SECTION 29 SUPPORT SERVICES FOR ADULTSWITH INTELLECTUAL DISABILITIES or AUTISTIC DISORDER

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29.01 INTRODUCTION

Effective 10/4/2011

Support Services for Adults with Intellectual Disabilities or Autistic Disorder are for adults who either live with their families or live on their own. Support Services are also designed to support members in the workplace. Support Services are provided under a Federal 1915 (c) waiver that meets Federal standards. Eligible MaineCare members may only receive services under one waiver benefit at a time. MaineCare members can receive covered services as eligible and as detailed in other Sections of the MaineCare Benefits Manual.

To be eligible for this benefit, members must meet medical eligibility, financial eligibility and require the level of care in order to receive services. The planning process identifies members' needs, which must be documented in a personal plan and then authorized on a Summary of Authorized Services (SAS). If all available funded openings are full the member is placed on a waiting list as described in Section 29.03.

29.02 DEFINITIONS

Effective 10/4/2011

29.02-1 **Autistic Disorder** means the member has received a diagnosis that falls within the category of Pervasive Developmental Disorders (to include Autistic Disorder, Pervasive Developmental Disorders-not otherwise specified, Asperger's Syndrome, Rett's Disorder and Childhood Disintegrative Disorder), as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association), and manifested during the developmental period, in accordance with the definition of autism codified in 34-B MRSA § 6002 and accompanying rules.

Effective 10/4/2011

29.02-2 **Case manager** is a person who works in determining, coordinating, and arranging appropriate and available services for members and facilitating the development of the Personal Plan.

Effective 10/4/2011

29.02-3 **Correspondent** is a person designated by the DHHS Maine Developmental Services Oversight and Advisory Board to act as an ally to a person who has no actively involved family or private guardian.

29.02-4 **Designated Representative** means the DHHS staff authorized by DHHS to perform specified functions.

29.02 DEFINITIONS (Cont.)

Effective 10/4/2011

29.02-5 **Direct supports** are a range of services that contribute to the health and well being of the member and his or her ability to live in or be part of the community. Direct support services may include personal assistance or services that support personal development, or services that support personal well being. Community Support, Employment Specialist Services and Work Support are direct supports. The emphasis and purpose of the direct support provided may vary depending on the type of service.

Direct supports include the following:

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

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

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

Effective 10/4/2011

Services that support personal development include teaching or modeling for a member self-care and self-management skills, physical fitness, behavior management; sensory, motor and psychological needs; interpersonal skills to cultivate supportive personal, family, work and community relationships; resources and opportunities for participation in services to promote social and community engagement; participation in spiritual services of the member's choice;

29.02 DEFINITIONS (Cont.)

motivating the pursuit of personal development and opportunities; teaching or modeling informed choice by gathering information and practicing decision making; and learning to exercise.

Effective 10/4/2011

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

29.02-6 **Employment Setting** means a work setting that is integrated with non-disabled employees in a variety of ways. The job must be one that is available to a non disabled employee with the same expectations for the member's job performance and attendance. The member works under similar work conditions as others without disabilities in similar positions; including access to lunchrooms, restrooms, and breaks. The member performs work duties with ongoing interaction with other workers without disabilities, and has contact with customers, suppliers and the public to the same degree as workers without disabilities in the same or comparable occupations. The member cannot be excluded from participation in company-wide events such as holiday parties, outings and social activities. Staff providing Work Support or Employment Support Services at the worksite are not considered non-disabled employees in determining the level of integration. For those agencies that currently operate under an award from NISH (www.nish.org), the federal workforce guidelines associated with this funding source will apply to the services funded by the NISH contract. The member can be on the employer's payroll. Members may receive additional employment supports from a provider agency. A member must be supervised in a manner identical to other employees. It is permissible, on a case by case basis to have the support agency offer and provide this supervision as long as the above conditions are met.

Effective 10/4/2011

29.02 DEFINITIONS (Cont.)

29.02-7 **Habilitation** is a service that is provided in order to assist a member to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising the level of physical, mental and social functioning of a member. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.

Effective 10/4/2011

29.02-8 **Intellectual disability** means a mental retardation, such that the criteria for eligibility set forth in § 29.03-2(B) below applies.

29.02-9 **Member** is a person determined to be eligible for MaineCare benefits by the Office of Integrated Access and Support (OIAS) in accordance with the eligibility standards published by the OIAS in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

29.02-10 **Mental Retardation** is a condition/disability that is manifested by: 1) significant sub-average intellectual functioning as measured on a standardized intelligence test; 2) significant deficits in adaptive behavior/functioning (e.g., daily living, communication and social skills); and 3) on-set during the developmental period of life (prior to age eighteen (18)).

29.02-11 **On Behalf Of** means the provision of a service for the benefit of individual members that and is not necessarily a direct face-to-face service. On Behalf Of is a component of Community Support, Employment Specialist Services and Work Support. It is included in the established authorization and is not a separately billable service. Billing "On Behalf Of" is not necessarily a habilitative service, it may not exceed a member's Community Support, Employment Specialist Services, and Work Support authorized units. Documentation detail must clearly identify and support periods of such service.

29.02-12 **Personal Plan** is a member's plan developed at least annually that lists the services offered under the waiver benefit. The Personal Plan may also include services not covered by the waiver but identified by the member. Only services included on the Personal Plan are reimbursable. The Personal Plan may also be known as a person centered plan, a service plan, an individual support plan, or an individual education plan, as long as the requirements of Section 29.04 are met.

Effective 10/4/2011

29.02-13 **Qualified Mental Retardation Professional (QMRP)** is a person who has at least one year of experience working directly with persons with intellectual disabilities or other developmental disabilities and is one of the following: 1) a doctor of medicine or osteopathy; 2) a registered nurse; or 3) an individual who holds at least a bachelor's degree in a human services field including but not limited to: sociology, special education, rehabilitation counseling, and psychology, as specified in title 42 Code of Federal Regulations (CFR) 483.430, paragraph (B)(5), 2010.

29.02 DEFINITIONS (Cont.)

29.02-13 **Qualified Vendor** is a provider approved by DHHS to provide waiver services to eligible members receiving services under this Section. DHHS requires agencies to provide high quality services that, at a minimum, meet the expectations of the members who utilize those services. DHHS may authorize agencies to provide services under this Section after an application, along with supporting documentation, has been submitted to a Designated Representative for review and approval. The Designated Representative will authorize only agencies that meet DHHS expectations in the areas of organization and operation, operation of individual programs or services, personnel administration, environment and safety, and quality management. Only Qualified Vendors will receive DHHS referrals and authorizations for reimbursement.

29.02-14 **Summary of Authorized Services (SAS)** is a list of the medically necessary services identified through the planning process that the parties signing the Personal Plan have agreed will meet the habilitation needs of the member. The SAS shall identify the nature and timing of the services as identified in the member's Personal Plan, including the MaineCare rates for each service. A DHHS Designated Representative shall sign (electronic or original) and date the SAS as a means to authorize payment for services provided. The Personal Plan may contain service needs that the member may pursue, but which are not covered by MaineCare, and are, therefore, not reflected on the SAS for HCB services. The SAS is a component of the Personal Plan. The SAS was formerly known as the CHECKLIST.

29.03 DETERMINATION OF ELIGIBILITY

Effective 10/4/2011

Eligibility for this benefit is based on meeting all three of the following criteria; 1) the member must require ICF/MR level of care as set forth under the MaineCare Benefits Manual, Chapter II, Section 50. 2) the member must have eligibility for MaineCare are determined by the DHHS Office of Integrated Access (OIAS), and 3) a funded opening is available.

29.03-1 **Funded Opening-** The number of MaineCare members that can receive services under this Section is limited to the number, or "funded openings," approved by the Centers for Medicare and Medicaid Services (CMS) and the appropriation of sufficient funding by the Maine Legislature. Persons who would otherwise be eligible for services under this Section are not eligible to receive services if all of the funded openings are filled or if there is not sufficient funding.

29.03-2 **General Eligibility Criteria**

Consistent with Subsection 29.03-1, a person is eligible for services under this Section if the person:

29.03 DETERMINATION OF ELIGIBILITY (Cont.)

A. Is age eighteen (18) or older; and

B. Has Mental Retardation or Autistic Disorder; and

C. Meets the medical eligibility criteria for admission to an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) as set forth under the MaineCare Benefits Manual, Chapter II, Section 50; and

D. Does not receive services under any other federally approved MaineCare Home and Community Based waiver program; and

E. Meets all MaineCare eligibility requirements as set forth in the MaineCare Eligibility Manual; and

Effective 10/4/2011

F. The member must have an adult services case manager or have begun the transition to an adult services case manager; and

G. Lives with family or on their own.

29.03-3 **Establishing Medical Eligibility**

In order to determine medical eligibility, the member and case manager must provide to DHHS the following:

A. A completed copy of the assessment referral form (BMS99) and

B. A copy of the member's Personal Plan approved and signed by the member or guardian and the case manager and any other relevant material indicating the member's service needs. The Personal Plan must be less than six (6) months old at the time of the member's medical eligibility determination or redetermination. If the Personal Plan is older than six (6) months, supporting documentation must accompany the Personal Plan that discusses the current services being recommended under this section, subject to case manager approval.

Effective 10/4/2011

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

DHHS shall notify each member or the member's guardian in writing of any decision regarding the member's medical eligibility, and the availability of benefit openings under this Section. The notice will include information about the member's right to

29.03 DETERMINATION OF ELIGIBILITY (Cont.)

appeal any of these decisions. Rights for notice and appeal are further described in Chapter I of the MaineCare Benefits Manual.

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

29.03-4 **Waiting List**

Effective 10/4/2011

DHHS will maintain a waiting list of eligible MaineCare members who cannot get Section 29 Services because a funded opening is not available. Members who are on the waiting list for the benefit services shall be served chronologically based on the date the waiver manager determines eligibility for the waiver. A member will have sixty (60) days to respond to the DHHS determination that there is a funded opening for the member. If there is no response, the member will return to the end of the waiting list.

29.03-5 **Determination of Continuing Eligibility**

When making a determination of continuing eligibility, the case manager will submit an updated Assessment Referral Form (BMS 99) to DHHS twelve (12) months from the date of initial approval, and every twelve (12) months thereafter. The Summary of Authorized Services will be updated annually when the assessment referral form is submitted. If the updated Assessment Referral Form is received after the due date, reimbursement for services will resume upon receipt of the assessment form. Whenever significant changes occur that alter level of care, the case manager will submit an updated Assessment Referral Form to DHHS. The case manger must complete and submit all waiver documents including the BMS 99 and the updated Personal Plan to the Resource Coordinator thirty (30) days in advance of the annual redetermination date.

29.04 PERSONAL PLAN

If the member or guardian chooses services under this Section, the request for services must be submitted to DHHS. As part of the planning process, the member's needs are identified and documented in the Personal Plan.

29.04-1 Authorization for Reimbursable Services

Medically necessary services and units of services must be identified in the Personal Plan. Requests for services must be submitted to DHHS. Requests will be reviewed

29.04 PERSONAL PLAN (Cont.)

and negotiated by DHHS, and may be examined and evaluated by DHHS, before units of service are authorized and entered on the SAS.

29.04-2 Personal Plan Requirements

Effective 10/4/2011

The case manager will ensure that a Planning Team is convened to initiate development of the Personal Plan prior to services being initiated.
The Personal Plan must contain at a minimum:

A. All MaineCare Home and Community waiver benefit services determined medically necessary by the team including all other services that may not be covered under this section but that the member identifies and may pursue;

B. The frequency of provision of the services;

C. How services contribute to the member's health and well-being and the member's ability to reside in a community setting;

D. The member's goals for strengthening and cultivating personal, community, family, and professional relationships;

E. The role and responsibility of the Direct Support Professional, the Employment Specialist and the member's other service providers in supporting the member's goals, including goals for strengthening natural and supportive personal, family, community and professional relationships; and

Effective 10/4/2011

F. Signatures of the participants; in order for the Personal Plan to be approved, the Personal Plan must include signatures of the member, guardian, if applicable, and case manager. Participants must sign and date any updates to the Personal Plan.

The Personal Plan will be used by DHHS to develop the Summary of Authorized Services (SAS), which is a component of the Personal Plan, and which identifies the type and units of authorized services the member may receive under this Section. If more than one provider is reimbursed for the same category of direct supports, an explanation of the differences in roles and responsibilities of each provider and how services will not be duplicated is required.

29.04-3 **Planning Team Composition**

Each member or guardian will determine the composition of the Planning Team. Planning will occur in a manner that is respectful and reflective of the member's preference. The planning team may include the following members, if applicable:

A. plan facilitator;

29.04 PERSONAL PLAN (Cont.)

B. case manager;

C. The member;

D. The member's parent, guardian or Correspondent;

E. The member's advocate or friend or any additional individual invited by the member;

F. Direct Support Professional providing services to the member;

G. Staff from the member's Community Support, Work Support or Employment Specialist Services Provider; and

H. Any professionals involved or likely to be involved with the member's Personal Plan.

29.04-4 **Updating the Personal Plan**

The member's Personal Plan must be revised and updated at least annually, when there is a revision or update to the member's SAS, or when other significant changes occur relating to the member's physical, social, or psychological needs, or the member's significant progress toward his or her goals. The case manager will reconvene the Planning Team to revise and update the Personal Plan. Planning meetings shall be held both prior to and subsequent to the planned move of a member to a new residence in order to coordinate supports and services and to evaluate the member's satisfaction with the change.

29.05 COVERED SERVICES

29.05-1 **Community Support** is Direct Support provided by a Direct Support Professional in order to increase or maintain a member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on community inclusion, personal development, and support in areas of daily living skills if necessary. Community Support may be provided as a center-based program in the local community, an individual program "without walls" (i.e. non center-based) or a combination of both. Community Support is available on a daily basis for one (1) or more days per week based on the member's needs and documented in the personal plan.

Community Support is intended to be flexible, responsive and provided to members consistent with his or her personal plan. The location of the service and staffing level may vary, allowing for a mix of individualized and group services. The average staff to member ratio for Community Support for each program location must not exceed 1:3.

29.05 COVERED SERVICES (Cont.)

Effective 10/4/2011

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

"On Behalf of" is a component of Community Support; and is included in the established authorization and is not a separate billable service.

A member may not receive Community Support while enrolled in high school. A member may not receive Community Support at his or her place of employment.

The cost of transportation related to the provision of Community Support is a component of the rate paid for the service and is not separately billable.

Effective July 1, 2011, if CMS approves the maximum annual allowance for Community Support is eleven hundred twenty-five (1,125) hours (forty five hundred (4500) quarter hour units) per year. For purposes of this cap, a year is defined as from July 1 to the following June 30.

29.05-2 **Employment Specialist Services** include services necessary to support a member in maintaining Employment. Services include: (1) periodic interventions on the job site to identify a member's opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion; (2) assistance in transitioning between employers when a member's goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the member in acclimating to a new job. Employment Specialist Services are provided by an Employment Specialist who may work either independently or under the auspices of a Supported Employment agency. The need for continued Employment Services must be documented in a member's Personal Plan as necessary to maintain employment over time.

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

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

"On Behalf of" is a component of Employment Specialist Service; and is included in the established authorization and is not a separate billable service.

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

29.05 COVERED SERVICES (Cont.)

Effective 10/4/2011

Nothing in this rule prohibits a member from working under a Special Minimum Wage Certificate issued by the Department of Labor under the Fair Labor Standards Act.

29.05-3 **Work Support** is Direct Support provided by a Direct Support Professional or an Employment Specialist that is a therapeutic and supportive service provided to improve a member's ability to independently maintain productivity and employment. This service is commonly provided after a period of Employment Specialist Services to provide long term employment support and encompasses adherence to workplace policies and productivity. It may also include offer training and assistance in areas such as hygiene, self-care, dress code, and related issues. Work Support is provided in an employment setting as defined in 29.02-6 and may be provided in a member's home in preparation for work.

Effective 10/4/2011

"On Behalf of" is a component of Work Support and is included in the established authorization and is not a separate billable service.

Effective July 1, 2011, if CMS approves, the maximum annual allowance for Work Support is six hundred (600) (twenty four hundred (2400) quarter hour units) hours. For purposes of this cap, a year is defined as from July 1 to the following June 30.

Nothing in this rule prohibits a provider from operating under a fair labor standards certificate program.

A member may not receive Work Support while enrolled in high school. A member may have services authorized while still enrolled in high school; however, the start date of the service may only begin after the date of graduation or termination of enrollment.

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

29.05-4 **Home Accessibility Adaptations** are those physical adaptations to the home, required by the member's Personal Plan, that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home.

Adaptations must not be covered under state plan services, including Section 60, Medical Supplies and Durable Medical Equipment of the MaineCare Benefits Manual and must be determined medically necessary as documented by a licensed physician and approved by DHHS Office of Adults with Cognitive and Physical Disabilities. Adaptations commonly include:

- Bathroom modifications
- Widening of doorways

29.05 COVERED SERVICES (Cont.)

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

The Manager of the Support Waiver must approve items not included above that have been recommended in a Personal Plan.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). In-floor radiant heating is not allowable. General household repairs are not included in this service. All services shall be provided in accordance with applicable State or local building codes. All providers must be appropriately licensed or certified in order to perform this service. This service applies to member owned or a member's family owned home only. Provision of this service in a property owned, rented or leased by an agency is acceptable as long as the adaptation is portable and is the property of the member.

Effective 10/4/2011

29.05-5 **Transportation** service offered in order to enable members to gain access to waiver and other community services, services and resources, as specified by the Personal Plan. This is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170 (a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the member's Personal Plan. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized.

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

Relatives and legal guardians may only be reimbursed if:

- They indicate that they are unable to transport at no charge; and
- There is no other viable option; and

29.05 COVERED SERVICES (Cont.)

- There is a recommendation by the planning team.

29.05-6 **Respite Services** provided to members unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the member. Respite may be provided in the member's home, provider's home or other location as approved by a respite agency or DHHS; example, motel in case of emergency.

29.06 NON COVERED SERVICES

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

29.06-1 Services not identified by the Personal Plan;

29.06-2 Services to any MaineCare member who receives services under any other federally approved MaineCare Home and Community based waiver program;

29.06-3 Services to any member who is a nursing facility resident, or ICF/MR resident;

29.06-4 Services that are reimbursable under any other sections of the MaineCare Benefits Manual;

29.06-5 Any service otherwise reimbursable under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act, including but not limited to job development and vocational assessment or evaluations;

29.06-6 Room and board; The term "room" means shelter type expenses, including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term "board" means three meals a day; or any other full nutritional regimen. Board does not include the provision of a meal at an adult day health or similar facility outside the member's home. Board also does not include the delivery of a single meal to a member at his/her own home through a meals-on-wheels service;

29.06-7 With the exception of transportation, services covered under 29.05-5, services provided directly or indirectly by a person legally responsible for the member, including the member's spouse or a member's parents, stepparents, or guardian. A guardian who is unrelated cannot be directly or indirectly reimbursed for services;

29.06-8 Work Support or Employment Specialist Services when the member is not engaged in employment. Employment means traditional employment or telecommuting that is compensated at a competitive wage; or self employment or business ownership. A competitive wage is a wage at or above the minimum wage, but not less than the

29.06 NON COVERED SERVICES (Cont.)

customary wage and level of benefits paid by the employer for the same or similar work performed by an employee without a disability. Employment does not include work in a setting in which the member has little or no interaction with customers or other employees not having a disability, unless the member is telecommuting, self-employed, or owns his or her own business;

29.06-9 Home Accessibility Adaptations unless the service has been determined non reimbursable under Medical Supplies and Durable Equipment, Section 60 or other sections of the MaineCare Benefits Manual; and

29.06-10 A member may not have wages from employment paid for with MaineCare reimbursement.

29.06-11 Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the member's spouse, parent, sibling or other biological family member. This rule will not be avoided by adult adoption. Current guardians, who are not biological family, and who are directly or indirectly reimbursed for services, may continue to receive reimbursement for up to one year after the adoption of this rule, during which time the guardian shall plan for alternative guardian or alternative reimbursement

29.07 LIMITS

29.07-1 MaineCare members can receive services under only one Home and Community Waiver Benefit at any one time.

Effective 10/4/2011

29.07-2 Effective July 1, 2011, if CMS approves, the maximum annual allowance for Community Support is eleven hundred and twenty five (1,125) hours (forty five hundred (4500) quarter hour units) per year. For purposes of this cap, a year is defined as from July 1 to the following June 30.

29.07-3 Employment Specialist Services are provided on an intermittent basis with a maximum of ten (10) hours (forty (40) quarter hour units) each month.

29.07-4 Effective July 1, 2011, if CMS approves, the maximum annual allowance for Work Support is not to exceed six hundred (600) hours (twenty four hundred (2400) quarter hour units) per year. For purposes of this cap, a year is defined as from July 1 to the following June 30.

29.07-5 Effective July 1, 2011, if CMS approves, members who receive Community Support and Work Support have an annual limit of Twenty three thousand, seven hundred and seventy one dollars (23,771.00) which when converted to hours is eleven hundred and twenty five (1,125) (forty five hundred (4500) quarter hour units) hours in combination as described in Appendix III.

29.07 LIMITS (Cont.)

29.07-6 Home Accessibility Adaptations are limited to five thousand dollars ($5,000) in a three (3) year (thirty six (36) months) period with an additional annual allowance up to three hundred dollars ($300) for repairs and replacement per year. General household repairs are not included in this service. All items in excess of five hundred ($500) dollars require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the member's need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit can be reimbursed under this section.

Effective 10/4/2011

29.07-7 A provider may only be reimbursed for providing transportation services when the cost of transportation is not a component of a rate paid for another service.

29.07-8 Respite Services are limited to one thousand dollars ($1000.00) per year. Additionally, the quarter hour (1/4) billing for Respite shall not exceed the per diem limit of (Ninety dollars ($90.00) for each date of service. Reimbursement for Respite is a quarter (1/4) hour billing code. After thirty three (33) quarter hour units of consecutive Respite Services, the provider must bill using the per diem billing code. The quarter hour (1/4) Respite amount billed any single day cannot exceed the Respite per diem rate of Ninety ($90.00) dollars.

Effective 10/4/2011

29.07-9 Services reimbursed under this section are not available to members who reside in an ICF/MR, nursing facility or are inpatients of a hospital.

29.07-10 A member may not receive services that are comparable or duplicative under another Section of the MaineCare Benefits Manual at the same time as services provided under this waiver benefit. Such comparable or duplicative services include, but are not limited to services covered under the MaineCare Benefits Manual, Section 2, Adult Family Care Services; Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities; Section 21, Home and Community Benefits for Person with Intellectual Disabilities or Autistic Disorder; Section 22, Home and Community Benefits for the Physically Disabled; Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations; Section 45, Hospital Services; Section 46, Psychiatric Facility Services; Section 50, ICF/MR Services; Section 67, Nursing Facility Services and Section 97, Private Non-Medical Institution Services.

Effective 10/4/2011

29.07-11 A member may not receive Community Support while enrolled in high school. A member may not receive Community Support at his or her place of employment.

29.07-12 A member may not receive Employment Specialist Services while enrolled in high school.

29.07 LIMITS (Cont.)

29.07-13 A member may not receive Work Support while enrolled in high school. A member may have services authorized while still enrolled in high school; however, the start date of the service may only begin after the date of graduation or termination of enrollment.

Effective 10/4/2011

29.07-14 Work Support Services are limited to one Direct Support Professional per member at a time.

29.07-15 The total amount of Services authorized may not exceed 50% of the cost of an ICF/MR.

29.07-16 If a current waiver recipient enters a nursing facility or a hospital, payment under the waiver will be temporarily suspended. If the waiver recipient remains in the nursing facility or hospital for more than thirty (30) consecutive days, enrollment in this waiver will be terminated unless there is a written request to the Department to continue holding the funded opening.

29.08 DURATION OF CARE

Each member receiving services under this Section is eligible for as many covered services as are authorized by DHHS in the member's personal plan. Services are authorized to meet the needs identified in the member's most recent assessment, subject to limits on covered service components specified elsewhere in this Section.

29.08-1 Voluntary Termination- A member who currently receives the benefit, but no longer wants to receive the benefit, will be terminated, after DHHS receives written notice from the member that he or she no longer wants the benefit.

29.08-2 Involuntary Termination-DHHS will give written notice of termination to a member at least ten (10) days prior to the effective date of the termination, providing the reason for the termination, and the member's right to appeal such decision. A member may be terminated from this benefit for any of the reasons listed below:

A. The member has been determined to be financially or medically ineligible for this benefit;

B. The member has been determined to be a nursing facility resident or ICF/MR resident without an approved Personal Plan to return to his or her home;

C. The member has been determined to be receiving MaineCare services from another Home and Community Based Waiver benefit;

D. The member is no longer a resident of the State of Maine;

29.08 DURATION OF CARE (Cont.)

E. The health and welfare of the member can no longer be assured because:

1. The member or immediate family, guardian or caregiver refuses to abide by the Personal Plan or other benefit policies;

2. The home or home environment of the member becomes unsafe to the extent that benefit services cannot be provided without risk of harm or injury to the member or to individuals providing covered services to the member; or

3. There is no approved Personal Plan.

29.08-3 Provider termination from the MaineCare program- The provider must provide the member and DHHS thirty (30) days written notice prior to the effective date of termination.

Effective 10/4/2011

29.08-4 After a member is determined eligible for this waiver, if there is any one (1) month period during which the member does not receive a waiver service, the case manager must include a note in the record indicating;

A. The reason a waiver service was not provided,

B. Whether the member continues to need services provided in the waiver.

29.09 MEMBER RECORDS

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

In addition, the member's records must contain:

A. The member's name, address, birth date, and MaineCare identification number;

B. The member's social and medical history, and diagnoses;

C. The member's Personal Plan.

D. The Summary of Authorized Services; and

E. Written progress notes that identify any progress toward the achievement of the goals, services and needs established by the member's Personal Plan signed by the staff performing the service.

29.09 MEMBER RECORDS (Cont.)

Effective 10/4/2011

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

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

29.10 PROVIDER QUALIFICATIONS

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

Effective 10/4/2011

29.10-1 **Direct Support Professional (DSP)** is a person who provides Community Support or Work Support and has successfully completed the Direct Support Professional curriculum as adopted by DHHS**,** or DHHS's approved Assessment of Prior Learning, prior to July 1, 2011 or has successfully completed the Maine College of Direct Support. The Maine College of Direct Support is accessed on the internet at: http://www.maine.gov/dhhs/OACPDS/DS/cds/index.shtml All DSP staff must:

A. Have a background check consistent with Section 29.10-4;

B. Have an adult protective and child protective record check;

C. Be at least eighteen (18) years of age; and

Effective 10/4/2011

D. Have graduated from high school or acquired a GED.

A DSP who provides Work Support services must successfully complete the work support lesson in the College of Direct Support in addition to the generally required lessons.

All new staff or subcontractors must complete the Maine College of Direct Support within six (6) months (one thousand forty hours (1,040)) of actual employment from date of hire, or two (2) consecutive years, from the date of first hire, whichever is sooner. Evidence of date of hire and enrollment in the training must be documented in writing in the employee's personnel file or a file for the subcontractor. Services provided during this time are reimbursable as long as the documentation exists in the personnel file.

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

29.10 PROVIDER QUALIFICATIONS (Cont.)

A DSP is legally authorized to assist with the administration of medication if the DSP is certified as a Certified Nursing Assistant-Medications (CNA-M); as a Certified Residential Medication Aide (CRMA); or otherwise has been trained to administer medications through a training program authorized, certified, or approved by DHHS.

29.10-2 **Employment Specialist** is a person who provides Employment Specialist Services or Work Support and has:

Effective 10/4/2011

A. Successfully completed the Maine Employment Curriculum for Employment Specialist Certification as approved by DHHS. (approved courses are listed at: http://www.employmentforme.org/providers/crp-training.html) Certification must occur within six (6) months of hire;

B. Supervision during the first six months of hire from a Certified Employment Specialist in order to provide services;

C. Graduated from high school or acquired a GED; Persons with out a high school diploma or a GED and currently providing the services as of the effective date of this rule shall have three (3) years to obtain the minimum educational requirements.

D. Satisfied a background check consistent with Section 29.10-4; and

E. Worked for a minimum of one (1) year with a person or persons having a disability in a work setting.

29.10-3 **Emergency Intervention-** All providers must follow DHHS's rule governing emergency intervention and behavioral treatment for persons with Intellectual Disabilities (14-197 CMR Chapter 5, 2007), and must meet training requirements on approved behavioral interventions procedures (e.g.,Mandt) if applicable and indicated as a need in the member's Personal Plan.

29.10-4 **Background Check Criteria**-The provider must conduct background checks on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide services under this Section. Background checks on persons professionally licensed by the State of Maine will include a confirmation that the licensee is in good standing with the appropriate licensing board or entity. The provider shall not hire or retain in any capacity any person who may directly provide services to a member under this Section if that person has a record of:

A. any criminal conviction that involves abuse, neglect or exploitation;

29.10 PROVIDER QUALIFICATIONS (Cont.)

B. any criminal conviction in connection to intentional or knowing conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person;

C. any criminal conviction resulting from a sexual act, contact, touching or solicitation in connection to any victim; or

D. any other criminal conviction, classified as Class A, B or C or the equivalent of any of these, or any reckless conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person within the preceding two (2) years; or

Effective 10/4/2011

E. any criminal conviction within Title 29-A, chapter 23, subchapter 2, article 1, or Title 29-A, chapter 23, subchapter 5.

Employment of individuals with records of such convictions more than five (5) years ago is a matter within the provider's discretion after consideration of the individual's criminal record in relation to the nature of the position. The provider shall contact child and adult protective services (including the Office of Adults with Cognitive and Physical Disability Services) units within State government to obtain any record of substantiated allegations of abuse, neglect or exploitation against an employment applicant before hiring the same. In the case of a child or adult protective services investigation substantiating abuse, neglect or exploitation by a prospective employee of the provider, it is the provider's responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with licensing standards. Providers are not required to obtain records from child protective services for employees who do not provide services to children.

29.11 APPEALS

Effective 10/4/2011

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

Office of Adults with Cognitive and Physical Disability Services
Department of Health and Human Services
11 State House Station
2nd Floor, Marquardt Building
Augusta, ME 04333-0011

29.12 REIMBURSEMENT

Effective 10/4/2011

Reimbursement methodology for covered services shall be the amount listed in Chapter III, Section 29, Allowances for Support Services for Adults with Intellectual Disabilities or Autistic Disorder or the provider's usual and customary charge, whichever is lower.

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

29.13 BILLING INSTRUCTIONS

Providers must bill in accordance with DHHS billing instructions.

29.14 APPENDIX I-Guidelines for Approval of Medical Add-On in Maine Rate Setting

The purpose of this Appendix is to detail guidelines for Office of Adults with Cognitive and Physical Disabilities personnel in approving a Medical Add-On to the established published rate. All current statutes, regulations, decree provisions, policies, and licensing standards regarding medical services are unaffected by these guidelines. This Appendix develops criteria that warrant an adjustment to the Department's established published rate for Community Support, Employment Specialist Services and Work Support Services.

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

A. Physician Order

1. There must be a written physician's order for the member. This order must specify:

a. The specific illness or condition to be addressed;

b. The specific procedure(s) that will be utilized;

c. The time span over which the treatment or intervention is expected to be needed. If the treatment or intervention is expected to be needed for an indefinite period of time then this expectation should be specified;

d. The anticipated frequency of treatment or intervention on a daily, weekly, or monthly basis;

e. Where applicable and possible:

1. The approximate length of time required for each episode of the treatment or intervention and
2. The degree of licensure or certification required for those who carry out the treatment, and those who provide training and oversight relative to its application.

B. Planning Team

1. The team must meet or otherwise confer for the following purposes:

a. To determine whether the setting where the member is served is appropriate to carry out the physician's recommended treatment or intervention;

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

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

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

C. Provider Requirements

1. The provider must be an enrolled MaineCare provider.

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

D. Approval Process

1. The DHHS will issue a written decision for the Medical Add-On, within twenty (20) working days of receipt of all required documentation. If additional information is required, a written request will be issued. Upon receipt of the additional information DHHS will approve or deny the request within five (5) working days.

2. Documents will be reviewed by a designated representative.

3. Approvals will include a specification of the authorized daily or weekly units of service which require the Medical Add-On. Approval may be retroactive to the date of application of the Add On based on documentation.

4. Treatments or interventions that are anticipated to be needed for an extended or indefinite period of time must be reviewed at minimum, annually by the team. Verification of this continued need must be provided to the DHHS within a year of the original approval, in order for the Medical Add-On to continue.

29.15 APPENDIX II- "On Behalf Of" Covered Services

"On Behalf Of" Covered Services:

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

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

Services and time that are directly related to a member that are associated with that member's personal plan, medical plan or behavioral plan including in-service training specific to a member's personal plan, consultations with supervisors, therapist, clinicians and or medical staff; services relating to a member's parent, guardian or CAB representative; documentation, reports and presentations to review committees.

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

Services and time that are directly related to a member's safety such as "shadowing" a member as he or she learns to take a bus.

"On Behalf Of" Non-Covered Services:

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

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

Services and time that are related to staff training, unless the training is specific and exclusive to the member.

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

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

29.15 APPENDIX II- "On Behalf Of" Covered Services (Cont.)

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

Services and time provided by a salaried staff member unless there is evidence that the salaried staff was working as a Direct Support Professional for the time being claimed.

29.16 APPENDIX III

Limit for members who use a combination of Work Support and Community Support

When a member's personal plan includes recommendations for both Community Support and Work Support, use one of the charts below to determine the annual maximum number of hours for Community Support and Work Support Services.

- **Chart 1** is for members who want to first establish a number of Community Support hours in Column A and then determine the maximum number of Work Support hours in Column B they may use.

- **Chart 2** is for members who want to first establish a number of Work Support hours in Column C and then determine the maximum number of Community Support hours in Column D they may use.

Chart 1

A	B
Annual Community Support Hours	Annual Work Support Hours
0	600
25	600
50	600
75	600
100	600
125	600
150	600
175	600
200	600
225	600
250	600
275	600
300	600
325	600
350	593
375	573

Chart 2

C	D
Annual Work Support Hours	Annual Community Support Hours
0	1125
25	1093
50	1060
75	1027
100	995
125	962
150	929
175	896
200	864
225	831
250	798
275	766
300	733
325	700
350	667
375	635

29.16 APPENDIX III-Limit for members who use a combination of Work Support and Community Support (cont.)

Chart 1 continued	
A	B
Annual Community Support Hours	Annual Work Support Hours
475	497
500	478
525	459
550	440
575	421
600	402
625	382
650	363
675	344
700	325
725	306
750	287
775	268
800	249
825	230
850	211
875	191
900	172
925	153
950	134
975	115
1,000	96
1,025	77
1,050	58
1,075	39
1,100	20
1,125	0

Chart 2 continued	
C	D
Annual Work Support Hours	Annual Community Support Hours
475	504
500	471
525	438
550	406
575	373
600	340