medical information regarding the member's condition;
  - C. The member's written ISP;
  - D. Documentation of each service provided, including the date of service, the type of service, the goal to which the service relates, the duration of the service, the progress the member has made towards goal attainment and the signature and credentials of the individual performing the service.
- 17.08-4 **Member Appeals.** Any decision made by DHHS or its Authorized Entity to terminate, reduce, or suspend MaineCare services will provide the member with notice of hearing rights as described in Chapter I of the MaineCare Benefits Manual.

17.09 **PROGRAM INTEGRITY AND QUALITY ASSURANCE**

- 17.09-1 **Role of Department of Health and Human Services.** DHHS or an Authorized Entity is responsible for Program Integrity, Quality Assurance and Utilization Review. Please refer to Chapter I of the *MaineCare Benefits Manual* for more information. DHHS is responsible for establishing, supporting, and maintaining quality assurance policies, licensing standards, and criteria and procedures for authorizing continuation of services in accordance with Section 17.04.
- 17.09-2 **Waiver Criteria.** In certain circumstances, DHHS may authorize waivers of Section 17.02-3 Specific Requirements (eligibility), Section 17.04 Covered Services (authorization of the continuation of services or concurrent services), Section 17.05 Limitations (the limitations on certain services), and 17.07-2 Other Qualified Individuals (supervision of other qualified individuals) beyond the criteria set forth in this Section. All waiver requests must be submitted to the Authorized Entity .
- A. **Eligibility**

Any request for a waiver of specific eligibility, as defined in Section 17.02-3, must explain why the member does not meet eligibility criteria and why the member is in need of services. The clinician must document that without the requested treatment, the member would likely deteriorate clinically to a point

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

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Section 17

COMMUNITY SUPPORT SERVICES  
EMERGENCY RULE

Established: 5/1/93  
Last Updated: 9/02/2016

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17.09 **PROGRAM INTEGRITY AND QUALITY ASSURANCE** (cont.)

where the criteria in Section 17.02 will be met; or demonstrate that without the requested continuation of services, the member would be unstable or deteriorate further; and, there is a reasonable expectation that the defined service(s) will reduce the current symptoms of the member's mental illness.

**B. Continuing or Concurrent Services**

Any request for a waiver for continuing services or concurrent services as defined in Sections 17.04-4, 17.04-5, or 17.04 -6 must include documentation that the member has improved with the current service, the anticipated goals of the future services, the skills development methods to be used, and a summary of the member's progress to date. Any approval for future services will be of limited duration.

**C. Limitations**

Any request for a waiver of limits as defined in Section 17.05 including 17.05-2 "Multiple Providers", 17.05-3 "Concurrent Services", and 17.05-5 "Private Non-Medical Institutions", must include documented demonstration that without the requested services, the member would be unstable or deteriorate further. There must be clinical evidence that the defined service(s) will reduce the current symptoms of the member's mental illness and that the needed service(s) cannot be provided in a manner that does not require a waiver.

**D. Supervision**

Any request for a waiver of the supervision requirements as defined in Section 17.07-2 for Other Qualified Individuals must meet DHHS's licensing standards and approval. Documented approval from DHHS's Division of Licensing and Regulatory Services must be kept in the Other Qualified Individual's personnel file.

All approvals for waivers described above must follow the prior authorization timelines and requirements in Chapter I, Section 1.17 of the *MaineCare Benefits Manual*.

17.10 **REIMBURSEMENT**

17.10-1 **Rates.** Reimbursement is specified in the *MaineCare Benefits Manual* Chapter III, Section 17.

17.10-2 **Services Provided in a Group.** When Community Support Services are provided in a group, one or two Community Support Providers may facilitate the session, as

10-144 Chapter 101  
MAINECARE BENEFITS MANUAL  
CHAPTER II

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Section 17	COMMUNITY SUPPORT SERVICES EMERGENCY RULE	Established: 5/1/93 Last Updated: 9/02/2016
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17.10 **REIMBURSEMENT** (cont.)

appropriate. However, only one facilitator may bill for the members participating in that group.

- 17.10-3 **Reimbursement Allowances.** In accordance with Chapter I of the *MaineCare Benefits Manual*, it is the responsibility of the provider to seek payment from every other source that is available for payment of a rendered service before billing MaineCare.

MaineCare will pay the lowest of the following:

- A. The fee established by MaineCare;
- B. The lowest payment allowed by Medicare; or
- C. The provider's usual and customary charge.

- 17.10-4 **Exemption from Rounding.** Providers of services under this Section will be reimbursed for any substantive contact at a minimum of fifteen (15) minutes. After the initial fifteen (15) minutes providers are subject to the rounding requirements in Chapter I of the *MaineCare Benefits Manual*.

17.11 **CONFIDENTIALITY**

The disclosure of information regarding persons eligible for or receiving covered services under Section 17 is strictly limited to purposes directly connected with the administration of the MaineCare Program. Providers must maintain confidentiality of information regarding these persons in accordance with applicable sections of state and federal law and regulation.

17.12 **BILLING INSTRUCTIONS**

Community Support Providers shall bill for services under this Section in accordance with the billing requirements of the Department of Health and Human Services, including use of the CMS 1500 claim form.

**For instructions and to download copies of Form CMS 1500, please see the OMS "Billing Instructions web page, available at:**  
<http://www.maine.gov/dhhs/oms/providerfiles/billinginstructions.html>.

10-144 Chapter 101  
 MAINECARE BENEFITS MANUAL  
 CHAPTER III

SECTION 17

ALLOWANCES FOR COMMUNITY SUPPORT SERVICES  
 EMERGENCY RULE

ESTABLISHED: 5/1/93  
 LAST UPDATED: 9/02/16

PROC CODE	DESCRIPTION	UNIT	MAXIMUM ALLOWANCE
	HIPAA CODES	SECTION 17 SERVICES	RATE
H2015	Comprehensive Community Support Services (Community Integration Services)	15 minutes	\$20.86
H0040	Assertive Community Treatment (Assertive Community Treatment)	Per Diem	By Report
H0038	CIPSS-Self Help/peer services	15 minutes	\$11.10
H2017	Psychosocial Rehabilitation (Daily Living Support Services)	15 minutes	\$7.77
H2018	Psychosocial Rehabilitation Service (Community Rehabilitation Services )	Per Diem	\$74.39
H2014	Skills Training and Development (Skills Development Services)	15 minutes	\$12.20
H2014 HQ	Skills Training and Development (Skills Development Services)	15 minutes	\$3.05
H2025	Ongoing Support to Maintain Employment (Skills Development Services/training)	15 minutes	\$12.20
H2012	Behavioral Health Day Treatment (Day Support Services)	Per hour	By Report
	SPECIALIZED GROUP SERVICES		
H2019	Therapeutic Behavioral Services (Wellness Recovery Action Planning)	15 minutes	\$10.18
	(Recovery Workbook Group)	15 minutes	\$10.18
	(Trauma Recovery and Empowerment Group)	15 minutes	\$10.18
	(Dialectical Behavior Therapy)	15 minutes	\$10.18

\*The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, the Department will reimburse providers under the new increased rate retroactively to 7/1/2016 pursuant to P.L. 2016, ch. 477 (eff. Apr. 15, 2016).