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GOVERNOR

Maine Department of Health and Human Services
MaineCare Services
11 State House Station
Augusta, Maine 04333-0011

BETHANY L. HAMM
ACTING COMMISSIONER

DATE: November 13, 2018

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Emergency Adoption: 10-144 C.M.R. ch. 101, MaineCare Benefits Manual, Chapters II & III, Section 96, Private Duty Nursing and Personal Care Services

This letter gives notice of emergency rules: 10-144 C.M.R. ch. 101, MaineCare Benefits Manual, Chapters II & III, Section 96, Private Duty Nursing and Personal Care Services.

These emergency rules increase reimbursement rates and level of care limits on personal care and other related services to comply with Public Law 2017, ch. 459, *An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government* (“the Act”), Part B.

The Act requires the Department to amend its rules for reimbursement rates and level of care limits for home-based and community-based personal care and related services provided under the provisions of 10-144 C.M.R. ch. 101, MaineCare Benefits Manual, Chapters II & III, Section 96, Private Duty Nursing and Personal Care Services and referenced in the February 1, 2016 report “Rate Review for Personal Care and Related Services: Final Rate Models” prepared for the Department by Burns & Associates, Inc. Part B-3 also directs the Department to ensure that caps and limitations on home-based and community-based personal care and related services are increased to reflect the increases in reimbursement rates that result from this change authorized by the Act.

This Chapter III emergency rule increases the following rates:

G0299 TD (0551)-RN Services

G0299 TD UN (0551)-RN Services–multiple patients (2)

G0299 TD UP (0551)-RN Services-multiple patients (3)

G0300 TE (0559)-LPN Services

G0300 TE UN (0559)-LPN Services–multiple patients (2)

G0300 TE UP (0559)-LPN Services–multiple patients (3)

T1000 TD-Independent RN

T1000 TD UN-Independent RN-multiple patients (2)

T1000 TD UP-Independent RN–multiple patients (3)

T1004 (0571)-Home Health Aide/Certified Nursing Assistant Services

T1004 UN (0571)-Home Health Aide/Certified Nursing Assistant Services-multiple patients (2)

T1004 UP (0571)-Home Health Aide/Certified Nursing Assistant Services–multiple patients (3)

T1019 (0589)-Personal Support Services

T1019-Personal Support Services (PCA Agencies only)
T1019 UN-Personal Support Services (PCA Agencies only) multiple patients (2)
T1019 UP-Personal Support Services (PCA Agencies only) multiple patients (3)
S5125 TF (0589)-PCA Supervisit
S5125 TF UN (0589)-PCA Supervisit-multiple patients (2)
S5125 TF UP (0589)-PCA Supervisit-multiple patients (3)
S5125 TF-PCA Supervisit (PCA Agencies only)
S5125 TF UN-PCA Supervisit (PCA Agencies only) multiple patients (2)
S5125 TF UP-PCA Supervisit (PCA Agencies only) multiple patients (3)

This Chapter II emergency rule increases the following level of care limits:

Level I
Level II
Level III
Level IV
Level V
Level VIII
Level IX

Through the Act, the Legislature determined that “these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety.” As such, the Act requires the Department to implement “immediate rate increases,” effective July 1, 2018. However, the Act did not become law until July 9, 2018, following a Legislative override of the Governor’s veto.

Because the Act involves MaineCare reimbursement, these rule changes are also governed by federal Medicaid law. 42 C.F.R. § 447.205(d) requires that public notice of changes in reimbursement for State Plan services must “be published **before** the proposed effective date of the change.” The Department published its notice of reimbursement methodology change for the Section 96 rates on July 31, 2018. Upon the advice of the Office of the Attorney General, the increased rates will be effective August 1, 2018; this effective date comports with the federal law requirement. Pending approval of the proposed changes to the Section 96 State Plan Amendment that were submitted to the Centers for Medicare and Medicaid Services, the increased rates will be implemented with an August 1, 2018 effective date.

There are four separate proposed rate changes and increased level of care limits pending before CMS, one submitted in September 2015 (effective July 1, 2015), one submitted in September 2016 (effective July 29, 2016), one submitted in September 2017 (effective September 6, 2017), and one submitted in July 2018(effective August 1, 2018); thus, there are four retroactive effective dates applicable for these rates included in Chapter III.

Pursuant to the Legislative determination regarding the urgent need for these reimbursement increases, the requirements of 5 M.R.S. §8054(1) are satisfied and emergency rulemaking is appropriate. Similarly, an August 1, 2018 retroactive effective date is necessary to implement these changes as soon as possible. The retroactive application comports with 22 M.R.S. § 42(8), which authorizes the Department to adopt rules with a retroactive application (where there is no adverse impact on providers or members) for a period not to exceed eight calendar quarters.

To remedy the difference between the July 1, 2018 effective date set forth in the Act, and the August 1, 2018 date that is permissible pursuant to federal Medicaid law, the Department has recalculated the

annual appropriation of funds for this service into a temporary eleven month rate. As such, providers will, over the course of eleven months, receive equivalent aggregate payments as would have been received under a twelve month rate. Beginning on July 1, 2019, rates will be annualized (based upon a twelve month appropriation). This is not a rate decrease, but rather a redistribution of the annual appropriation over twelve months, rather than eleven months.

Pursuant to 5 M.R.S. § 8054, these emergency rules may be effective for up to ninety (90) days. The Department intends to proceed with routine technical rulemaking to permanently adopt these rules.

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 Emergency Adoption

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

CHAPTER NUMBER AND TITLE: 10-144 C.M.R. ch. 101, MaineCare Benefits Manual (MBM) Chapters II & III, Section 96, Private Duty Nursing and Personal Care Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The Department of Health and Human Services (“the Department”) adopts these emergency rules to increase the rates of reimbursement and level of care limits for personal care and other related services pursuant to Public Law 2017, ch. 459, *An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State* (“the Act”), Part B.

The Act requires the Department to amend its rules for reimbursement rates and level of care limits for home-based and community-based personal care and related services provided under the provisions of 10-144 C.M.R. Ch. 101, MaineCare Benefits Manual, Chapters II & III, Section 96, Private Duty Nursing and Personal Care Services (“Section 96”) and referenced in the February 1, 2016 report “Rate Review for Personal Care and Related Services: Final Rate Models” prepared for the Department by Burns & Associates, Inc. Further, Part B-3 directs the Department to ensure that caps and limitations on home-based and community-based services are increased to reflect increases in reimbursement rates that result from P.L. 2017. In addition, a recipient of services may not experience a reduction in hours solely as a result of the increased reimbursement rates authorized by the Act.

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To remedy the difference between the July 1, 2018 effective date set forth in the Act, and the August 1, 2018 date that is permissible pursuant to federal Medicaid law, the Department has recalculated the annual appropriation of funds for this service into a temporary eleven month rate. As such, providers will, over the course of eleven months, receive equivalent aggregate payments as would have been received under a twelve month rate. Beginning on July 1, 2019, rates will be annualized (based upon a twelve month appropriation). This is not a rate decrease, but rather a redistribution of the annual appropriation over twelve months, rather than eleven months.

Pursuant to 5 M.R.S. § 8054, these emergency rules may be effective for up to ninety (90) days. The Department intends to proceed with routine technical rulemaking to permanently adopt these rules.

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

EFFECTIVE DATE: November 13, 2018

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MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 96 **PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES** 6/9/86
EMERGENCY RULE

Effective: 11/13/18

96.01 **DEFINITIONS**

- 96.01-1 **Private Duty Nursing (PDN) and Personal Care Services (PCS)** are those covered services provided to an eligible Member, as defined in this Section, when determined to be medically necessary, when prior approved, and in the best interest of the Member according to the orders and written plan of care reviewed and signed by a licensed physician. With the exception of those medically necessary services that are prior authorized for children under the age of 21, all services provided are not to exceed the cost limits set forth in Section 96.03.
- 96.01-2 **Covered Services** are those services for which payment can be made under Title XIX or XXI by the Department of Health and Human Services.
- 96.01-3 **Private Duty Nursing Services** are those services that are provided by a registered nurse and/or a licensed practical nurse, in accordance with the Board of Nursing Regulations, under the direction of the Member's physician, to a Member in his or her place of residence or outside the Member's residence, when required life activities take the Member outside his or her residence (school, preschool, daycare, medical appointments, etc.). Reimbursement for services provided outside a Member's residence can include only authorized nursing services and authorized personal care services and may not exceed that which would have been allowed strictly in a home setting. For purposes of this Section, "place of residence" does not include such institutional settings as nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs-IID), or hospitals. If nursing services are covered under a private non-medical institution's per diem rate, then Level I, II, III, VI, VII private duty nursing services are not allowed under this Section.
- 96.01-4 **Personal Care Services** are those Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), and medication administration services provided to a Member by a home health aide, certified nursing assistant, personal support specialist (PSS), or certified residential medication aide (CRMA), as appropriate, while completing tasks in accordance with an authorized plan of care. Under this Section, personal care services are not covered in the following settings: nursing facilities, intermediate care facilities for individuals with intellectual disabilities, hospitals, or adult family care homes, or assisted living facilities that do not meet the definition in §96.01-28. If personal care services are covered under a private non-medical institution's per diem rate, then Level I, II, III, VI, VII personal care services are not allowed under this Section.
- 96.01-5 **A Unit of Service** is a reimbursable unit of direct service as specified in Chapter III of this Section. A unit of service requires personal contact in or outside the Member's place of residence made for the purpose of providing a covered service. When two or more persons provide separate and distinct types of services simultaneously, each must be recorded separately.

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96.01 **DEFINITIONS** (cont.)

- 96.01-6 **Average Monthly Cost** is one twelfth of the average annual cost of nursing facility services as defined by the Department of Health and Human Services. The costs of MaineCare physical therapy, occupational therapy, speech and hearing services and medical social worker services shall not be included in the calculation of this average monthly cost.
- 96.01-7 **Cuing** means any spoken instruction or physical guidance which serves as a signal to do something. Cuing is typically used when caring for individuals who are cognitively impaired.
- 96.01-8 **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 7 days, or 24 to 48 hours if in a hospital setting, help of the following type(s) was provided:
- Guided maneuvering of limbs or other non-weight-bearing assistance three or more times, or
 - Guided maneuvering of limbs or other non-weight-bearing assistance three or more times plus weight-bearing support provided only one or two times.
- 96.01-9 **One-person Physical Assist** requires one person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last 7 days, or 24 to 48 hours if in a hospital setting. This does not include cuing.
- 96.01-10 **Extensive Assistance** means although the individual performed part of the activity over the last 7 days, or 24 to 48 hours if in a hospital setting, help of the following type(s) was provided:
- Weight-bearing support three or more times, or
 - Full staff performance during part (but not all) of the last 7 days.
- 96.01-11 **Total Dependence** means full staff performance of the activity during the entire previous 7 day period across all shifts, or during each 8 hour period in 24 hours.
- 96.01-12 **Significant Change** means a major change in the Member's status that is not self limiting, impacts on more than one area of functional or health status, and requires multi-disciplinary review or revision of the plan of care. A significant change assessment is appropriate if there is a consistent pattern of change with either two or more areas of improvement, or two or more areas of decline.

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96.01 **DEFINITIONS** (cont.)

- 96.01-13 **Assessing Services Agency (ASA)** is authorized to conduct face-to-face assessments, using the Department's Medical Eligibility Determination (MED) form, and the timeframes and definitions contained therein, to determine medical eligibility for covered services. Based upon a Member's assessment outcome scores recorded in the MED form, the ASA is responsible for authorizing a plan of care, which must specify all services to be provided under this Section, including the number of hours for services, and the provider types. The ASA is the Department's Authorized Entity for medical eligibility determinations, care plan development, and authorization of covered services under this Section. The ASA conducts assessments for all Members age 21 and over and those under age 21 receiving care under the family provider services option, and excluding those Members classified for medication or venipuncture services under this Section.
- 96.01-14 **Authorized Entity** means an organization authorized by the Department to perform functions under a valid contract or other approved, signed agreement. The Assessing Services Agency is the Authorized Entity under this Section.
- 96.01-15 **Service Coordination Agency** is an organization that has the capacity to provide Care Coordination and Skills Training to eligible Members under Private Duty Nursing and Personal Care Services, 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 must coordinate with the Department's contracted Fiscal Intermediary for those Members who have chosen to direct their personal care services through the FPSO. The Service Coordination Agency providing care coordination services to a Member may not be a provider of direct care services.
- 96.01-16 **Contraindicated** means the Member's condition renders some particular line of treatment improper or undesirable.
- 96.01-17 **Medical Eligibility Determination Form** means the form approved by the Department for medical eligibility determinations and service authorization for the plan of care based upon the assessment outcome scores. The definitions, scoring mechanisms and time-frames relating to this form are outlined in Section 96.02-4 and provide the basis for services and the care plan authorized by the ASA. The care plan summary contained in the MED form documents the authorized service plan. The care plan summary also identifies other services the Member is receiving, in addition to the authorized services provided under this Section. For all Members age 21 and over, and those under age 21 receiving care under the family provider services option, and excluding those classified for medication services or venipuncture

96.01 **DEFINITIONS** (cont.)

services under this Section, the Assessing Services Agency has the authority to conduct the medical eligibility determination. For all Members under age 21, excluding those receiving care under the family provider service option, and for all those classified for medication services or venipuncture services under this Section, the PDN provider conducts the medical eligibility determination.

96.01-18 **Authorized Plan of Care** means a plan of care that is authorized by the Assessing Services Agency, or the Department, which shall specify all services to be delivered to a Member under this Section, including the number of hours for all covered services. The plan of care must be based upon the Member's assessment outcome scores recorded in the Department's medical eligibility determination form.

96.01-19 **Activities of Daily Living (ADL)** that will be considered for the purpose of determining eligibility are:

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

96.01-20 **Instrumental Activities of Daily Living (IADL)** for the purpose of determining eligibility, include only the following: main meal preparation; routine housework; grocery shopping and storage of purchased groceries; and laundry either within the residence or at an outside laundry facility.

96.01-21 **Unstable medical condition** is 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 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

96.01 **DEFINITIONS** (cont.)

record. The loss of function resulting from a temporary disability from which full recovery is expected does not constitute an unstable medical condition.

96.01-22 **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 individual 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, occupational and physical therapy activities such as assistance with prescribed exercise regimes.

96.01-23 **Family Provider Service Option** is an option available to certain eligible Members that allows the Member to manage his or her own personal care services. The management includes: hiring, firing, training, maintaining records and scheduling the personal support specialist(s). If the MaineCare Member does not have the ability or does not desire to manage his or her own care, a family Member related by blood, marriage or adoption, or a significant other in a committed partnership, can manage the personal support services on the Member's behalf. To use the family provider service option, the MaineCare Member, or his or her family Member, as applicable, must be a family provider agency.

96.01-24 **Family Provider Agency** is a State-registered personal care services agency that manages personal care services for up to two Members of a given family, under the family provider service option.

96.01-25 **Fiscal Intermediary (FI)** is an organization that provides administrative and payroll services on behalf of a family provider agency for the services of personal care assistants under the family provider service option. FI services include, but are not limited to, preparing payroll and withholding taxes, making payments to suppliers of goods and services and ensuring compliance with State and Federal tax and labor regulations and the requirements under this Section.

96.01-26 **Cognitive Capacity** is determined during the MED assessment process conducted by the ASA RN assessor. For purposes of this Section, sufficient cognitive capacity is established by any combination of the MED scores specified below for all of the following items:

- A. decision making skills: a score of 0 or 1; and
- B. making self understood: a score of 0, 1, or 2; and

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- C. ability to understand others: a score of 0, 1, or 2; and
- 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.

96.01-27 **Medication Administration** for Level IX is the daily administration of routine prescription medications performed by a Certified Residential Medication Aide (CRMA) in a licensed assisted living facility, as defined in §96.01-28, that holds a valid contract with the Office of Aging and Disability Services (OADS) and under the supervision of a Registered Nurse.

96.01-28 **Licensed Assisted Living Agency** is an agency licensed with the Department as an assisted living program and holds a valid contract with the Office of Aging and Disability Services to provide services. These providers employ CRMAs with the intention to serve MaineCare Members who have daily medication administration needs as outlined in Level IX.

96.01-29 **Acute/Emergency Episode** is the unforeseen occurrence of an acute health episode that requires a change in the member's physician-ordered treatment plan and authorized plan of care, or the unforeseen circumstance where the availability of the member's caregiver, or informal support system is compromised.

96.01-30 **Care Coordination Services** are those covered services provided by a care coordinator who is employed, or contracted, by the 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 so that the Member is offered choices in service delivery based on his/her needs, preferences, and goals. Care Coordination Services may 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 covered under this Section only for Members age 21 years or older receiving services under levels I, II, III, V and VIII, or under 21 years receiving services under the FPSO. Care Coordination Services are not covered under for those Members receiving services under Levels VI, VII and IX.

96.01-31 **Skills Training** is a service that provides Members with the information and skills to assist them in carrying out their responsibilities when choosing to participate in the self-directed option. This is a required service for those Members choosing the FPSO.

96.02 **ELIGIBILITY FOR CARE**

96.02-1 **General and Specific Requirements**

An individual is eligible to receive services as set forth in this Section if he or she meets the general MaineCare eligibility requirements, the specific MaineCare eligibility requirements, and the medical eligibility requirements.

96.02-2 **General MaineCare Eligibility Requirements**

Individuals must meet the financial eligibility criteria as set forth in the *MaineCare Eligibility Manual*. Some Members may have restrictions on the type and amount of services they are eligible to receive.

96.02-3 **Specific Eligibility Requirements**

- A. Only individuals under age 21 are eligible for Level IV under this Section.
- B. Individuals of any age are eligible for all other Levels of care.

96.02-4 **Medical Eligibility Requirements**

Applicants for services under this Section must meet the eligibility requirements as set forth in this Section and as documented on the Medical Eligibility Determination form. A Member meets the medical eligibility requirements for a particular level of care if he or she requires a combination of assistance with the following services: medication administration, the required numbers of Activities of Daily Living and/or Instrumental Activities of Daily Living and nursing services, as appropriate. The requirements for each level of care are defined below. The clinical judgment of the Department's Assessing Services Agency shall be the basis of the scores entered on the Medical Eligibility Determination form.

Medical eligibility and the scores for criteria: (l) extensive assistance or total dependence, (m) behavior and (n) cognition, as well as, the Activities of Daily Living and the Instrumental Activities of Daily Living, must be reviewed in the context of an individual's age-appropriate development. A child or infant shall not qualify for covered services by virtue of scoring high dependency requirements with the ADLs or IADLs, or the aforementioned criteria, when these dependency requirements are normal for the child's age. The clinical judgment of the Department's Assessing Services Agency, or the PDN provider as required (for individuals under age 21), shall be determinative of the scores on the medical eligibility determination assessment.

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

Determination of Eligibility

A registered nurse trained in conducting assessments with the Department's approved MED form, shall conduct the medical eligibility assessment. In the process of completing the assessment the nurse assessor shall use professional nursing judgement. The assessor shall, as appropriate within the exercise of professional nursing judgment, consider documentation, perform observations, and conduct interviews with the applicant/Member, family Members, direct care staff, the applicant's/Member's physicians, and other individuals and document in the record of the assessment all information considered relevant in his or her professional judgment.

A. Level I

A Member meets the medical eligibility requirements for Level I if he or she requires:

1. cuing 7 days per week for eating, toilet use, bathing, and dressing; **or**
2. limited assistance and a 1 person physical assist with at least 2 ADLs; **or**
3. limited assistance and a one person physical assist with at least 1 ADL plus physical assistance with at least 2 IADLs; **or**
4. any of the following nursing services, at least once per month, that are or otherwise would be performed by or under the supervision of a registered professional nurse:
 - a. intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding, for treatment of unstable conditions requiring medical or nursing intervention; other than daily insulin injections for an individual whose diabetes is under control;
 - b. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past 30 days) or unstable condition;
 - c. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within the last 30 days) or unstable condition;
 - d. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of

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SECTION 96

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

- wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);
- e. administration of oxygen on a regular and continuing basis when the Member's medical condition warrants professional nursing observations, for a new or recent (within past 30 days) condition;
 - f. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the Member's medical record;
 - g. services to manage a comatose condition;
 - h. care to manage conditions requiring a ventilator/respirator;
 - i. direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e. grand mal);
 - j. professional nursing assessment, observation, and management for problems including wandering, or physical abuse, or verbal abuse or socially inappropriate behavior;
 - k. professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;
 - l. administration of treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring. Treatments include:
 - (i) administration of medication via a tube;
 - (ii) tracheostomy care;
 - (iii) urinary catheter change;
 - (iv) urinary catheter irrigation;
 - (v) barrier dressings for stage 1 or 2 ulcers;
 - (vi) chest PT by RN;
 - (vii) oxygen therapy by RN;
 - (viii) other physician ordered treatments; or
 - (ix) teaching and training activities for patient and family; or

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- m. professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis.

B. Level II

A person meets the medical eligibility requirements for Level II, if he or she meets the criteria for requiring (B)(1) nursing services and assistance with (B)(2) activities of daily living as described below:

1. Nursing Services

To meet the nursing services criteria, a person must need any of the following services, at least once per month, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described below:

- a. intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding, for treatment of unstable conditions requiring medical or nursing intervention; other than daily insulin injections for an individual whose diabetes is under control;
- b. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past 30 days) or unstable condition;
- c. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within the last 30 days) or unstable condition;
- d. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);
- e. administration of oxygen on a regular and continuing basis when the Member's medical condition warrants professional nursing observations, for a new or recent (within past 30 days) condition;
- f. professional nursing assessment, observation and management of a medical condition;

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

- g. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the Member's medical record;
- h. services to manage a comatose condition;
- i. care to manage conditions requiring a ventilator/respirator;
- j. direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e. grand mal);
- k. professional nursing assessment, observation, and management for problems including wandering, or physical abuse, or verbal abuse or socially inappropriate behavior;
- l. professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;
- m. administration of treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring;
 - (i) administration of medication via a tube;
 - (ii) tracheostomy care;
 - (iii) urinary catheter change;
 - (iv) urinary catheter irrigation;
 - (v) barrier dressings for stage 1 or 2 ulcers;
 - (vi) chest PT by RN;
 - (vii) oxygen therapy by RN;
 - (viii) other physician ordered treatments; or
 - (ix) teaching and training activities for patient and family; or
- n. professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis.

2. **Activities of Daily Living**

An individual must require daily (7 days per week) cuing for all of the following ADLs: eating, toilet use, bathing, dressing; or, at least limited

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

assistance and a one person physical assist is needed with at least any 2 activities of daily living.

C. Level III

1. A person meets the medical eligibility requirements for Level III if he or she requires at least limited assistance and a one person physical assist with 2 of the following ADLs: bed mobility, transfer, locomotion, eating, or toileting, and if he or she meets the criteria for nursing services below.
2. To meet the nursing services criteria, a person must need any of the following services, at least once per month, that are or otherwise would be performed by, or under the supervision of, a registered professional nurse, as described below:
 - a. intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding, for treatment of unstable conditions requiring medical or nursing intervention, other than daily insulin injections for an individual whose diabetes is under control;
 - b. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within the last 30 days) or unstable condition;
 - c. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent, (within the last 30 days) or unstable condition;
 - d. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);
 - e. administration of oxygen on a regular and continuing basis when the Member's medical condition warrants professional nursing observations, for a new or recent (within last 30 days) condition;
 - f. professional nursing assessment, observation and management of a medical condition;
 - g. insertion and maintenance of a urethral or suprapubic catheter as

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an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the Member's medical record;

- h. services to manage a comatose condition;
- i. care to manage conditions requiring a ventilator/respirator;
- j. direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e. grand mal);
- k. professional nursing assessment, observation, and management for problems including wandering, or physical, or verbal abuse, or socially inappropriate behavior;
- l. professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;
- m. administration of treatments, procedures, or dressing changes that involve prescription medications for post-operative or chronic conditions according to physician orders and require nursing care and monitoring; or
- n. professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis.

D. Level IV

An individual who is under 21 years of age is eligible for Level IV, if he or she meets the medical eligibility requirements set forth in Section 67.02-3, "Nursing Facility Services", of the *MaineCare Benefits Manual*.

E. Level V

A person meets the medical eligibility requirements for Level V if he or she requires either (1) or (2) below.

- 1. Daily (7 days per week) nursing services and ventilator support for a person who is ventilator-dependent;

Or

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

2. a. Daily (7 days per week), 24-hour nursing care for at least one of the following treatments and procedures: 96.02-4(B)(1)(a); (b); (c); (d); (h) or (j); required every 8 hours (or all 3 shifts), which are, or otherwise would be, performed by an RN or LPN;

And

- b. Daily (7 days per week) nursing care for at least any 2 of the following professional nursing services: 96.02-4(B)(1)(a); (b); (c); (d); (h); or (j).

- F. **Level VI** Medication and Venipuncture Services for Members who are Severely Mentally Disabled.

An individual meets the medical eligibility requirements for Level VI if the following are met:

1. The individual meets the eligibility requirements for services under Section 17, "Community Support Services for Persons with Severe and Persistent Mental Illness", and requires medication administration or monitoring services for the treatment of mental illness. The Member's eligibility shall be established by a completed "verification of eligibility form" described in Section 17, or otherwise by a signed certification by a physician that the Member is eligible/covered under Section 17. Dated copies of this form/certification must be maintained in the Member's record to verify eligibility for covered services;

and

2. A physician must sign and certify a statement that the Member's medical condition prevents the safe use of outpatient services and outpatient services are contraindicated for specific reasons. The reasons must be listed and the likelihood of such a bad result must be probable or definite as opposed to possible or rare. Reasons may include lack of services within a 20 mile radius of the Member's residence. MaineCare covers transportation to all MaineCare covered services, therefore, lack of transportation does not qualify as an exemption.

- G. **Level VII** Venipuncture Only Services

An individual meets the medical eligibility requirements for Level VII if the following are met:

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

1. The individual requires only venipuncture services on a regular basis, as ordered by a physician;

and

2. A physician must sign and certify a statement that the Member's medical condition prevents the safe use of outpatient services and outpatient services are contraindicated for specific reasons. The reasons must be listed and the likelihood of such a bad result must be probable or definite as opposed to possible or rare. Reasons may include lack of services within a 20 mile radius of the Member's residence. MaineCare covers transportation to all MaineCare covered services, therefore, lack of transportation does not qualify as an exemption.

H. **Level VIII** Nursing Services Only for Members receiving Personal Care Services under other Sections of the MBM.

A Member meets the requirements for Level VIII if he or she is receiving personal care services under any of the following Sections: Section 2, "Adult Family Care Services"; Section 12, "Consumer Directed Attendant Care Services"; Section 97, "Private Non-Medical Institution Services"; and Section 21, "Home and Community-Based Waiver Services for Members with Intellectual Disabilities or Autism Spectrum Disorder", or Level IX under this Section and requires any of the following nursing services, at least once per month, that are or otherwise would be performed by or under the supervision of a registered professional nurse:

1. intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding, for treatment of unstable conditions requiring medical or nursing intervention; other than daily insulin injections for an individual whose diabetes is under control;
2. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past 30 days) or unstable condition;
3. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent (within the last 30 days) or unstable condition;
4. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective

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

- services (including, but not limited to, ulcers, 2nd or 3rd degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);
5. administration of oxygen on a regular and continuing basis when the Member's medical condition warrants professional nursing observations, for a new or recent (within past 30 days) condition;
 6. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care. In such instances, the need for a catheter must be documented and justified in the Member's medical record;
 7. services to manage a comatose condition;
 8. care to manage conditions requiring a ventilator/respirator;
 9. direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e. grand mal);
 10. professional nursing assessment, observation, and management for problems including wandering, or physical abuse, or verbal abuse or socially inappropriate behavior;
 11. professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;
 12. administration of treatments, procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring. Treatments include:
 - a. administration of medication via a tube;
 - b. tracheostomy care;
 - c. urinary catheter change;
 - d. urinary catheter irrigation;
 - e. barrier dressings for stage 1 or 2 ulcers;
 - f. chest PT by RN;
 - g. oxygen therapy by RN;
 - h. other physician ordered treatments; or
 - i. teaching and training activities for patient and family.

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

13. professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis.

I. **Level IX** Personal Care Services for Members with Daily Medication Needs.

An individual meets the medical eligibility requirements for Level IX if the following are met:

1. The individual requires daily assistance with medication administration for routine prescription medications delivered by a CRMA and physical assistance with at least 2 IADLs, **Or**
2. The individual requires daily assistance with medication administration for routine prescription medications delivered by a CRMA and physical assistance with at least 1 ADL.

96.03 **DURATION OF CARE**

Each Title XIX and XXI Member may receive as many covered services as are medically necessary within the following limitations and exceptions as described below. MaineCare coverage of services under this Section requires prior approval from the Department or its Assessing Services Agency. Beginning and end dates of an individual's medical eligibility determination period correspond to the beginning and end dates for MaineCare coverage of the plan of care approved by the ASA or the Department.

- A. **Exception to the Limit:** For all individuals under the age of 21 years, the caps described in Sections 96.03(B), (C) and (D), may be exceeded if services beyond these levels are determined medically necessary pursuant to the criteria described in "Prevention, Health Promotion and Optional Treatment Services", formerly EPSDT, of the *MaineCare Benefits Manual*. A determination of medical necessity for PDN/PCS shall not be determinative of medical necessity under "Prevention, Health Promotion and Optional Treatment Services". These additional services require prior authorization by the Department as described in Chapter I, Section 1, "General Administrative Policies and Procedures" and Chapter II, Section 94, "Prevention, Health Promotion, and Optional Treatment Services".

Limits (when applicable) for individuals under age 21 years shall be based upon a yearly cap to better serve children who have episodic service needs.

- B. Except as described in (A) above, for individuals classified for Levels of care I, II, III, VIII, or IX, the total monthly cost of covered private duty nursing, and personal care services, either alone or in combination with home health services provided under Chapters II & III, Section 40 of the *MaineCare Benefits Manual*, may not exceed the monthly Level I, II, III, VIII and IX caps established by the Department and the plan of care authorized by the ASA on the MED form. The amount of services an individual Member is authorized to

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receive is based upon the Member's MED assessment outcome scores. The Level I, II, III, VIII and IX caps are tied to allowing coverage for a range of services to meet the medical and excluding Level VIII, personal care service needs of each level.

- C. Except as described in (A) above, for individuals classified for Level IV of care, the total cost of private duty nursing and personal care services, either alone or in combination with home health services provided under Chapters II & III, Section 40 of the *MaineCare Benefits Manual*, may not exceed 100% of the average MaineCare annual cost of NF institutional services.
- D. Except as described in (A) above, for all individuals who are determined medically eligible for Level V care, the total monthly cost of private duty nursing and personal care services, either alone or in combination with home health services provided under Chapters II & III, Section 40 of the *MaineCare Benefits Manual*, may not exceed the monthly Level V cap established by the Department. The Department reserves the right to request additional information to evaluate medical necessity.
- E. Members who are receiving any of the following MaineCare services may only access nursing services under this Section, and are prohibited from receiving personal care services under this Section, since personal care services are provided under these Sections: Section 2, "Adult Family Care Services"; Section 12, "Consumer Directed Attendant Care Services"; Section 97, "Private Non-Medical Institution Services"; and Section 21, "Home and Community-Based Waiver Services for Members with Intellectual Disabilities or Autism Spectrum Disorder".
- F. Services under this Section may be denied, reduced, suspended, or terminated by the Department, its Authorized Entity, or the PDN provider, as appropriate, for the following reasons:
 - 1. A significant change occurs in the Member's medical status such that an authorized plan of care under this Section can no longer be developed; or
 - 2. The Member becomes an inpatient of a hospital, nursing facility, ICF-IID; or
 - 3. The Member is not medically eligible to receive services under this Section or financially eligible to receive Title XIX or XXI benefits; or
 - 4. Based upon the most recent MED assessment, the plan of care service authorization may be reduced to match the Member's needs as identified in the reassessment and subject to the limitations of the service cap, as follows:
 - a. for Members age 21 and over, and those under age 21 receiving care under the family provider services option, and excluding those classified for medication

96.03 **DURATION OF CARE** (cont.)

services or venipuncture services under this Section according to the clinical judgment of the Department, the ASA or Service Coordination Agency;

- b. for Members under age 21, as well as those classified for medication services or venipuncture services under this Section, by the Department or the PDN provider; but excluding those receiving care under the family provider services option; or
 - 5. The Member declines services; or
 - 6. The Member refuses personal care or nursing services; or
 - 7. The Department, ASA, or the provider documents that the Member, or someone living in or frequently visiting the household, harasses, threatens, or endangers the health or safety of individuals delivering services; or
 - 8. The Member begins receiving any of the following MaineCare services: Section 2, “Adult Family Care Services”; Section 12, “Consumer Directed Attendant Care Services”; Section 19, “Home and Community Benefits for Elderly and Adults with Disabilities”; Section 97, “Private Non-Medical Institution Services”; and Section 21, “Home and Community-Based Waiver Services for Members with Intellectual Disabilities or Autism Spectrum Disorder”, in which case the personal care services are not covered under this Section.
- G. **Suspension.** Services may be suspended for up to 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.

As described in Section 96.03 (B), (C), and (D) above, the monthly cost of private duty nursing and personal care services, in combination with home health services under Section 40, must not exceed the monthly cap for the approved PDN level. If a member has a skilled need for short-term nursing services, the PDN services may be suspended, for up to 60 days, if the cost of the Section 40 home health services in combination with private duty nursing and personal care services would exceed the cost cap for the approved PDN level of care.

96.04 **COVERED SERVICES**

Covered services are available for individuals meeting the eligibility requirements set forth in Section 96.02. 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 delay long-term institutional care. These services require prior approval by the Department, or its Assessing Services Agency, and are subject to the limits in Section 96.03.

96.04 **COVERED SERVICES** (cont.)

Services provided must be reasonable and necessary for meeting the medical needs of the individual, based upon the medical record, and upon the outcome scores on the MED form, and as authorized in the plan of care. Payment will be denied if the services provided are not consistent with the Member's authorized plan of care. The Department may also recoup payment for inappropriate service provision, as determined through post payment review.

For Members age 21 and over, and those under age 21 receiving care under the family provider service option, and excluding those classified for medication services or venipuncture services (Level VI) under this Section, the Assessing Services Agency has the authority to determine the plan of care, which shall specify all services to be provided, including the number of hours for each covered service.

For Members under age 21 at any level of service, as well as Level VI and Level VII Members, but excluding those receiving care under the family provider service option, the PDN provider shall establish a plan of care. The plan of care shall be based upon the Member's assessment outcome scores recorded in the Department's Medical Eligibility Determination form and the timeframes therein.

Section 40, "Home Health Services", shall not replace or be delivered and reimbursed in lieu of authorized Section 96 covered services. (Section 40, "Home Health Services", must be delivered and reimbursed pursuant to those rules.)

Covered services under this Section include the following:

96.04-1 **Private Duty Nursing Services (PDN)**

- A. PDN services must be provided according to a written plan of care, reviewed and signed by a licensed physician, and available to the Department or the Service Coordination Agency upon request. At least monthly nursing services must be delivered to all Level II and III Members, as well as those Level I Members who are eligible for services based upon the need for monthly nursing services.
- B. For individuals age 21 and over, and those under age 21 receiving care under the family provider service option, and excluding those classified for medication services or venipuncture services (Level VI) under this Section, PDN services shall be authorized by the Assessing Services Agency, and ordered and monitored by the Service Coordination Agency, in accordance with the authorized plan of care for covered services under this Section.
- C. For individuals under age 21, as well as all individuals classified for venipuncture services or medication services for the severely mentally disabled (Level VI), and excluding those receiving care under the family provider service option, the Department shall classify the Member based on the plan of care developed by the provider, subject to the process described under Section 96.06.

96.04 **COVERED SERVICES** (cont.)

- D. Nursing services may be provided by:
1. an independently practicing registered professional nurse;
 2. a registered professional nurse or licensed practical nurse employed by, or under contract with, a licensed home health agency.
- E. Except as allowed in Section 96.04-1(F) below, nursing services shall not be covered when provided by the Member's husband or wife, natural or adoptive parent, child, or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild, spouse of grandparent or grandchild or any person sharing a common abode as part of a single family unit.
- F. "Special circumstances nursing" allows a relative, including a spouse or the parent of a minor child, to be paid to provide nursing services to the Member under this Section. To qualify for this coverage the Member's relative must meet the requirements in (1) and (2) below.
1. The relative must: (all of the following are required)
 - a. meet all licensing, training, reporting and other requirements otherwise specified in this Section; and
 - b. be employed by a licensed home health agency; and
 - c. abide by the requirement that an independent nurse or physician must conduct any required assessments and/or develop the plan of care; and
 - d. implement the Member's authorized plan of care; and
 - e. if applicable, expect to continue non-reimbursed family caregiver responsibilities; and
 - f. pass a criminal background check. The family nursing provider must not have any criminal convictions, except for Class D and Class E convictions over 10 years old that did not involve as a victim of the act a patient, client, or resident of a health care entity; or any specific documented findings by the State Survey Agency of abuse, neglect, or misappropriation of property of a resident, client, or patient.
 2. The relative must: (one of the following is required)

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- a. have resigned from full-time or part-time employment specifically to provide PDN services to the Member; or
- b. have changed from full-time employment to part-time employment resulting in less compensation in order to provide PDN services to the Member; or
- c. have taken a leave of absence without pay from employment in order to provide PDN services to the Member;
- d. have incurred substantial expenses by providing PDN services to the Member; or
- e. be needed to provide an adequate number of qualified nurses to meet the Member's plan of care because of labor conditions or intermittent hours of care.

To apply for coverage under this Section, contact the Director, Office of Aging and Disability Services, 11 State House Station, Augusta, ME 04333-0011.

- G. Multiple patient nursing services are for nursing services (RN, LPN, and Independent RN) throughout this Section. The multiple patient procedure codes and modifiers must be used whenever it is determined (by the home health agency, the Department, or the Department's authorized entity, whichever has authority to authorize the Member's plan of care) to be safe and appropriate for one nurse to provide nursing services to more than one patient in the same home or building, during the same visit and it is specified in each Member's plan of care. Providers must bill with the Chapter III procedure codes and modifiers designated for multiple patients.

96.04-2 **Personal Care Services**

- A. For Members under the age of 21, excluding those receiving care under the family provider service option, personal care services must be ordered by a physician and delivered under a plan of care prepared by the PDN provider and signed by the physician.
- B. For Members age 21 and over, and for those under age 21 receiving care under the family provider service option, personal care services must be approved by the Department, or its Assessing Services Agency, and specified in the authorized plan of care.

As a general rule, there shall be no more than one personal care staff Member delivering services at a time. If the Department, or its ASA, (or the physician for individuals under age 21) determines that an individual, based upon his/her health status, requires more than one personal care staff Member to perform a specific ADL task (e.g. to transfer a large person), then this can be authorized and specified in the plan of care.

96.04 **COVERED SERVICES** (cont.)

If a single provider of personal care services is providing this service to multiple Section 96 members in a single visit, then the two (2) or three (3) person modifier shall be used, as outlined in Chapter III, Section 96, Private Duty Nursing and Personal Care Services.

Personal care services include services related to a Member's physical requirements for assistance with the activities of daily living, including assistance with related health maintenance activities.

C. Additionally, when authorized and specified in the Department, or ASA authorized plan of care, personal care services may include IADL and related health maintenance tasks, which are directly related to the Member's plan of care. These tasks must be performed in conjunction with direct care to the Member. Health maintenance and IADL tasks are those that would otherwise be normally performed by the Member if he or she were physically or cognitively able to do so. It must also be established that there is no family Member or other person available to assist with these tasks. A child or infant shall not qualify for coverage of IADL tasks because an infant or child does not normally perform these tasks. Coverage of IADL tasks is provided to assist individuals with disabilities to live independently in the community. IADL services may be authorized and covered only if the Member also requires ADL or medication administration services. IADL services are not covered as stand-alone personal care services; these may be covered only in combination with ADL or medication administration services.

1. The maximum hours per week allowed for IADL tasks for Levels I, II, III and IX is as follows: Level I is two hours; Level II is three hours; and Level III and IX is four hours. ADL and IADL tasks, and the allotted hours, must be specified and authorized in the plan of care.

D. Certified nursing assistants, home health aides, or personal support specialists may transport a Member only to carry out necessary covered services in the Member's plan of care. Escort services may be provided only when a Member is unable to be transported alone, there are no other resources (family or friends) available for assistance, and the transportation agency can document that the agency is unable to meet the request for service.

Such documentation must be included in the Member's record. Coverage is not available to reimburse for mileage or vehicle usage under this Section. Only the provider's services are covered.

E. Personal care services shall be provided, as appropriate, by a:

1. Home health aide; or
2. Certified nursing assistant; or
3. Personal support specialist; or

96.04 **COVERED SERVICES** (cont.)

4. Certified Residential Medication Aide employed by a licensed assisted living agency, as defined in §96.01-28, that holds a valid contract with OADS and provides medication administration as allowable under certification.
- F. Personal care services shall not be covered when delivered by a spouse of the Member, the parents or stepparents of a minor child, or a legally responsible relative.
- G. The task time allowances set forth in Appendix 1 must be used to authorize the time covered to complete covered and authorized ADL tasks for the plan of care. For Members age 21 and over, and those receiving care under the family provider services option the ASA shall abide by Appendix 1. For Members under age 21, the PDN provider shall abide by Appendix 1. These allowances reflect the time normally allowed to accomplish the listed tasks. The ASA and the PDN provider will use these allowances when authorizing a Member's care plan. If these times are not sufficient when considered in light of a Member's unique circumstances as identified and documented by the ASA or the PDN Provider, the ASA or the PDN Provider may make an appropriate adjustment as long as the authorized hours do not exceed the established limits for the Member's assessed level of care.
- H. The PSS supervisit is a one-hour visit to deliver personal care services and health maintenance activities to a Member, no more than once per day. This service may be authorized up to seven days per week. If the Member requires more than one hour of personal care services on a given day, then the regular PSS services must be billed with the appropriate unit procedure codes, and the one-hour visit procedure code shall not be used.

This is not a covered service under the family provider services option defined in Section 96.01-23.
- I. Medication services delivered by Certified Residential Medication Assistants, and unrelated to the medication services described under Level VI, are covered services for those Members meeting the eligibility criteria under Level IX.

96.04-3 **Venipuncture Only services (Level VII)**

- A. These services shall be covered when it is the only identified nursing need and is required on a regular basis, as ordered by the physician. An RN or LPN must deliver venipuncture services. Personal care services are not covered services under venipuncture services. If the Member requires additional services, then he/she must meet (at least) the eligibility requirements for Level II or III. If the Member qualifies for Level II or III then all services including venipuncture services shall be authorized and delivered under Level II or III.

96.04 **COVERED SERVICES** (cont.)

96.04-4 **Medication and venipuncture services (Level VI)**

- A. Level VI services are directly related to the administration and/or monitoring of medications intended for the treatment and management of mental illness in the context of community support services for people with severe and persistent mental illness (Level VI under this Section).
- B. Monitoring services may include venipuncture services for Members under this Section.
- C. A psychiatric nurse or a registered professional nurse must deliver these services.
- D. Personal care services are not covered services under this Section 96.04(F). If the Member requires additional services, then he or she must meet (at least) the eligibility requirements for Level II care. If the Member qualifies for Level II or III then all services including medication services shall be authorized and delivered under the Level II or III.

The following services are covered upon Centers for Medicare and Medicaid Services (CMS) approval.

96.04-5 **Care Coordination** activities are guided by the Member's authorized plan of care. Care coordination services include the following functions:
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 as appropriate.
For Members who choose to self-direct their services, Care Coordination includes assisting the Member in arranging for, directing and managing his/her self-directed services as allowed, and coordinating access to Skills Training 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 of care coordination services to discuss choice of provider(s), service delivery options, clarify issues, and answer questions;
- 2. Assisting with the implementation of the authorized plan of care and coordinating service providers who are responsible for delivering services, by making referrals and providing service authorizations to qualified service provider(s) the Member chooses; or if the Member chooses to self-direct, providing access to Skills Training;

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3. Visiting the Member at his/her residence within 30-45 days of receipt of notification of authorization of care coordination services to review needs and goals, and address unmet needs;
4. Visiting the Member annually to monitor the Member's overall health status by following up on identified needs and issues;
5. 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;
6. 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;
7. Responding timely to assist the Member with resolving problems and other concerns;
8. Advocating on behalf of the Member for appropriate community resources and services by providing information, making referrals and otherwise facilitating access to these supports;
9. Modifying the authorized plan of care, within the following parameters:
 - a. In the event a Member experiences a change in the need for services, the care coordinator has the authority to adjust the frequency of services under the authorized plan of care, in order to address the needs. However, the total number of hours authorized for the eligibility period shall not be exceeded.
 - b. 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.
10. Making referrals for reassessments prior to the end of the eligibility period, and based upon a significant change in the Member's health status or change in service needs;

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11. 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;

B. Other activities include, but are not limited to:

1. Comply with the Department's internal authorization protocols,
2. Maintaining Member records,
3. Providing information as required by the Department,
4. Following requirements regarding mandated reporting.

96.04-6 **Skills Training** includes the following functions:

- A. Instructing the Member in the management of personal support specialists. Instruction in management of PSS includes instruction in recruiting, interviewing, selecting, training, scheduling, and directing a competent PSS in the activities in the authorized plan of care and obligations under this Section. Providers of skills training must instruct each new eligible Member prior to the start of services.
- B. The provider must document that initial skills training has occurred within thirty (30) calendar days of the Member electing the FPSO option.
- C. The Skills Training provider may substitute a competency-based assessment in lieu of repeat instruction for Members having previously completed such training under an earlier eligibility period or from another provider of like services.

96.05 **NON-COVERED SERVICES**

The following services are not reimbursable under this Section:

- A. Services for which the cost exceeds the limits described in this Section, except as described in 96.03(A);
- B. Psychiatric nursing services, except as described under Section 96.04(A);
- C. Those services that can be reasonably obtained by the Member outside his/her place of residence;
- D. Unless qualified for the "special circumstances nursing" (see Section 96.04(B)), nursing services when provided by the Member's husband or wife, natural or adoptive parent, child, or sibling, stepparent, stepchild, stepbrother or stepsister, father in law, mother in law, son in law, daughter in law, brother in law, sister in law, grandparent or grandchild, spouse of grandparent or grandchild or any person sharing a common abode as part of a single family unit;

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- E. Personal care services provided by a spouse of the Member, the parents or stepparents of a minor child, or a legally responsible relative;
- F. Homemaker and chore services not directly related to medical necessity. Homemaker and chore services are covered in this Section only as authorized by the ASA in the plan of care when required;
- G. Services in an ICF-IID, nursing facility or hospital;
- H. Services to Members receiving any Home and Community Benefits for the Elderly, or Adults with Disabilities (nursing and personal care services are covered under these waiver benefits);
- I. Escorting Members outside of the home, except as described in Section 96.01-3 or 96.04(C);
- J. Custodial care or respite care;
- K. Except for those services delivered under Level IX, personal care services delivered in an Adult Family Care Home setting or other licensed Assisted Living Facility that is reimbursed for providing personal care services It is the responsibility of the AFCH or assisted living provider to deliver personal care services;
- L. Personal care services may not be provided to Members receiving Home and Community Benefits for Persons with Intellectual Disabilities or Autism Spectrum Disorder. Personal care services are covered services under this Waiver. These Members may receive nursing services only under this Section;
- M. Supervisory visits made for the purpose of supervising home health aides, certified nursing assistants or personal care assistants;
- N. Services which are not approved by the plan of care; or
- O. Services in excess of 40 hours per week, provided by an individual PSS, home health aide or certified nursing assistant, for an individual Member.

96.06 LIMITS

- A. Skills training shall not exceed 14.25 hours annually including any hours needed for initial instruction.
- B. Care Coordination shall not exceed 18 hours annually.

96.07 POLICIES AND PROCEDURES

96.07-1 Eligibility Determination

Applicants for services under this Section must meet the eligibility requirements set forth in Section 96.02. An eligibility assessment, using the Department's approved MED assessment form, shall be conducted by the Department, the ASA, or the PDN provider, as applicable.

Eligibility for individuals under the age of 21, and for medication services or venipuncture services, and excluding all seeking services under the family provider services option, shall be determined by the PDN provider, in accordance with the requirements of Section 96.02 and the MED form.

These services require prior approval by the Department. All other PDN/PCS services, for Members age 21 and over, and those requesting services under the family provider service option, require eligibility determination and prior approval by the ASA.

Applicants ages 18 and over who meet the NF medical eligibility criteria also qualify for Home and Community Benefits. These benefits may provide a greater array and quantity of services than otherwise available under this Section 96; therefore, applicants must be assessed to determine whether they qualify for NF level of care.

Members are prohibited from receiving Home and Community Benefits and services under this Section simultaneously, except as described in Section 96.05(L).

- A. If financial eligibility for MaineCare has not been determined, the applicant, family Member or guardian, must be referred to the regional Office for Family Independence, concurrent with the relevant medical eligibility determination process.
- B. The Department, or its ASA, shall conduct a medical eligibility assessment using the Department's approved 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 with 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.
- C. The PDN provider shall develop a nursing plan of care, which shall be reviewed and signed by the Member's physician. It shall include the personal care and nursing services authorized by the ASA or the Department, and the nursing plan signed by the Member's physician.

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

- D. The anticipated costs of services under this Section to be provided under the authorized plan of care must conform to the limits set forth in Section 96.03 and 96.06.
- E. An individual's specific needs for medical services must be reviewed and approved by the Member's physician at least every 62 days, and so documented in the medical record and nursing plan of care by the RN.
 - 1. Applicants, age 21 and over, and Members requesting services under the family provider service option, who meet the eligibility criteria for PDN services, as set forth in Section 96.02, and as documented by the Department's approved MED assessment form, shall:
 - a. Be assigned, by the ASA, to the appropriate level of care, and receive an authorized plan of care based upon the scores, timeframes, findings and covered services recorded in the MED assessment. The covered services to be provided in accordance with the authorized plan of care shall: 1) not exceed the established financial caps; 2) be authorized by the Department or its ASA; and 3) be under the direction of the Member's physician for the nursing plan of care.
 - b. The assessor shall approve an eligibility period for the Member, based upon the scores, timeframes and needs identified in the MED assessment for the covered services, and the assessor's clinical judgment. The eligibility period shall not exceed 12 months.
 - c. Except for those Members who qualify under Level IX, the assessor shall notify the Service Coordination Agency within two business days of the medical eligibility determination and authorization of the plan of care. For those Members who are eligible under Level IX, the assessor shall forward the completed assessment and plan of care to the Licensed Assisted Living Agency, as defined in §96.01-28.
 - 2. Members under age 21, excluding those requesting services under the family provider service option.
 - a. Services require prior approval by the Department. The Department shall approve an eligibility period, not to exceed one year.

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

- b. An individual under age 21, who does not meet the eligibility criteria for PDN services as set forth in Section 96.02, may be reviewed under Prevention, Health Promotion, and Optional Treatment Services. If the provider determines that services are medically necessary pursuant to the criteria of Prevention, Health Promotion, and Optional Treatment Services, then services shall be provided in accordance with a plan of care and billed under this Section, adhering to all applicable financial caps unless authorization to exceed that cap has been granted by the Department as outlined under Section 96.03(A).
- c. If a provider determines that any of the requested services, for an individual under age 21, are medically necessary, but are not available from that provider, the provider shall notify the family in writing (in the Department's approved notice format) which services are not available from that provider. A copy of the letter shall be sent to the Department's Prevention, Health Promotion, and Optional Treatment Services staff, and Prevention, Health Promotion, and Optional Treatment Services staff shall offer to assist the Member in locating other providers.
- d. If the provider determines that the PDN/PCS services are not medically necessary, then the provider shall notify (using a notice format approved by the Department) the family in writing of which services will be provided and which services will not be provided, or provided only on a reduced basis. The notice shall contain an understandable explanation of the reasons and inform them of their appeal rights and of Prevention, Health Promotion, and Optional Treatment Services. A copy of any denial/reduction notice shall be sent to the Prevention, Health Promotion, and Optional Treatment Services. Prevention, Health Promotion, and Optional Treatment Services will then offer to assist the family to see what other services may be provided to meet the child's needs.
- e. The private duty nursing services provider shall develop a nursing plan of care and an authorized plan of care.
- f. The anticipated costs of services to be provided under the plan of care must conform to the limits set forth in Section 96.03. The costs of physical therapy, occupational therapy, speech and hearing services shall not be included in the calculation of either the average annual cost of institutional services or the cost of PDN services required by the individual.

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

- g. The PDN/Personal care services provider shall obtain the signature of the physician on the plan of care or a physician's order for private duty nursing and personal care services and for the medical treatment plan. This shall be made available to the Department or its Authorized Entity upon request. Services must also be authorized by the Department or its Authorized Entity.
- h. For services to individuals under age 21, as well as individuals classified for venipuncture services and medication services, but excluding those receiving services under the family provider service option, the eligibility assessment form and the plan of care shall be maintained in the Member's medical record, available upon request for review by the Department. The provider must submit a copy of the medical eligibility determination form to the Department.
- i. The provider shall be responsible for assuring that the plan of care shall not exceed the financial cap established by the Department.

96.07-2 **Redetermination of Eligibility**

- A. For all Members 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 at least 5 days prior to and no later than the reclassification date.

For Members under the age of 21, as well as Members classified for venipuncture services and medication services, but excluding those receiving care under the family provider service option, the MED assessment tool shall be submitted to MaineCare Services, Quality Improvement Division within 72 hours of completion of the MED form, for initial assessments or reassessments. MaineCare payment ends with the reassessment date, also known as the eligibility end date.

- B. An individual's specific needs for medical services are reviewed at least every 62 days, and so documented in the medical record and nursing plan of care by the RN.

96.07-3 **Family Provider Service Option.** All requirements of Section 96 apply to the family provider service option unless exempted specifically in this sub-Section, or elsewhere in this Section. This option allows, under certain conditions specified below, a MaineCare Member (or a family Member on his or her behalf,) to solely manage the Member's authorized personal support services, if the Member (or a family Member,) is a family provider agency. The management of the personal support services

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includes: hiring, firing, training, maintaining records and scheduling the PSS(s). This service option is not available to those Members who receive services based on Level IX eligibility criteria.

A. The following provisions apply:

1. The MaineCare Member, or his or her family Member (see below), as applicable, must be age 21 years or older, and register with the Department as a personal care agency, pursuant to the Department's "Rules and Regulations Governing In-Home Personal Care and Support Workers".
2. A family Member related by blood, marriage or adoption, or a significant other in a committed partnership, must register as the personal care agency in order to manage the personal care services on behalf of the MaineCare Member, if the Member does not have the ability, or does not meet the required standards for cognitive capacity, or otherwise does not desire to manage his or her own care.
3. The MaineCare Member must meet the minimum standards for cognitive capacity as defined in Section 96.01-26, in order to be the family provider agency.
4. For children and youth under age 21 years, a parent or guardian may be the family provider agency, if the child has all required medical eligibility determination assessments performed by the ASA and management performed by the Service Coordination Agency, as is required of all other Members using this family provider service option. (Note: under other Sections of this rule, children's services do not go through the ASA and the Service Coordination Agency.)
5. Participation is subject to the approval (and ongoing approval) of the Service Coordination Agency.
6. The family provider agency may manage personal care services for up to two family Members.
7. The family provider agency may hire a family Member to deliver the personal care services, with the exception of the MaineCare Member's spouse, or the parent (including stepparent) of a minor child who is a MaineCare Member. Refer to Federal regulation 42 CFR 440.167, and the State Medicaid Manual, Section 4480, "Personal Care Services" (prohibits the coverage of personal care services delivered by these legally responsible family Members.)

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8. The adult who is registered as the personal care agency will not be paid to provide care to the Member.
9. A Member's guardian will not be paid to provide care to the Member.

B. The family provider agency must:

1. check the Maine Registry of Certified Nursing Assistants and Direct Care Workers and conduct a criminal history background check for any individual hired as a personal care assistant and not employ an individual who is prohibited from employment under Title 22 MRSA §1717(3);
2. use a fiscal intermediary payroll entity that has been approved by the Department;
3. receive authorization from the ASA, including an authorized plan of care;
4. implement the authorized plan of care;
5. comply with the Department's quality assurance oversight activities and visits; failure to comply will result in termination of the Member's participation in the family provider service option.

C. As part of the family provider services option, the Service Coordination Agency must:

1. check the Maine Registry of Certified Nursing Assistants and Direct Care Workers and conduct a criminal background check on the individual who registers as a personal care agency; and
2. manage the Member's authorized professional services (i.e., RN services); and
3. assist the Member with contacting a fiscal intermediary.

D. As part of the family provider services option, the Assessing Services Agency must serve as the Department's authorized entity for Members under age 21 who are receiving services under the family provider services option as defined in Section 96.01-23.

96.07-4 **Discharge Notification**

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

- A. A provider serving children under age 21, and Members receiving venipuncture services and medication services, must notify the Department within 48 hours of discharging a Member from care.
- B. A provider serving Members age 21 and over must notify the Service Coordination Agency within 48 hours of discharging a Member from care.

96.07-5 **Professional and Other Qualified Staff**

All professional staff must be conditionally, temporarily, or fully licensed as documented by written evidence from the appropriate governing body. All professional staff must provide services only to the extent permitted by qualified professional staff licensure. Services provided by the following staff are reimbursable under this Section.

A. **Registered Professional Nurse**

A registered professional nurse employed directly or through a contractual relationship with a home health agency or acting as an individual practitioner may provide private duty nursing services by virtue of possession of a current license to practice their health care discipline in the state in which the services are performed.

B. **Psychiatric Registered Nurse**

A registered professional nurse that is licensed by the state or province in which services are provided and has met requirements for approval to practice as an advanced practice psychiatric nurse or is certified as a psychiatric and mental health nurse by the appropriate national accrediting body.

C. **Licensed Practical Nurse**

A licensed practical nurse employed directly by or through a contractual relationship with a licensed home health agency may provide private duty nursing services by virtue of possession of a current license to practice their health care discipline in the state in which the services are performed provided they are supervised by a registered professional nurse.

D. **Home Health Aide**

Any home health aide employed directly by, or acting under a contractual relationship with, a licensed home health agency must have satisfactorily completed training for certified nurse assistants consistent with the rules and regulations of the Maine State Board of Nursing. Home health aides employed by

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

a home health agency must also have satisfactorily completed an agency orientation as defined by the Regulations governing the Licensing and Functioning of Home Health Care Services and be listed on the Maine Registry of Certified Nursing Assistants and Direct Care Workers. The HHA must meet all applicable state laws and regulations as are currently in effect.

E. Certified Nursing Assistant

A CNA employed by, or acting under a contractual relationship with, a licensed home health agency must have satisfactorily completed training for certified nurse assistants consistent with, and receive supervision consistent with, the Rules and Regulations of the Maine State Board of Nursing and be listed on the Maine Registry of Certified Nursing Assistants and Direct Care Workers registry. The CNA must meet all applicable state laws and regulations as are currently in effect.

F. Certified Nursing Assistant/Medications

A CNA who meets the requirements in Section 96.06-4(E) above and has satisfactorily completed a Department-approved medication course for Certified Nursing Assistants, consistent with the Rules and Regulations of the Maine State Board of Nursing and be listed on the Maine Registry of Certified Nursing Assistants and Direct Care Workers.

G. Personal Support Specialist (PSS)

A PSS must be employed by, or acting under a contractual relationship with a licensed home health agency, registered personal care agency, or licensed assisted living agency, as defined in §96.01-28, under contract with Office of Aging and Disability Services. The following requirements must be met:

1. **Criminal background check and CNA and Direct Care Workers registry check.** A provider agency must check the Maine Registry of Certified Nursing Assistants and Direct Care Workers and conduct criminal background checks for applicants for positions as PSSs, CNAs or home health aides and must not employ an individual who is prohibited from employment under Title 22 MRSA §1717.
2. **Training.** A provider agency must verify that a PSS meets one of the training and examination requirements below. An individual without the required training may be hired and reimbursed for delivering personal care 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 months of employment and

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

meets all other requirements. If the individual fails to pass the examination within nine 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 of the following)

- a. Hold a valid certificate of training for nursing assistants or have official documentation of equivalent training as verified by the office of the Maine Registry of Certified Nursing Assistants and Direct Care Workers, and be currently listed on the Maine Registry of Certified Nursing Assistants and Direct Care Workers without any annotation that would prohibit that individual from employment; or
- b. Hold a valid certificate of training, issued within the past three years, for nurse's aide or home health aide training which meets the standards of the Maine State Board of Nursing- nursing assistant training program; or
- c. Pass the competency-based examination of didactic and demonstrated skills from the Department's approved personal support specialist curriculum if a CNA whose status on the Maine Registry of Certified Nursing Assistants has lapsed, or an individual who holds a valid certificate of training issued more than three years ago, for nurse's aide or home health aide training which meets the standards of the Maine State Board of Nursing nursing assistant training program. A certificate of training as a personal care assistant/personal support specialist will be awarded upon the successful passing of this examination; or
- d. Hold a valid certificate of training as a personal support specialist/personal care assistant issued as a result of completing the Department-approved personal support specialist training curriculum and passing the competency-base examination of didactic and demonstrated skills. The training course must include at least 50 hours of formal classroom instruction, demonstration, return demonstration, and examination. Tasks covered under this Section must be covered in the training; or
- e. Be a personal support specialist (PSS) who successfully completed a Department-approved curriculum prior to September 1, 2003. Such individuals will be grand fathered as a qualified personal care assistant/PSS; or
- f. Obtain a waiver from the Department, the ASA, or the Service

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

Coordination Agency. At their discretion, the Department, the ASA, or the Service Coordination Agency, may waive training requirements for Personal Support Specialists under the family provider service option if the PSS has provided services to the Member prior to July 1, 2004 under Section 12, "Consumer Directed Attendant Services" or the state funded Consumer Directed Home Based Care program, under Section 63, "In-home and Community Support Services" of the Office of Aging and Disability Services *Policy Manual*. Otherwise, PSSs under the family provider service option must meet the training and competency requirements described above.

3. **New employee orientation**

- a. A PSS, newly hired by 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.
 - b. With the exception of family provider service option PSSs, a newly hired PSS who does not yet meet the Department's training and examination requirements must undergo an 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, where by a PSS can demonstrate competency via on the job training once being assigned to a member's home.
 - c. A family provider agency must provide adequate orientation for the PSS to meet the needs of the Member(s). Adequacy shall be determined by the Service Coordination Agency. The provision of orientation, including the specific dates and times of training, and the content matter of the orientation must be documented in the PSS's personnel record.
4. Provider agency responsibilities include, but are not limited to the following:

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

- a. Assure that PSSs meet the training, competency, and other requirements of this Section. Maintain documentation of how each requirement is met in the PSS's personnel file, including: evidence of orientation, Maine Registry of Certified Nursing Assistants and Direct Care Workers check, and criminal background checks, and the verification of credentials including the certificate of training and/or verification of competency.
- b. **Initial and Supervisory visits**
 - i. **Initial visit.** A provider agency supervisor or representative must make an initial visit to a Member's home prior to the start of personal care 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.
 - ii. **Scheduled supervisory visits.** Excluding the family provider service option, for Level III, IV, and V Members, 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 care plan tasks. For Level I and II Members, on-site supervision must be at least once every 6 months along with quarterly phone calls to the Member. More frequent or additional on-site supervision visits of the PSS is at the discretion of the provider agency as governed by its personnel policies and procedures.
 - iii. **Supervisory visits for the family provider service option.** PSSs reimbursed under the family provider service option must have on-site home supervisory visits by the Service Coordination Agency to evaluate the condition of the Member, implementation of the care plan, and the Member's satisfaction with the services. Failure to allow the Service Coordination Agency on-site visits is grounds for terminating reimbursement to the PSS worker or agency.
- c. A provider agency must develop and implement written policies and procedures to ensure that PSSs do not smoke or consume alcohol or controlled substances in the Member's home or vehicle during work hours.

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

- d. A provider agency must develop and implement written policies and procedures that prohibit abuse, neglect or misappropriation of a Member's property.
5. A family Member who meets the requirements of this Section may be a PSS and receive reimbursement for delivering personal care services, with the exception of the MaineCare Member's spouse, or the parent (including stepparent) of a minor child who is a MaineCare Member. Refer to Federal regulation 42 CFR 440.167, and the State Medicaid Manual, Section 4480, "Personal Care Services" (prohibiting the coverage of personal care services delivered by these legally responsible family Members.)
6. The Department has the authority to recoup funds for services provided if the provider agency does not provide required documentation to support qualifications of the agency, staff or services billed.
7. The Office of Aging and Disability Services has the responsibility of ensuring the quality of services and the authority to determine whether a PCA agency has the capacity to comply with all service requirements. Failure to meet standards must result in non-approval or termination of the contract for PCA services.

H. Fiscal Intermediary

For purposes of this subsection, the Fiscal Intermediary acts as an entity of the employer in accordance with Federal Internal Revenue Service Codes and procedures in matters related to the employment of support workers and purchases of other support services or goods. The Fiscal Intermediary Entity has an established contract with the Department, but is not a billable service under this Section. The use of a FI is required under the family provider service option.

- I. Certified Residential Medication Aides (CRMAs) are allowed to administer medications to persons served by DHHS Licensed Assisted Housing Programs, as defined in 22 M.R.S.A. §7852, and other licensed facilities only after they have successfully taken a 40-hour class, passed a written test, and demonstrated medication administration competence to an RN. CRMA services are reimbursable under this Section only when employed by the Licensed Assisted Living Agency, as defined in §96.01-28, that holds a valid contract with Office of Aging and Disability Services and the CRMA is working under the consultation of an R.N.

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

96.07-6 **Member's Records**

A. **Authorized Entity, Service Coordination Agency and Direct Care Provider Records**

There shall be a specific record for each Member which shall include the following:

1. Member's name, address, phone number, emergency contact, birth date;
2. The Member's medical eligibility determination form, release of information, authorized plan of care and copies of the eligibility determination notice and service authorizations issued by the Service Coordination Agency for Members over age 21;
3. Names and telephone numbers of the persons to call in case of an emergency or for advice or information. This information must be readily available to the HHAs, CNAs, PSSs, CRMAs and other in-home care workers;
4. The plan of care which specifies the tasks and the schedule of tasks to be completed by the PSS, CNA, HHA or CRMA and authorized services. Whenever a RN or LPN delivers services to more than one patient in the same setting, during the same visit (see Section 96.04(F) multiple patient nursing services) then this service must be described and documented in each Member's plan of care;
5. Entrance and exit times, and total hours spent in the home for each visit by each nurse, PSS, HHA, and CNA;
6. The number of medication passes performed by the CRMA for each Member under Level IX; and
7. Progress notes reflecting changes in the Member's condition, needs, communications with the Member, other information about the Member, and contacts with other involved agencies. Progress notes must be signed and dated by the person entering the note.

B. **Authorized Plan of Care**

1. The authorized plan of care must indicate the type of services to be provided to the Member, specifying who will perform the service, the number of hours per week, specifying the begin and end dates, and specifying the tasks and reasons for the service.

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

For all Members age 21 and over, excluding those eligible for medication services or venipuncture services, and for those Members under age 21 receiving care under the family provider service option, the Assessing Services Agency has the authority to determine and authorize the plan of care.

2. Members may receive Medicare covered services, as applicable, during the same time period they receive MaineCare covered PDN/PCS. The authorized plan of care must identify the types and service delivery levels of all other home care services to be provided to the Member whether or not the services are reimbursable by MaineCare. These additional home care services might be provided by such individuals as homemakers, personal care attendants and companions. These additional services shall include, but not be limited to, case management, home-delivered meals, physical therapy, speech therapy, occupational therapy, MSW services and hospice.

C. Nursing Treatment Plan of Care

The licensed home health agency provider or independent contractor shall obtain the signature of the physician at least every 62 days on the nursing plan of care and on the physician's orders for nursing treatments and procedures, medications, medical treatment plan, and the frequency and level of personal care services. (The physician orders and nursing plan of care may be combined into one document.) These shall be made available to the Department or its Authorized Entity upon request. Covered services must be authorized by the Department or the ASA. Content of the nursing treatment plan must include the following information:

1. All pertinent diagnoses, including mental status;
2. All services, supplies, and equipment ordered;
3. The level of care, frequency and number of hours to be provided;
4. Prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, and any additional items the PDN services provider or physician choose to include. Orders for care must indicate a specific range in the frequency and number of hours. Orders may not be open-ended or "as needed;" and

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

5. The nursing plan of care and physician's orders for nursing treatments and procedures must be reviewed and signed by the Member's physician as required by the Department in this Section at least every 62 days.
- D. Written Progress Notes for Services Delivered by a Direct Care Provider must contain:
1. The service provided, date, and by whom;
 2. Entrance and exit times of nurse's, home health aides, certified nursing assistants and personal care assistant's visits and total hours spent in the home for each visit. Exclude travel time (unless provided as a service as described in this Section);
 3. a written service plan that shows specific tasks to be completed and the schedule for completion of those tasks;
 4. Progress toward the achievement of long and short-range goals. Include explanation when goals are not achieved as expected;
 5. Signature of the service provider; and
 6. Full account of any unusual condition or unexpected event, dated and documented.
- E. Written Progress Notes for the Service Coordination Agency must contain:
1. Date and time of every contact with the Member and by whom; and
 2. Progress toward the achievement of long and short range goals. Include explanation when the goals are not met as expected; and
 3. Signature and date of the Service Coordination Agency staff Member entering the note; and
 4. Full account of any unusual condition or unexpected event, dated and documented; and
 5. All entries must be signed by the individual who performed the service. Authorized and valid electronic signatures are acceptable.

96.07-7 **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.

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

96.07-8 **Member Appeals**

A Member or applicant has the right to appeal in writing or verbally any decision made by the Department or its Authorized Entity, to reduce, deny or terminate services provided under this benefit. In order for a Member's services to continue during the appeal process, a request must be received by the Department within 10 days of the notice to reduce or terminate services. Otherwise, an individual has 60 days in which to appeal a decision. Members or applicants shall be informed of their right to request an Administrative Hearing in accordance with this Section and Chapter I of this Manual.

- A. An appeal for Members or Applicants, aged 21 and over, and those under age 21 receiving care under the family provider services option, 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

- B. For Members under the age of 21, and for all Members classified for medication services or venipuncture services, but excluding those receiving care under the family provider services option, an appeal must be made by the Member or his or her representative, in writing or verbally, for a hearing to:

Director
MaineCare Services
Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011

For the purposes of determining when a hearing was requested, the date of the fair hearing request shall be the date on which the Director receives the request for a hearing. The date a verbal request for a fair hearing is made is considered the date of the request for the hearing. MaineCare Services may also request that a verbal request for an administrative hearing be followed up in writing, but may not delay or deny a request on the basis that a written follow-up has not been received.

96.08 **REIMBURSEMENT**

96.08-1 **Reimbursement for Private Duty Nursing and Personal Support Services**

Reimbursement will be made on the unit rate as specified in Chapter III of this Section and shall be the lower of:

- A. The amount listed in Chapter III, Section 96, "Allowances for Private Duty Nursing and Personal Care Services"; or

96.08 **REIMBURSEMENT** (cont.)

- B. The provider's usual and customary charge.

In accordance with Chapter I of the *MaineCare Benefits Manual*, it is the responsibility of the provider to seek payment from any other sources that are available for payment of the rendered service prior to billing the MaineCare Program.

96.08-2 **Licensed Home Health Care Agencies**

In order to qualify for reimbursement under this Section as a Home Health Care Agency, the Home Health Agency must have in effect a license pursuant to the Department's Regulations Governing the Licensing and Functioning of Home Health Care Services, as are currently in effect. These standards are incorporated into this Section by reference as if set out fully herein.

96.08-3 **Registered Personal Care Agency**

In order to qualify for reimbursement under this Section as a Personal Care Agency, the Agency must have in effect a registration pursuant to the Department's "Rules and Regulations Governing In-Home Personal Care and Support Workers", as are currently in effect.

96.08-4 **Licensed Assisted Living Agency**

In order to qualify for reimbursement under this Section as a Licensed Assisted Living Agency, the Agency must be licensed with the Department as an assisted living program and hold a valid contract with the Office of Aging and Disability Services to provide services, and employ CRMAs to serve MaineCare Members who have daily medication administration needs.

96.08-5 **Family Provider Service Option Rates**

The rates for family provider services consist of two components:

- a) PSS services rate, which is the portion of the family provider services rate that is designated as the PSS's gross hourly wage for authorized care provided by the family provider;
- b) Family provider expense component, which is the portion of the family provider services rate designated for the mandated employer's share of Social Security, Federal and State unemployment taxes, Medicare, and Workers' Compensation insurance premiums.

96.08 **REIMBURSEMENT** (cont.)

96.08-6 **Service Coordination Agency**

In order to qualify for reimbursement under this Section as a Service Coordination Agency, the Agency must have met the MaineCare provider enrollment requirements of the Department **and** any additional provider qualifications required by the Office of Aging and Disability Services.

96.09 **COPAYMENT**

96.09-1 **Copayment Amount**

- A. A copayment will be charged to each MaineCare Member receiving services. The amount of the copayment shall not exceed \$3.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
\$10.00 or less	\$.50
\$10.01 - 25.00	\$1.00
\$25.01 - 50.00	\$2.00
\$50.01 or more	\$3.00

- B. The Member shall be responsible for copayments up to \$5.00 per month whether the copayment has been paid or not. After the \$5.00 cap has been reached, the Member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.

Providers are subject to the Department's copayment requirements. Refer to Chapter I, "General Administrative Policies and Procedures", for rules governing copayment requirements, exemptions and dispute resolution.

96.10 **BILLING INSTRUCTIONS**

- A. Billing must be accomplished in accordance with instructions for either the CMS 1500, or the UB04 Form, as appropriate.
- B. In order to receive full MaineCare reimbursement for claims submitted for a service that is defined as an exemption in Chapter I, refer to the billing instructions distributed by the Department and to Chapter I, "General Administrative Policies and Procedures".
- C. All services provided on the same day shall be submitted on the same claim form for MaineCare reimbursement.

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96.10 **BILLING INSTRUCTIONS** (cont.)

- D. All providers involved in the delivery of services to a Member are responsible for billing for those services with appropriate procedure codes outlined in Chapter III.

Billing for services delivered to children under age 21, excluding those receiving care under the family provider service option, and for all Level VI and Level VII services, shall be submitted to the Department.

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ADL = Activities of Daily Living				
APPENDIX #1 TASK TIME ALLOWANCES				
Activity	Definitions	Time Estimates		Considerations
Bed Mobility	How person moves to and from lying position, turns side to side and positions body while in bed.	5 – 10 minutes		Positioning 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		Use of slide board, gait belt, swivel aid, supervision needed, positioning after transfer, cognition
		up to 15 minutes		Mechanical lift transfer
Locomotion	How person moves between locations in his/her room and other areas on same floor. If in wheel- chair, 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		Set up, cut food and place utensils Individual is fed Supervision of activity due to swallowing, chewing, cognition issues
		30 minutes		
		30 minutes		
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
Personal Hygiene	How person maintains personal hygiene. (EXCLUDE baths and showers)	Washing face, hands, perineum, combing hair, shaving and brushing teeth	20 min/day	Disability level, pain, cognition, adaptive equipment.
		Shampoo (only if done separately)	15 min up to 3 times/week	
		Nail Care	20 min/week	
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 of tub/shower	15 - 30 minutes		If shower used and shampoo done then consider as part of activity, cognition

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Appendix #1 Task Time Allowances (cont.)

Task time allowances are used for the authorization of covered services under this Section. Refer to Section 96.04(C).

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

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APPENDIX #2
Level of Care Caps

Members are assigned to a level of care based upon the eligibility criteria in Section 96.02.

The Department is seeking and anticipates receiving CMS approval for this Section. There are four separate proposed rate changes pending before CMS: one that was submitted in September 2015, one that was submitted in September 2016, one submitted in September 2017, and one submitted in July 2018; thus there are four retroactive effective dates applicable for these rates. Pending CMS approval, the following levels of care will be effective. Members under the age of 21 years can exceed the caps when it is medically necessary as outlined under Section 96.03(A). Reimbursement of care coordination and skills training do not count toward the monthly cost caps.

Level of Care	Effective 7/1/15 to 7/28/16	Effective 7/29/16 to 6/30/17 and 7/1/18 to 7/31/18	Effective 7/1/17 to 6/30/18	Effective Retroactive to 8/1/18	Effective 7/1/19
Level I	\$820/month	\$925/month	\$1,092/month	\$1,124/month	\$1,114/month
Level II	\$1,035/month	\$1,165/month	\$1,375/month	\$1,415/month	\$1,402/month
Level III	\$1,690/month	\$1,904/month	\$2,248/month	\$2,314/month	\$2,292/month
Level IV (under 21 years of age, only)	\$3,133/month	\$3,532/month	\$4,041/month	\$4,160/month	\$4,119/month
Level V	\$22,233/month	\$23,966/month	\$27,420/month	\$28,222/month	\$27,941/month
Level VIII	\$750/month	\$847/month	\$938/month	\$966/month	\$957/month
Level IX	\$1,570/month	\$1,769/month	\$2,088/month	\$2,149/month	\$2,129/month

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PROCEDURE CODE	DESCRIPTION	UNIT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT
			Effective 7/1/15 to 7/28/16	Effective 7/29/16 to 2/21/17	Effective 2/22/17 to 6/30/17 and 7/1/18 to 7/31/18	Effective 7/1/17 to 6/30/18	Effective 8/1/18 to 6/30/19	Effective 7/1/19
G0299 TD 0551	RN Services	15 minutes	\$10.58	\$12.16	\$12.16	\$13.47	\$13.88	\$13.74
G0299 TD UN 0551	RN Services –multiple patients (2)	15 minutes	\$6.94	\$6.94	\$6.69	\$7.41	\$7.63	\$7.56
G0299 TD UP 0551	RN Services – multiple patients (3)	15 minutes	N/A	N/A	\$4.87	\$5.39	\$5.55	\$5.50
G0300 TE 0559	LPN Services	15 minutes	\$6.32	\$8.04	\$8.04	\$9.56	\$9.90	\$9.75
G0300 TE UN 0559	LPN Services – multiple patients (2)	15 minutes	\$4.74	\$4.74	\$4.43	\$5.27	\$5.45	\$5.37
G0300 TE UP 0559	LPN Services – multiple patients (3)	15 minutes	N/A	N/A	\$3.21	\$3.83	\$3.96	\$3.90
T1000 TD	Independent RN	15 minutes	\$8.17	\$10.96	\$10.96	\$13.47	\$13.88	\$13.74
T1000 TD UN	Independent RN – multiple patients (2)	15 minutes	\$6.13	\$6.13	\$6.03	\$7.41	\$7.63	\$7.56
T1000 TD UP	Independent RN– multiple patients (3)	15 minutes	N/A	N/A	\$4.39	\$5.39	\$5.55	\$5.50

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T1502	Administration of oral, intramuscular and/or subcutaneous medication	Per visit	\$6.32	\$6.32	\$6.32	\$6.32	\$8.09	\$7.42
T1004 0571	Home Health Aide/ Certified Nursing Assistant Services	15 minutes	\$4.30	\$4.90	\$4.90	\$5.39	\$5.55	\$5.50
T1004 UN 0571	Home Health Aide/Certified Nursing Assistant Services – multiple patients (2)	15 minutes	N/A	N/A	\$2.70	\$2.97	\$3.05	\$3.03
T1004 UP 0571	Home Health Aide/Certified Nursing Assistant Services – multiple patients (3)	15 minutes	N/A	N/A	\$1.96	\$2.16	\$2.22	\$2.20
T1019 0589	Personal Support Services (PSS)	15 minutes	\$4.10	\$4.62	\$4.62	\$5.03	\$5.18	\$5.13
T1019	Personal Support Services (PSS) – (for PCA Agencies only)	15 minutes	\$4.10	\$4.62	\$4.62	\$5.03	\$5.18	\$5.13
T1019 UN	Personal Support Services (PSS) – (for PCA Agencies only) multiple patients (2)	15 minutes	N/A	N/A	\$2.54	\$2.77	\$2.85	\$2.82

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T1019 UP	Personal Support Services (PSS) – (for PCA Agencies only) multiple patients (3)	15 minutes	N/A	N/A	\$1.84	\$2.01	\$2.07	\$2.05
S5125 TF 0589	PCA Supervisit	15 minutes	\$4.81	\$5.10	\$5.10	\$21.14 Per visit	\$23.51per visit	\$21.57 per visit
S5125 TF UN 0589	PCA Supervisit – multiple patients (2)	15 minutes	N/A	N/A	\$2.81	\$11.64 per visit	\$12.93per visit	\$11.87 per visit
S5125 TF UP 0589	PCA Supervisit – multiple patients (3)	15 minutes	N/A	N/A	\$2.04	\$8.46 per visit	\$9.40per visit	\$8.63 per visit
S5125 TF	PCA Supervisit (for PCA Agencies only)	15 minutes	\$4.81	\$5.10	\$5.10	\$21.14 per visit	\$23.51per visit	\$21.57 per visit
S5125 TF UN	PCA Supervisit (for PCA Agencies only) multiple patients (2)	15 minutes	N/A	N/A	\$2.81	\$11.64 per visit	\$12.93 per visit	\$11.87 per visit
S5125 TF UP	PCA Supervisit (for PCA Agencies only) multiple patients (3)	15 minutes	N/A	N/A	\$2.04	\$8.46 per visit	\$9.40per visit	\$8.63 per visit

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S5125	Personal Support Services (FPSO)	15 minutes	\$3.71	\$3.72	\$3.72	\$3.72	\$3.73	\$3.73
S5125 UN	Personal Support Services (FPSO) multiple patients (2)	15 minutes	N/A	N/A	\$2.04	\$2.04	\$2.05	\$2.05
S5125 UP	Personal Support Services (FPSO) multiple patients (3)	15 minutes	N/A	N/A	\$1.49	\$1.49	\$1.49	\$1.49
H2014	Skills Training (FPSO only)	15 minutes	\$14.03	\$14.03	\$14.03	\$14.03	\$14.03	\$14.03
G9001	Care Coordination Service (Initial Visit)	15 minutes	\$17.00	\$17.00	\$17.00	\$17.00	\$17.00	\$17.00
G9002	Care Coordination Service (Maintenance Visit)	15 minutes	\$17.00	\$17.00	\$17.00	\$17.00	\$17.00	\$17.00
S5120	Chore Services	15 minutes	\$2.30	\$2.30	\$2.30	\$2.30	\$2.30	\$2.30