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SECTION 32 Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders ESTABLISHED: 7/1/11
EFFECTIVE: 11/1/11

32.01 INTRODUCTION

Effective 11/1/11

MaineCare members who are at least five (5) years of age and under seventeen (17) years and who have Intellectual Disabilities or Pervasive Developmental Disorder are eligible for this Home and Community Waiver Benefit. Once admitted into the program, a member may remain in it until his or her 21st birthday, assuming that the member continues to meet other conditions of eligibility.

The intent of this service is to provide members the opportunity to remain in their own homes or in other homes in the community, avoiding or delaying institutional care. Home and Community Waiver benefits supplement, but do not replace, the natural support of family and community relationships. These benefits complement, but do not duplicate, the services that are available to members through other sections of the MaineCare Benefits Manual. MaineCare members can receive Home and Community Waiver benefits under only one Home and Community waiver at a time.

The Home and Community Waiver Benefit is offered in a community-based setting as an alternative for members who qualify for the level of care provided in an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) or a Psychiatric Hospital.

To be eligible for this Home and Community Waiver Benefit, members must meet medical eligibility requirements and a funded opening must exist. If the number of eligible members exceeds the number of funded openings, members will be placed on a waiting list in priorities established in accordance with § 32.03-6 of these regulations.

32.02 DEFINITIONS

32.02-1 **Agency Home Support** means a facility that routinely employs direct care staff to provide direct support services in an agency operated facility.

32.02-2 **Comprehensive Assessment** is a thorough evaluation intended to identify strengths and needs of the member and family. The Comprehensive Assessment provides the basis of the Waiver Service Plan. The comprehensive assessment process determines the intensity and frequency of medically necessary services and includes use of tests as may be approved or required by DHHS.

32.02-3 **Children's Behavioral Health Services (CBHS)** is a division within the Office of Child and Family Services of the Department of Health and Human Services. CBHS is responsible for authorizing services and approving service providers.

Effective 11/1/11

32.02-4 **Crisis/Safety Plan** is a plan that addresses the safety of the member and others surrounding a member experiencing a crisis.

32.02 DEFINITIONS (Cont)

32.02-5 Department of Health and Human Services (DHHS) is the state agency that manages the Office of MaineCare Services (OMS), and the Office of Child and Family Services (OCFS).

32.02-6 Discharge Plan is a document that describes the circumstances of completion of the member's treatment. The plan must identify discharge criteria and any after care or support services the member requires. The discharge plan must be reviewed annually, at a minimum or more frequently as necessary, as part of the required review of the Waiver Service Plan.

32.02-7 Discharge/Closing Summary is a document that describes treatment and other support services that the member received from admission through discharge from treatment under this program.

32.02-8 Family, unless otherwise defined in this Section, means the primary caregiver(s) in a member's daily life, and may include a biological or adoptive parent, foster parent, legal guardian or designee, sibling, stepparent, stepbrother or stepsister, brother-in-law, sister-in-law, grandparent, spouse of grandparent of grandchild, a person who provides kinship care, or any person sharing a common residence as part of a single family unit.

32.02-9 Family Home Support means services provided to the member in the family environment with the family and the member sharing a home that is not owned by a provider agency.

32.02-10 Member is a person who is eligible for MaineCare.

32.02-11 Natural Supports include the relatives, friends, neighbors, and community resources that a family goes to for support. They may participate in the treatment team, but their services will not be paid for by MaineCare.

32.02-12 Office of Child and Family Services (OCFS) is the DHHS service office responsible for administration and oversight of this Home and Community Waiver benefit.

32.02-13 Parent or Guardian is the biological or adoptive parent, or the legal guardian of the member. He or she must be a participant in the Support Team, but MaineCare will not pay the parent or guardian for participation. The member's parent or guardian must sign the Waiver Service Plan.

32.02-14 Prior Authorization is the formal process of approval by the Department of waiver services before they are delivered.

32.02 DEFINITIONS (Cont)

32.02-15 Support Team is the group of people responsible for developing and reviewing a member's Waiver Service Plan. The team may include the member, to the extent possible, and, may also include the member's family, case manager, any other professionals, and those who provide natural supports**.**

32.02-16 Utilization Review is a formal assessment of the medical necessity, efficacy and appropriateness of services in the Waiver Service Plan on a prospective, concurrent or retrospective basis.

32.02-17 Waiver Service Plan **is the plan of care developed by the Support Team. The Waiver Service Plan is based on a comprehensive assessment of the member.**

The Waiver Service Plan includes measurable goals and objectives, timelines and Crisis/Safety and Discharge Plans, where appropriate.

32.03 DETERMINATION OF ELIGIBILITY

Effective 11/1/11

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

32.03-1 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). 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.

If the member is found to be medically eligible, DHHS must send the member or guardian written notice that the member has the choice of receiving institutional care or services under this Section. In order to receive services under this section, the member or guardian must submit to DHHS a signed choice letter documenting the member's choice to receive services under this section.

32.03-2 Reserved Capacity

The Department reserves a portion of the funded openings of the waiver for specified purposes subject to CMS review and approval in order to address the needs of members with health and safety concerns.
Eligible members who will be considered for reserved capacity are defined as children who need a high level of supervision including frequent restraint or

32.03 DETERMINATION OF ELIGIBILITY (Cont)

seclusion and require or would require one to one (1:1) or more staff on a prolonged basis within a restrictive setting such as a psychiatric hospital or residential setting.

The number of reserved capacity funded openings associated with 32.03-2 is an average based on Department data from recent years.

32.03-3 General Eligibility Criteria

Effective 11/1/11

To be eligible for these services, members must be at least five (5) years of age and under seventeen (17) years and meet the criteria in section 32.03-4 and all of the following criteria:

A. Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual (MEM).

B. All Home and Community Waiver benefit services provided must be reviewed and be authorized at least annually by the Department.

C. All services must be necessary and identified in the Waiver Service Plan.

D. Once admitted to the Home and Community Waiver benefit, a member may continue to receive waiver services until the member turns twenty-one (21), assuming that the member continues to meet all other criteria for eligibility.

32.03-4 Specific Eligibility Criteria for Services

To be eligible for these services members must meet the criteria in section 32.03-3 and must have:

A. **Intellectual Disabilities:**
An Axis II diagnosis of Mental Retardation as described in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM)

OR

B. **Pervasive Developmental Disorders (PDD):**
An Axis I diagnosis of Pervasive Developmental Disorders (PDD) known as Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS), Rett's Disorder, and or Childhood Disintegrative Disorder as described in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM).

AND

32.03 DETERMINATION OF ELIGIBILITY (Cont)

A documented assessment of functional impairment measured as two (2) standard deviations below the mean on the composite score of the Vineland Adaptive Behavior Scale or the Adaptive Behavioral Assessment Scales (ABAS).Other comparable functional assessment tools that are proven to be reliable and valid, and that are approved by the Department may also be used.

32.03-5 Priority

When a member is found to be eligible under Sections 32.03-3 and 32.03-4 for these services, the priority for a funded opening shall be established in accordance with the following:

A. Priority 1: One or more of the following, as documented in the member's medical record :

Frequent and severe aggression to self and/or others across multiple environments or severe enough within one environment to have caused serious injury; or

Frequent daily need of restraint, behavioral interventions and high level of supervision to maintain safety; or

A history of or at risk of repeated (more than two (2) in twelve (12) months) and prolonged (over one hundred and twenty (120) days) hospitalization or residential stays; or

At present in an institution due to severe behavioral needs or medical need, or both.

B. Priority 2: One or more of the following, as documented in the member's medical record:

Frequent and severe aggression causing or having the potential to cause injury to self or others or property destruction;

Medical and/or behavioral needs are so severe that level of available home and community supports is not sufficient;

Routine daily need of restraint, behavioral interventions, or high level of supervision, to maintain safety;

32.03 DETERMINATION OF ELIGIBILITY (Cont)

Symptoms of Mental Retardation or Pervasive Developmental Disorder so severe that they result in an inability to care for oneself at a developmentally appropriate level even with home and community supports and services;

Has not responded to lower level of care or would have a significant risk of harm to self or others if a lower level of care were attempted.

32.03-6 Wait List

DHHS will maintain a wait list of eligible MaineCare members who cannot get Home and Community Benefits because a funded opening is not available. Members who are on the wait list for the benefit services shall be served in accordance with the priorities identified above.

32.03-7 Choosing Whom to Serve Within the Same Priority

If the number of openings is insufficient to serve all members on the waiting list who have been determined eligible, at the time that any opening is determined to be available, to be within the same priority group, DHHS shall first determine whether each member continues to meet the financial and medical eligibility criteria to be served through this benefit. For those who continue to meet such criteria, DHHS will request updated documentation and will redetermine current services and DHHS shall determine which members to serve. The determination will be based on a comparison of the members' known needs, the availability of capable service providers who can adequately meet those needs, and the comparative degree of risk of harm that each member will likely experience in the absence of the provision of the benefit.

32.03-8 Redetermination of Eligibility

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The family must submit a Redetermination of Eligibility Referral form and accompanying documentation to DHHS twelve (12) months from the date of initial approval, and every twelve (12) months thereafter. Late submission of a Redetermination of Eligibility form may result in termination or delays of reimbursement to the provider for services or termination of services. If the updated Redetermination of Eligibility form is received after the due date, reimbursement for services will resume upon receipt of the form. Whenever significant changes occur that alters eligibility, the family must submit an updated Redetermination of Eligibility form to DHHS within ten (10) days of the change.

32.04 COVERED SERVICES

A covered service is a medically necessary service provided to a member for which payment may be made under the MaineCare Program, and through contract with DHHS. The following services are covered under this program when provided to an eligible member by approved staff.

Covered Services in this section are:

32.04-1 **Home Support Services** are medically necessary support services designed to improve or preserve functional abilities that have been negatively affected by the member's intellectual disabilities or pervasive developmental disorders. These services are focused on behavior modification and management, social development, and acquisition and retention of developmentally appropriate skills.

Home Support is direct support to a member and is primarily habilitative training and/or personal assistance to support developmental stability or growth, and to promote personal well-being. This habilitative service focuses on community inclusion, personal development, and support in areas of daily living skills. Home Support is intended to be flexible, responsive and provided to members consistent with his or her Waiver Service Plan. Comprehensive Assessment and Waiver Service Plan development are components of Home Support. Home Support Services are provided in the member's home or an agency owned home.

Home Support activities include the following:

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

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

Effective 11/1/11

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

32.04 COVERED SERVICES (Cont)

the permission of a member's representative payee. Self-management also includes teaching coping skills, giving emotional support, and guidance to other resources the member may need to access.

Activities that support personal development include teaching or modeling for a member self-care and self-management skills, physical fitness, behavior management; sensory, motor and psychological needs; interpersonal skills to cultivate supportive personal, family, work and community relationships; resources and opportunities for participation in activities to promote social and community engagement; participation in spiritual activities of the member's choice; motivating the pursuit of personal development and opportunities; teaching or modeling informed choice by gathering information and practicing decision making; and learning to exercise.

Activities that support personal well-being include directly or indirectly intervening to promote the health and well-being of the member. This may include identifying risks such as risk of abuse, 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. It may also be necessary to seek emergency medical or safety assistance when needed and comply with incident reporting requirements.

32.04-2 **Respite Services** are services furnished on a short-term basis due to the absence of or need for relief of those persons who normally provide care. Respite services are provided to members unable to care for themselves. Respite care can be given in the member's home, respite provider's home or other location as approved by DHHS. The setting must be identified on the Waiver Service Plan and approved by the parent or guardian. This service is available to members residing in their own homes or family member's homes, but not to members residing in homes owned or operated by an agency or provider.

32.04-3 **Home Accessibility Adaptations** are all physical alterations to a member's home or the member's family home that are necessary to ensure the health, welfare and safety of the member. The need for Home Accessibility Adaptations must be documented in the member's Waiver Service Plan. Home Accessibility Adaptations allow the member to function with greater independence in the home, and without them the member would require more restrictive environment or institutionalization.

Reimbursement for Home Accessibility Adaptations under this section is available only for home accessibility adaptations that are not covered under other sections of the MaineCare Benefits Manual. Reimbursement is available only for adaptations that are medically necessary as documented by a licensed physician or other

32.04 COVERED SERVICES (Cont)

appropriate professional such as an Occupational Therapist, Physical Therapist or Speech Therapist and approved by DHHS.

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Only items in excess of five hundred dollars ($500) require documentation from a physician or other appropriate professional that the purchase is appropriate and medically necessary to meet the member's need.

Adaptations commonly include:

Bathroom modifications;
Widening of doorways;
Light, motion, voice and electronically activated devices;
Fire safety adaptations;
Air filtration devices;
Ramps and grab-bars;
Lifts (can include barrier-free track lifts);
Specialized electric and plumbing systems for medical equipment and supplies;
Non-breakable windows, e.g. Lexan, for health & safety purposes;
Specialized flooring (to improve mobility and sanitation).

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MaineCare will not pay for those adaptations or improvements to the home that are of general utility, and that are not of direct medical or remedial benefit to the member. Adaptations that add to the total square footage of the home are also excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). In-floor radiant heating will not be paid for under this program. General household repairs are not included in this benefit.

All adaptations must comply with applicable local, State or Federal building codes.

MaineCare will pay for home accessibility adaptations only to a home owned by the member or member's family; payment is not available for adaptations to homes owned or operated by a provider or agency. Home Accessibility Adaptation benefits are subject to the limitations in § 32.06.

32.04-4 Consultation Services are services provided to persons responsible for developing or carrying out a member's Waiver Service Plan. Consultation Services are advisory in nature and are provided by licensed or certified professionals in their areas of expertise. Brief, goal oriented consultation services are used to assist parents, service providers, and the Support Team to provide for the needs of the member.

Consultation Services include:

32.04 COVERED SERVICES (Cont)

A. Professional evaluations and assessments of the member's present and potential level of psychological, physical, speech, occupational, recreational and social functioning, direct interviews with the member and others involved in the Waiver Service Plan; review and analysis of previous reports and evaluations; review of current treatment modalities and the particular applications to the individual member; advice to the support team.

B. Technical assistance to individuals primarily responsible for carrying out the member's Waiver Service Plan in the member's home, or in other community sites as appropriate.

C. Assisting in the design and integration of individual development objectives as part of the overall Waiver Service Planning process, and training persons providing direct service in carrying out special habilitative strategies identified in the member's Waiver Service Plan.

D. Monitoring progress of a member in accordance with his or her Waiver Service Plan and assisting individuals primarily responsible for carrying out the member 's Waiver Service Plan in the member 's home or in other community sites as appropriate, to make necessary adjustments.

E. Providing information and assistance to the member and Support Team.

MaineCare will pay for consultation services only in the following specialties: Occupational Therapy, Physical Therapy, Speech Therapy, Recreational Therapy, Psychiatry, Behavioral Services and Psychological services.

32.04-5 Communication Aids are devices or services necessary to assist a member with hearing, speech or vision impairments to effectively communicate with service providers, family, friends, and other community members. MaineCare will also pay the cost of repairing and maintaining these Communication Aids.

Communication Aids include:

A. Communicators (including repair and maintenance) such as direct selection, alphanumeric, scanning and encoding communicators; and

B. Speech amplifiers, aids and assistive devices if not otherwise covered for reimbursement under other sections of the MaineCare Benefits Manual.

32.04-6 Transportation is offered in order to enable members to gain access to waiver and other community services, activities and resources, as specified by the Waiver Service Plan. Transportation services covered under this section are in addition to

32.04 COVERED SERVICES (Cont)

Effective 11/1/11

medical transportation available to members under Section 113 of the MaineCare Benefits Manual, and do not replace them. Transportation services under the waiver are provided in accordance with the member's Waiver Service Plan.

Whenever possible, family, neighbors, friends, or community agencies, who can provide this service without charge, must be utilized.

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

32.05 POLICIES AND PROCEDURES

32.05-1 Comprehensive Assessment

A. A supervisor or staff with qualifications comparable to a supervisor (as set forth in 32.05(4)) must complete a comprehensive assessment within thirty (30) days of the member's referral to the provider agency. A report of the Comprehensive Assessment must be included in the member's record. The comprehensive assessment must include a direct encounter with the member, if appropriate, and with the parents or guardians. The comprehensive assessment must be updated annually, or more frequently, as needed.

B. The comprehensive assessment must be in writing and contain the following:

1. The member's identifying information, including the reason for referral,

2. Medical information, including medications, dental and vision,

3. Developmental history, educational history, vocational history, (if appropriate), and current status,

4. History and current status of other services,

5. The current status, including the member's strengths and needs, in the following areas:

a. Functional life skills including activities of daily living and, if 14 or older, independent living skills,

32.05 POLICIES AND PROCEDURES (Cont)

b. Behavioral functioning,

c. Social functioning,

d. Family information that may impact treatment, including stressors,

e. Child care information,

f. Natural supports and community resources,

g. Other significant information that may affect treatment including, but not limited to, member or family history of mental health or developmental issues,

h. Involvement with substance abuse, and

i. History of involvement with trauma, such as physical or sexual violence or personal loss.

C. The assessment must be summarized, signed, credentialed and dated by the person performing the assessment, the parent or guardian and the member, if appropriate. The assessment must include the source and date of the diagnosis from the 5 axes of the current version of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).

D. If any of the information required above is not included in the assessment, the assessment must state what is missing and the reason the information cannot be obtained.

32.05-2 Waiver Service Plan

If the member or guardian chooses services under this Section, the request for services must be submitted to DHHS in the form of a Waiver Service Plan. As part of the planning process, the member's needs are identified and documented in the Waiver Service Plan. Except for out-of-home agency services, other services shall be provided to the member no later than ninety (90) days following the completed Waiver Service Plan. For out-of-home agency services, such services shall be provided no later than six (6) months from the date of the completed Waiver Service Plan. The time periods set forth in this section are subject to the funded opening and waiting list provisions in this Section.

32.05 POLICIES AND PROCEDURES (Cont)

Effective 11/1/11

Medically necessary services and units of services must be identified in the Waiver Service Plan and receive Prior Authorization by DHHS. If there is a need for an increase in the amount of Covered Services, the member or guardian must submit a revised Waiver Service Plan including information justifying the need for the increase which must be authorized by DHHS.

A. The Support Team must develop a Waiver Service Plan within thirty (30) days of referral. The Waiver Service Plan is based on the comprehensive assessment and must be appropriate to the developmental level of the member.

B. The Waiver Service Plan must contain the following:

1. The member's diagnosis (es) and reason for receiving the waiver service.

2. Measurable long-term goals with target dates for achieving the goals and objectives that allow for measurement of progress.

3. Measurable short-term goals with target dates for achieving the goals and objectives that allow for measurement of progress.

4. Specific support services to be provided with methods, frequency and duration of services and designation of who will provide each service.

5. Discharge plan.

6. Crisis/Safety Plan.

The plan must:

a. Identify the precursors or circumstances of behaviors preceding a potential crisis;

b. Identify the strategies and techniques that may be utilized to stabilize the situation;

c. Identify the individuals responsible for the implementation of the Crisis/Safety Plan including any individuals whom the member (or parents or guardian, as appropriate) identifies as significant to the member's stability and well-being.

32.05 POLICIES AND PROCEDURES (Cont)

Effective 11/1/11

7. Discharge Plan

The plan must be in writing and must:

a. Identify discharge criteria that are related to goals and objectives described in the Waiver Service Plan;

b. Identify the individuals responsible for implementing the Discharge Plan; and

c. Be reviewed annually, or more frequently, as necessary, as part of the required review of the Waiver Service Plan.

8. Special accommodations needed to address barriers to provide the service.

C. Signature and Review

1. The parent or guardian and the member, if applicable, and the supervisor must sign, date and credential the Waiver Service Plan.

2. The Waiver Service Plan must be reviewed every 90 days or whenever a significant change occurs in the member's needs.

3. The initial 90-day period commences when the service plan is signed.

4. If indicated, the member's needs may be reassessed and the Waiver Service Plan may be reviewed and amended more frequently than every ninety (90) days.

5. Changes and reviews to the Waiver Service Plan are considered to be in effect as of the date they are signed by the parent or guardian, the member, if applicable and the supervisor.

6. The provider will supply the member, or parent or guardian, as appropriate, with a copy of the initial and reviewed Waiver Service Plan within seven (7) days of signing the Waiver Service Plan.

32.05 POLICIES AND PROCEDURES (Cont)

D. Progress Notes

1. Providers must maintain written daily progress notes for all waiver services, in chronological order.

2. All entries must describe the Waiver Service provided and include the signature and credentials of the person providing the service, the date on which the service was provided, the duration of the service and the progress the member is making toward attaining the goals or outcomes identified in the Waiver Service Plan.

3. For in-home services, the provider must ask the member, or an adult responsible for the member, to sign a document noting the date, time of arrival, and time of departure of the provider. The documentation must be kept in the member's file.

E. Discharge/Closing Summary:

The Summary must:

1. Document the reason for discharge;

2. Include a summary of the member's progress, or lack thereof, in reaching the goals set forth in the Waiver Service Plan and any after care or support services recommended at the time of discharge;

3. Be completed within fifteen (15) days of discharge, and be placed in the member's record.

32.05-3 Provider Agency Requirements

All providers of services under this Section must be enrolled and approved as MaineCare providers by MaineCare Services (OMS). In addition to meeting the general requirements for MaineCare enrolled providers, providers of services under this program must be approved by CBHS and must meet all applicable provider requirements of this Section. Providers are also subject to all requirements of MaineCare Benefits Manual (MBM), Chapter I, General Administrative Policies and Procedures.

A. Requirements for Children's Home and Community Waiver Provider Contract

32.05 POLICIES AND PROCEDURES (Cont)

All providers must have a current contract for purchase of services and a MaineCare Provider/Supplier agreement with DHHS. The content of this contract must stipulate that the provider will comply with Rider A specifications including: 1) reporting requirements; 2) service specifications and performance guidelines; and 3) process objectives or expected outcomes.

B. Prior Authorization is required for all services furnished under this program.

C. Utilization Review will be conducted by DHHS at least annually.

D. Agency Home Support must at a minimum have at least one staff provider of Home Support Services physically present for all hours in which a member is present or may be present and must otherwise be available at all times.

32.05-4 Requirements for Providers of Services for Children's Home and Community Waiver

1. Certification as Behavioral Health Professional

Effective 11/1/11

Provider agencies must assure that all non- licensed direct service providers under this Section are certified or provisionally certified as a Behavioral Health Professional. Provider agencies must maintain documentation of certification in personnel files.

MaineCare will not reimburse providers for services performed by staff without appropriate certification. DHHS may recoup reimbursement from providers not appropriately certified.

To be certified as a Behavioral Health Professional (BHP), the employee must meet the following minimum requirements:

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

b. Have a high school diploma or equivalent;

c. Have successfully completed the Behavioral Health Professional training;

d. Have current certification in first aid and CPR, and a blood borne pathogens training.

2. Provisional Approval as a Behavioral Health Professional

32.05 POLICIES AND PROCEDURES (Cont)

Non-licensed staff who provide direct service must begin the Behavioral Health Professional training within thirty (30) days of hire and obtain provisional certification. The provisional candidate must complete the training and obtain full certification within one (1) year from the date of hire.

Providers may employ on a provisional basis Behavioral Health Professionals who meet all of the requirements, but have not yet obtained DHHS certification.

3. Supervision of a Behavioral Health Professional

Provider agencies must identify supervisors meeting the professional qualifications in the next section for each direct care position. On-site supervision for each Behavioral Health Professional must occur at least quarterly. Behavioral Health Professionals employed full time must be supervised a minimum of four (4) hours per month. Behavioral Health Professionals employed part time must receive a prorated amount of supervision, with a minimum requirement of one (1) hour per month.

Provisionally approved Behavioral Health Professional must be supervised at least six(6) hours per month. Part-time provisionally approved Behavioral Health Professional must receive prorated supervision with no less than one (1) hour of supervision per month.

4. Professional Qualifications for Supervisors

Supervisors of Behavioral Health Professional must meet the following professional qualifications:

a. Have a Bachelor's degree in a human services or social services field and at least two (2) years' related experience; or

b. Have a Master's degree in a human services or social services field and at least one (1) year of related experience; or

c. Be a licensed social worker (LSW) with at least one (1) year of related experience; or

32.05 POLICIES AND PROCEDURES (Cont)

d. Be a licensed social worker (LSW) who has attained a related Master's degree; or

e. Be a licensed professional counselor (LPC), licensed clinical professional counselor (LCPC), licensed clinical social worker (LCSW), psychologist, physician, or advanced practice registered nurse; or

f. Be a registered professional nurse with three (3) years' related experience, or

g. Be a Board Certified Behavior Analyst (BCBA).

5. Consultation Services.

Consultation staff must be licensed as an Occupational Therapist; Physical Therapist; Speech Therapist; Child Psychiatrist; Child Psychologist; Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker Conditional Clinical (LMSW-Conditional Clinical); Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-Conditional (LCPC-Conditional); License Marriage and Family Therapist (LMFT); or Licensed Marriage and Family Therapist-Conditional (LMFT-Conditional). Consultation staff may also be a Certified Therapeutic Recreation Specialist (CTRS) or Board Certified Behavior Analyst (BCBA).

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32.05-5 Program Integrity

The Program Integrity Unit audits and reviews provider billing and supporting records to determine the necessity and appropriateness of services. In addition to the requirements of this section, the requirements set forth in Chapter I of the MaineCare Benefits manual, General Administrative Policies and Procedures, apply to individuals and agencies providing services under this section.

32.06 **LIMITATIONS**

The following limitations apply to reimbursement of services:

MaineCare will limit reimbursement for services under this Section to those covered services documented and approved in the Waiver Service Plan. Reimbursement is also contingent upon the provider's adherence to any applicable licensing standards and contractual agreements set forth by DHHS.

32.06 **LIMITATIONS** (cont)

MaineCare expenditures for a service under this waiver for an individual member will be limited to the amount approved by CMS in the waiver application.

Non-Duplication of Services

Comparable Services: Services under this Section are not covered if the member is receiving comparable or duplicative services under this or another Section of the MaineCare Benefits Manual.

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

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 and the request is approved.

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

All items in excess of five hundred dollars ($500) require documentation from a physician or other appropriate professional such as an Occupational Therapist, Physical Therapist or Speech Therapist that the item is medically necessary and appropriate to meet the member's need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this section only if they meet all requirements of this Section. This benefit applies to private homes only; it is not available in agency owned or operated homes.

Communication aids costing more than five hundred dollars ($500), the member must obtain documentation from a licensed speech-language pathologist assuring that the purchase is appropriate to meet the member's need and assuring the medical necessity of the devices or services. Only communication aids that cannot be obtained as a covered service under other sections of the MaineCare Benefits Manual will be reimbursed under this Section.

Consultation Services are limited to those providers not already reimbursed for consultation as part of another service. Personnel who provide targeted case management services to the member may not be reimbursed for consultation services.

Respite Services are limited to three (3) days per month.

32.07 DURATION OF CARE

32.07-1 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.

32.07-2 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 Waiver Service 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;

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 Waiver Service 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 Waiver Service Plan.

F. The member fails to pay his/her cost of care for two (2) consecutive months.

G. The member has not received at least one service in a thirty (30) day period.

32.07 **DURATION OF CARE (cont)**

32.07-3 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.

32.08 **NON-COVERED SERVICES**

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

A. Services not identified by the Waiver Service Plan;

B. Services to any MaineCare member who receives services under any other federally approved MaineCare waiver program;

C. Services to any member who is a nursing facility resident or ICF/MR resident;

D. Services that are reimbursable under any other sections of the MaineCare Benefits Manual;

E. 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 evaluation;

F. 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. ;

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

32.09 **REIMBURSEMENT**

Beginning July 1, 2011, MaineCare will reimburse for services provided under this Section using the maximum allowance listed in Chapter III. Reimbursement will be limited to the maximum number of billable hours approved.

HOME SUPPORT REIMBURSEMENT: Family Home Support hours less than five (5) hours in a day (24 hours period) will only be reimbursed on a quarter hour rate.

RESPITE REIMBURSEMENT: Respite hours less than seven (7) hours in a day (24 hours period) will only be reimbursed on a quarter hour rate.