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**21.01 INTRODUCTION**

 The Home and Community Benefit (HCB or Benefit) for Members with Intellectual Disabilities (ID) or Autism Spectrum Disorder (ASD) gives Members eligible for this Benefit the option to live in their own home or in another home in the community thus avoiding or delaying institutional services. The Benefit is offered in a community-based setting as an alternative for Members who qualify to live in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The Benefit supplements, rather than replaces supportive, natural personal, family, work, and community relationships. It does not duplicate other MaineCare services.

 The HCB Benefit is a Home and Community-Based Service provided under a Federal 1915(c) waiver that meets Federal standards. MaineCare Members may receive covered services as detailed in other sections of the *MaineCare Benefits Manual*, but can receive services under only one Home and Community Based waiver at any one time.

 In addition, the planning process includes identifying and documenting the Member’s needs in a Person-Centered Service Plan (PCSP). The PCSP describes certain facilitative, therapeutic and intervention services and supplies with an overall goal of community inclusion.

 The Benefit is a limited one. Each year the Department of Health and Human Services (DHHS) must identify the total number of unduplicated Members to whom it will provide the benefit during that year. If there is no funded opening, or if a Member is not eligible for a funded opening based on priority, the Member is placed on a waiting list as described in this rule.

 This rule does not alter or supplant other sections of Maine statute, regulation, or DHHS policy.

**21.02 DEFINITIONS**

**21.02-1 Abuse** means the infliction of injury, unreasonable confinement, intimidation or cruel punishment that causes or is likely to cause physical harm or pain or mental anguish; sexual abuse or sexual exploitation; or the intentional, knowing or reckless deprivation of essential needs as defined in 22 MRSA §3472.

**21.02-2 Activities of Daily Living (ADLs)** is a term used to collectively describe fundamental skills that are required to independently care for oneself including:

1. **Bed Mobility**: How a person moves to and from lying position, turns side to side, and positions body while in bed;

B. **Transfer**: How a person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet);

C. **Locomotion**: How a person moves between locations, in room and other areas. If in wheelchair, self-sufficiency once in chair;

D. **Eating**: How a person eats and drinks (regardless of skill);

**21.02 DEFINITIONS** (cont.)

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

F. **Bathing**: How a person takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (exclude washing of back and hair); and

G. **Dressing**: How a person puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis.

**21.02-3 Administrative Oversight Agency** means a provider agency that

1. Is approved by DHHS-Office of Aging and Disability Services (OADS).
2. Enters into a contractual agreement with the Shared Living Provider for oversight and monitoring services.
3. Bills and receives MaineCare reimbursement; and
4. Satisfies the Provider Qualifications and Requirements set forth in this rule.

**21.02-4 Agency Home Support** means a provider Managed Service Location that routinely employs direct support staff to provide Direct Support Services.

**21.02-5 Autism Spectrum Disorder** (ASD) means a diagnosis that meets diagnostic criteria set forth in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, (American Psychiatric Association), that manifested during the developmental period..

**21.02-6** **Authorized Entity** is the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions pursuant to a signed contract or other approved signed agreement.

**21.02-7** **Case Manager** is a person responsible for assuring the timely convening of the service planning team, developing the Person-Centered Plan (PCP), monitoring the planned services received by the Member, and assuring that those services meet the requirements set forth in the Member’s Person-Centered Plan.

**21.02-8** **Clinical Review Team (CRT)** is a multi-disciplinary team of qualified professionals that have work experience with adults with Intellectual Disabilities or Autism Spectrum Disorder. The CRT will partner with the resource coordinators to review and approve the following: Increased level of support for Shared Living and Family-Centered Support; Medical Add-On; all initial classifications to the waiver; and home

**21.02 DEFINITIONS** (cont.)

 support service requests. The CRT will also be responsible for systematic reviews to determine that Members are authorized at an appropriate level of service in accordance with the Member’s Person-Centered Service Plan.

**21.02-9 Competitive Integrated Employment** is employment that occurs in a competitive integrated setting, and which meets the specific requirements outlined in the Workforce Innovation and Opportunity Act (*See* 34 C.F.R. §361.5), including:

 (1) receiving compensation that is the higher of the federal, state or locally established minimum wage where the Member works, as well as being eligible for the level of benefits provided to other, non-disabled employees doing similar work and working similar hours; (2) occurring in location(s) typically found in the community that are not disability-specific settings; (3) enabling the Member to interact with co-workers and customers to the same extent as a person without a disability filling a similar position; (4) for wage employment, having the employer of record be the business or organization ultimately benefitting from the work done by the Member; (5) offering the Member an individualized position in which the Member does not work side-by-side with one or more other individuals with disabilities on the same schedule; and (6) presenting, as appropriate, opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

**21.02-10 Correspondent** is a person designated by the Maine Developmental Services Oversight and Advisory Board (MDSOAB), to act as a next friend of a person with Intellectual Disabilities or Autism Spectrum Disorder.

**21.02-11 Designated Representative** means the DHHS staff or Authorized Entity authorized by DHHS to perform specified functions.

**21.02-12 Direct Supports** are a range of activities 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 activities may include personal assistance or activities that support personal development, or activities that support personal well-being. The emphasis and purpose of the Direct Support provided may vary depending on the type of service.

Direct 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 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,

**21.02 DEFINITIONS** (cont.)

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 Person-Centered Service 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.

**Activities that support personal development** include teaching or modeling for a Member’s 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, neglect or exploitation; 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 Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5). It may also be necessary to seek emergency medical or safety assistance when needed and comply with incident reporting requirements.

**21.02-13 Employment Setting** foreither Work Support-Individual or Work Support-Groupmust be one with the highest level of integration possible. 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

**21.02 DEFINITIONS** (cont.)

 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. Provider owned/controlled businesses are subject to the same integration standards as other businesses. Staff providing employment 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 AbilityOne, the federal workforce guidelines associated with this funding source will apply to the services funded by the contract. The Member can be on the employer’s payroll or the provider agency 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 provider offer and provide this supervision as long as the above conditions are met.

**21.02-14 Exploitation** means the illegal or improper use of an incapacitated or dependent Member or that Member’s resources for another’s profit or advantage as defined in 22 M.R.S. §3472.

**21.02-15 Family-Centered Support** is a model designed to provide home support to a Member in a family environment, with the family and the Member sharing a home that is not owned by the Member or Member’s family. No more Family-Centered Support will be approved after December 30, 2007. The Family-Centered Provider must be a Certified Direct Support Professional (DSP) who meets all the requirements to provide this service.

**21.02-16 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.

**21.02-17 Instrumental Activities of Daily Living (IADLs)** are activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and communication. The extent to which a person requires assistance in performing IADLs is often assessed in conjunction with the evaluation of medical eligibility.

**21.02 DEFINITIONS** (cont.)

**21.02-18 Intellectual Disability** means a disorder as defined in 34-B M.R.S. §5001 and diagnosed in accordance with Diagnostic Criteria set forth in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, (American Psychiatric Association), that manifested during the developmental period.

**21.02-19 Medical Add-On** is an increase in the rate paid to address short or long-term medical needs and is reviewed and approved by the CRT. Medical Add-On is a component of Home Support, Community Support, Employment Specialist Services and Work Support-Individual and is included in the established authorization (as described in Section 21.04-1). It is not a separately billable activity.

 Billing may not exceed the Home Support, Community Support, Employment Specialist Services or Work Support authorized units of service. It is not a separately billable activity. Documentation must clearly identify and support periods of such activity. Refer to Appendix II for more information.

**21.02-20 Member** is a person determined to be eligible for MaineCare benefits by the Office for Family Independence (OFI) in accordance with the eligibility standards published by the OFI in the *MaineCare Eligibility Manual*. Some Members may have restrictions on the type and amount of services they are eligible to receive.

**21.02-21 Neglect** means a threat to a Member’s health or welfare by physical or mental injury or impairment, deprivation of essential needs or lack of protection from these as defined in 22 MRSA §3472.

**21.02-22 On Behalf Of** is a billable activity that is provided for individual Members and is not necessarily a direct face-to-face service. On Behalf Of is a component of Home Support, Community Support, Employment Specialist Services and Work Support. It is included in the established authorization and is not a separately billable activity. Refer to Appendix III for more information.

**21.02-23 Person-Centered Service Plan (PCSP)**is a Member’s plan developed at least annually based on the effective plan date, that identifies the services required under the waiver benefit. The PCSP must also include services and supports not covered by the waiver but identified by the Member. Only covered services included on the PCSP are reimbursable. The PCSP may also be known as a Person-Centered Plan, a plan of care, or a service plan, as long as the requirements of Section 21.04 are met.

**21.02-24 Primary Caregiver:** The Primary Caregiver is the adult who takes primary responsibility for the health and well-being of a Member who cannot fully care for himself/herself. This is unpaid assistance and support, typically provided by a family member.

**21.02 DEFINITIONS (**cont**.)**

**21.02-25 Prior Authorization** is the process of obtaining written prior approval by the Department’s Designated Representative as to the medical necessity and eligibility for a service.

**21.02-26 Qualified Intellectual Disability Professional (QIDP)** 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 as specified in title 42C.F.R. §483.430, (b)(5).

**21.02-27 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 authorizations for reimbursement. Qualified Vendors are required to provide notice to the Department upon the need for agency closure or termination of services to Members.

**21.02-28 Shared Living** (Foster Care-adult) is a model in which services are provided to a Member by a person who meets all of the requirements of a Direct Support Professional with whom that Member shares a home.

 **21.02-29 Shared Living Provider** is a provider who subcontracts with an agency to provide Direct Support to a Member, with whom they share a home.

**21.02-30 Utilization Review** is a formal assessment of the medical necessity, efficiency and appropriateness of services on a prospective, concurrent or retrospective basis.

**21.02-31 Year:** Services are authorized on the state fiscal year, July 1 through June 30.

**21.03 DETERMINATION OF ELIGIBILITY**

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

**21.03-1 Funded Opening**

**21.03 DETERMINATION OF ELIGIBILITY** (cont.)

The number of MaineCare Members that can receive services under this Section is limited to the number, or “funded openings,” and point in time 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.

#### 21.03-2 Reserved Capacity

The DHHS reserves a portion of Member capacity of the waiver for specified purposes in order to:

* Meet the needs of incapacitated or dependent adults who require adult protective services to alleviate the risk of serious harm resulting from abuse, neglect and/or exploitation; and
* Meet the needs of those individuals who choose to leave an ICF/IID, long term nursing home placement, state psychiatric hospital, or hospital and
* Meet the needs of Members under age 21 in out of state residential placements funded by MaineCare or State funds.

The number reserved associated with Section 21.03-2 above is an average based onthe DHHS’s data for those in need of adult protective services in recent years. The

number reserved for ICF/IID, long term nursing home placement, state psychiatric hospital or hospital residents is based on currently known referrals. The number reserved for Members in out-of-state residential placements is based on the number of current out of state residential placements funded by MaineCare or State funds.

**21.03-3 General Eligibility Criteria**

Consistent with Subsection 21.03-1, a person is eligible for services under this Section if the person:

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

B. Has an Intellectual Disability as defined in the Definitions Section above, or Autism Spectrum Disorder also defined in the Definitions Section above, or Rett Syndrome as defined by the DSM; and

C. Meets the medical eligibility criteria for admission to an ICF/IID 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

F. The estimated annual cost of the Member’s services under the waiver is equal to or less than two hundred percent (200%) of the state-wide average

**21.03 DETERMINATION OF ELIGIBILITY** (cont.)

annual cost of care for an individual in an ICF/IID, as determined by the DHHS.

**21.03-4 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 form (BMS 99) or current functional assessment approved by the DHHS; and

B. A copy of the Member’s Person-Centered Service Plan approved and signed by the Member, guardian and the Case Manager within the preceding six months; and

C) Any other relevant material indicating the Member’s service needs.

Based on review of the Assessment Form and the Member’s Person-Centered Service Plan, a QIDP 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 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 eligible, DHHS must send the Member or guardian written notice that the Member can receive ICF/IID 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.

 **21.03-5** **Calculating the Estimated Annual Cost**

Prior to formal determination of eligibility for services under this section, each applicant and the applicant’s planning team must identify the required mix of services to meet the applicant’s needs and to assure the applicant’s health and welfare. The applicant and the applicant’s planning team shall submit a detailed estimate of the total annual cost for waiver services identified in the Person-Centered Service Plan, including the specific services and the number of units for each service.

**21.03-6 Priority**

When a Member is found to meet MaineCare eligibility criteria and medical eligibility criteria for these services, the priority for a funded opening shall be established in accordance with the following:

**21.03 DETERMINATION OF ELIGIBILITY** (cont.)

**A. Priority 1:** Any Member on the waiting list shall be identified as Priority 1 if:

1. The Member has been determined by DHHS to be in need of adult protective services in accordance with 22 M.R.S. §§3470 *et seq.*, and if the Member continues to meet the financial and medical eligibility criteria at the time that need for adult protective services is determined.

OR

2. Although DHHS has not determined the Member to be in need of adult protective services, the Member is at risk for abuse, neglect, or exploitation because the Member meets the following criteria:

1. The Member resides with his or her Primary Caregiver and the Primary Caregiver has reached age sixty–five (65) or has a terminal illness, and is having difficulty providing the necessary supports to the Member; AND
2. The Member has no other responsible or willing caregiver; AND
3. The Member meets at least one of the following criteria, and is at risk of one other:
4. Within the last 12 months, the Member has demonstrated a significant medical/behavioral need, as evidenced and documented by:
	* Increased functional needs and required supports as a result of a mental health or medical condition; OR,
	* Criminal behavior resulting in involvement with the criminal justice system (not dependent upon conviction) that impacts or results in the harm or threat to others; OR
5. Prolonged and unresolved crisis involvement resulting in high-risk for institutionalization; OR
6. Three or more hospital admissions over the last 12 months due to a medical or behavioral decline that is expected to continue; OR
7. The health, safety or welfare of the Member or others is at imminent danger.

 B. **Priority 2:** Any Member on the waiting list shall be identified as Priority 2 if the Member does not satisfy Priority 1 criteria, yet has been determined to be at risk for abuse, neglect, or exploitation in the absence of the provision of benefit services identified in his or her service plan. Examples of Members who shall be considered Priority 2 include:

**21.03 DETERMINATION OF ELIGIBILITY** (cont.)

1. a Member whose Primary Caregiver has reached age sixty (60) and is having difficulty providing the necessary supports to the Member in the family home; or

2. a Member living in unsafe or unhealthy circumstances but who is not yet in need of adult protective services, as determined by DHHS Adult Protective Services.

C. **Priority 3:** Any Member on the waiting list shall be identified as Priority 3 if the Member is not at risk of abuse, neglect, or exploitation in the absence of the provision of the benefit identified in the service plan. Examples of Members who shall be considered Priority 3 include:

1. a Member living with family, who has expressed a desire to move out of the family home;
2. a Member whose medical or behavioral needs are changing and who may not be able to receive appropriate services in the current living situation;
3. a Member who resides with family, if the family must be employed to maintain the household but cannot work in the absence of the benefit being provided to the Member; or
4. A Member who has graduated from high school in the State of Maine, has no continuing support services outside of the school system, but is in need of such services.

D. Annual Waiting List Confirmation: The Member must confirm on an annual basis his/her interest in remaining on the Section 21 waiting list in accordance with the following process:

1. The Office of Aging and Disability Services will notify the Member, his/her guardian, and the Member’s Case Manager of the need to complete the Section 21 Waiver Information Form to confirm the Member’s continued interest in remaining on the waiting list.

2. The Member, his/her guardian, and the Member’s Case Manager will complete the Section 21 Waiver Information Form and submit the form to the Department.

3. If the Section 21 Waiver Information Form is not received within forty-five (45) days of notice to the Member, his/her guardian, and Case Manager, then the Department will issue a second reminder notice.

4. In the event that the Section 21 Waiver Information Form is not received by the Department within six (6) months of the initial notice to the Member, his/her guardian, and Case Manager, then the Department will notify the Member of his/her removal from the

**21.03 DETERMINATION OF ELIGIBILITY** (cont.)

waiting list. The Member can reapply for Section 21 services thereafter.

E. Reconsideration of Priority: If the Member would like the Department to consider new information and re-evaluate priority level, then a Section 21 Waiver Information Form must be submitted to the Department. This can be done at any time, or at the time of the annual waiting list confirmation.

**21.03-7 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, 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, the DHHS will utilize the most current assessment that is entered into the Enterprise Information System (EIS), or current database, and submitted by the individual Member, guardian or Case Manager. Upon review of information concerning all Members within the same priority group who continue to meet financial and medical eligibility criteria and for whom current

service plans are in place, DHHS shall determine which Members to serve. The determination will be based on a comparison of the Members’ known needs and the

comparative degree of abuse, neglect or exploitation or risk of abuse, neglect or exploitation that each Member will likely experience in the absence of the provision of the benefit.

**21.03-8 Waiting List and Offers for Funded Opening**

DHHS will maintain a waiting list of eligible MaineCare Members who cannot access Home and Community Benefits because a funded opening is not available. Members who are on the waiting list for the benefit services shall be served in accordance with the priorities identified above. At the time a Member is offered a funded opening the Member will be removed from the waiting list.

A Member has sixty days from the receipt of notification by DHHS of a funded opening to respond with intent to accept waiver services. A Member has six (6) months from the receipt of notification to start services. If the Member fails to respond to DHHS with intent to accept the funded opening within sixty (60) days of this notice or fails to begin services within six (6) months, the waiver offer will then be withdrawn. A Member may reapply at any time for waiver services.

**21.03-9 Redetermination of Eligibility**

Every twelve (12) months from the date of initial eligibility approval, the Member’s Case Manager will submit to OADS: a Current Person-Centered Service Plan based

**21.03 DETERMINATION OF ELIGIBILITY** (cont.)

on the effective plan date that is less than six (6) months old and an updated assessment form (BMS 99) or current assessment approved by the Department.

 If the updated Assessment Form and Person-Centered Service Plan are not received by OADS, by the due date, reimbursement for services will be denied until receipt of the assessment form and Person-Centered Service Plan. Reimbursement for services will resume upon receipt of the Assessment Form and a signed Person-Centered Service Plan.

**21.04 PERSON-CENTERED SERVICE PLAN (PCSP)**

The Person-Centered Service Plan (PCSP), and the planning for the PCSP, must comply with the requirements of the Global HCBS Waiver Person-Centered Planning and Settings Rule (“Global HCBS Rule”), *MaineCare Benefits Manual*, Chapter 1, Section 6.

If the Member or guardian chooses services under this Section, the request for services must be submitted to DHHS or its Authorized Entity. As part of the planning process, the Member’s needs are identified and documented in the Person-Centered Service Plan.

Except for residential services, other services shall be provided to the Member within ninety (90) days of the completed execution of a service agreement or amended service agreement. For

residential services, if the service agreement or amended service agreement identifies a need, such services shall be provided within eighteen (18) months of the execution of the agreement. The time periods set forth in this section are subject to the funded opening and waiting list provisions in sections 21.01 and 21.03.

**21.04-1 Prior Authorization for Reimbursable Services**

Services and units of services must be identified in the Person-Centered Service Plan. Requests for all Section 21 services must be submitted to DHHS or its Authorized Entity for Prior Authorization in order for the services to be reimbursed.

All Prior Authorizations are time-limited, and the length of the authorization may vary by Member and service as documented in the Person-Centered Service Plan. Upon expiration of an authorization, a new authorization must be obtained before reimbursement may be provided for the service.

DHHS and its Authorized Entity reserve the right to conduct Utilization Review of any service authorized under this Section, applying the service-specific eligibility standards set forth in this Section. DHHS and its Authorized Entity may terminate or revise a service authorization upon finding that the Member no longer satisfies the eligibility standards for the service or level of service authorized.

**21.04 PERSON-CENTERED SERVICE PLAN** (cont.)

**21.04-2 Person-Centered Service Planning Process**

In addition to the Global HCBS Rule provisions concerning Person-Centered Planning, the following requirements must be met.

 Case Managers shall meet with the Member prior to each planning meeting to ensure conflict-free planning and informed choice. The planning process must reflect the Member’s cultural preferences and provide information in plain language that is accessible to the Member and, when applicable, his or her legal representative. In addition to the above, and according to Title 34-B §5466, Members are entitled to have access to an advocate. Providers must ensure Members are aware of this entitlement prior to the planning meeting to allow for inclusion of an advocate if the Member so chooses.

**21.04-3 Person-Centered Service Plan Requirements**

Pursuant to the Global HCBS Rule, the Person-Centered Service Plan must reflect the services and supports that are important for the Member to meet the needs identified through an assessment of functional need, as well as what is important to the Member with regard to preferences for the delivery of services and supports. The effective plan date must be less than six (6) months old at the time of the Member’s eligibility determination or redetermination. The planning process must comply with the requirements described in the Global HCBS Rule.

The PCSP must include the following:

A. All MaineCare Benefit services determined medically necessary by the team including all other services that may not be covered under this section but the Member identifies and may pursue;

B. The frequency of provision of the services including transportation 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 Member’s providers in supporting the Member’s goals, including goals for strengthening natural and supportive personal, family, community and professional relationships;

F. Members who choose to receive Home Support-Remote Support must have a safety/risk plan, which shall describe the potential risks to the Member’s health and welfare while receiving Home Support-Remote Support and the reasonable steps to alleviate those risks; and

G. In order for the Plan to be authorized, the Plan must include signatures of (1) the Member and guardian, if applicable, (2) the Case Manager and (3) the individuals and providers responsible for the plan’s implementation.

**21.04 PERSON-CENTERED SERVICE PLAN** (cont.)

The PCSP will be used by DHHS to identify 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 support activities, an explanation of the differences in roles and responsibilities of each provider and how services will not be duplicated is required.

All providers must ensure that notice of the grievance process outlined in 14-197 CMR ch. 8 (Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism) is regularly provided to Members served by the provider. Providing notice includes, at a minimum, ensuring that written notice of the

grievance process is provided to the Member and their guardian at any planning meeting; posting notice of the grievance process in an appropriate common area of all facilities operated by the provider; and posting notice of the grievance process on any website maintained by the provider. In addition, the provider must ensure that all staff are trained in the grievance process. Staff must receive training in the grievance process upon hire, prior to working with Members and then every thirty-six (36) months thereafter.

**21.04-4 Planning Team Composition**

Each Member or guardian will determine the composition of the Planning Team. The Member will lead and direct the Person-Centered Service Planning Process whenever possible, including leading the planning meeting if he/she desires. The Member's

guardian should have a participatory role, as defined by the Member, unless state law confers decision-making authority to the legal guardian.

The Case Manager will ensure that the plan meeting is scheduled. The Case Manager or Case Management Supervisor will support the Member or legal guardian to schedule the meeting at times and locations of convenience to the Member and to include individuals of the Member’s choosing.

In addition to the Member, the planning team may include the following members, or when invited by the Member:

A. The Case Manager;

B. The Member’s guardian;

C. An approved Correspondent through the Maine Developmental Services Oversight and Advisory Board

D. The Member’s advocate or friend or any additional individual invited by the Member;

E. Operator of the Member’s home or a Direct Support Professional providing services to the Member;

F. Staff from the Member’s providers; and

**21.04 PERSON-CENTERED SERVICE PLAN (**cont.**)**

G. Other professionals involved or likely to be involved with the Member’s Person-Centered Service Plan.

**21.04-5 Updating the Person-Centered Service Plan**

The Member’s Person-Centered Service Plan must be reviewed, revised and updated at least annually, based on the plan’s effective date or at the request of the Member or guardian; or when other significant changes occur relating to the Member’s physical, social, behavioral, medical, communication, or psychological needs; or when the Member has made significant progress toward his or her goals. The Case Manager must reconvene the Planning Team to revise and update the Person-Centered Service Plan as service needs change including the location where services are received. Planning meetings must be held both prior to and thirty (30) days subsequent to the planned move of a Member to a new service in order to coordinate and to evaluate the Member's satisfaction with the change.

**21.05 COVERED SERVICES**

**21.05-1 Home and Community Based Settings**

Each home and community-based setting must comply with the requirements of the Global HCBS Waiver Person-Centered Planning and Settings Rule (“Global HCBS Rule”), *MaineCare Benefits Manual*, Chapter 1, Section 6.

 In addition, the following additional settings requirements apply to Community Support Services, and Work Support Group services:

 1. Members are allowed to have visitors at these service settings, so long as the Member’s PCSP provides for visitors, and so long as the Provider approves each of the visitors. The PCSP must state that the Provider will not charge for additional reimbursement for the visitors: and

 2. Members may have visitors at the Employment Setting comparable to the standards related to visitors for any other non HCBS employee that is employed in the business.

**21.05-2** **Assistive Technology**- Assistive Technology device means a Department approved item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of Members. Assistive Technology service means a service that directly assists a Member in the selection, acquisition, or use of an assistive technology device.

 Assistive Technology includes;

 A. Assistive Technology-Assessment:

**21.05 COVERED SERVICES** (cont.)

1. The evaluation of the assistive technology needs of a Member, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the Member in the customary environment of the Member;

2. The coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;

3. The training or technical assistance for the Member, or, where appropriate, the family Members, guardians, advocates, or authorized representatives of the Member; and

4. The training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of, Members.

B. Assistive Technology-Devices:

1. The purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for Members; and

2. The selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing of assistive technology devices.

C. Assistive Technology-Transmission (Utility Services):

1. The transmission of data required for use of the Assistive Technology Device via internet or cable utility.

**21.05-3** **Career Planning** is a person-centered, comprehensive employment planning and direct support service. It is a focused, time-limited service engaging a Member in identifying a career direction and developing a plan for achieving Competitive Integrated Employment at or above the State’s minimum wage. The service assists Members to obtain, maintain, or advance in competitive employment or self-employment. Career Planning assists in identifying skills, priorities, and capabilities determined through an individualized discovery process. This may include a referral to benefits planning, referral for an assessment for potential use of assistive technology to increase independence in the workplace, and/or for development of experiential learning opportunities and career options consistent with the Member’s skills and interests. Career Planning may be used in preparation to gather information to be used as part of a referral to Vocational Rehabilitation. When career exploration identifies an interest in self-employment, the Member will have the opportunity to explore similar businesses and determine potential steps necessary to develop a business. The outcome of this service is documentation of the Member’s stated career objective and a career plan used to guide individual employment support.

**21.05 COVERED SERVICES** (cont.)

 In order to receive Career Planning services, the Member’s Person-Centered Service Plan must identify the need to explore work, identify a career direction, and describe how the Career Planning services will be used to achieve those goals.

Career Planning services can be provided within a variety of community settings such as a Career Center, the community and local business and must be documented in the Person-Centered Service Plan with related goals.

The cost of Transportation related to the provision of Career Planning is a component of the rate paid for the service.

**21.05-4 Communication Aids** are devices or services necessary to assist Members with hearing, speech, or vision impairments to effectively communicate.

 Communication Aids include:

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

B. Speech amplifiers (includes hearing aids), aids and assistive devices (including repair and maintenance) if not otherwise covered for reimbursement under other sections of the *MaineCare Benefits Manual*;

C. Augmented communication. Providers must submit a written plan for DHHS’s approval defining the augmented communication services that will be offered to the Member.

Only Communication Aids that cannot be obtained as a covered service under other sections of the *MaineCare Benefits Manual* may be reimbursed under this Section. For Communication Aids costing more than five hundred dollars ($500), the Member must obtain documentation from a licensed speech-language pathologist, Audiologist

or Assistive Technology Professional (ATP) assuring the medical necessity of the devices or services.

 **21.05-5 Community Support** is provided by a Direct Support Professional employed by an OADS approved provider, 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 is intended to be flexible, responsive and provided to Members as defined by the Member’s choice and needs, including non-disability specific community settings, as documented in the Member’s PCSP.

**21.05 COVERED SERVICES** (cont.)

Community Support takes place in a non-residential setting, separate from the Member's private residence or other residential living arrangement; however, this service can originate or terminate in the Member’s private residence or other residential living arrangement. Community Support may not be provided in a PNMI, Agency Group Home, Shared Living, or any institutional setting.

Community Support can be provided in general community places of the Member’s choosing or may be in an agency setting that complies with the Global HCBS Rule.

Community Support allows for opportunities for career exploration and the facilitation of discussions about the benefits of working. Activities and discussions related to work should be relevant to identifying a Member’s employment interests, their individual strengths as related to employment, employment goals, and the conditions, such as workplace policies and safety, necessary for the Member to achieve and maintain successful employment. Use of Job Clubs, business tours, soft skill building curriculums, volunteer opportunities and skill building all are allowable under Community Supports to assist the Member on a Path to Employment and must be documented in a Member’s plan.

Community Support may also be used to provide supported retirement activities. As some people get older (55 plus) they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities. This might involve altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs and/ or other senior related activities in their communities.

Community Support is separated into three tiers of service delivery: Community Only-Individual, Community Only-Group, and Center-Based, to support individualized needs of the participant population more broadly. The Community Only tiers (individual and group) are delivered outside of a participant’s home or facility setting. The Center-Based tier is delivered from a facility setting but must ensure community integration and community inclusion to the greatest extent possible for participants as documented in the Person-Centered Service Plan. Community inclusion is the intentional process of connecting HCBS waiver participants and their families to other people in the community; identifying and securing generic, paid and natural supports; and supporting relationship development, contribution and reciprocity to support participants to be actively engaged and valued participants of the broader community.

The community support tiers are as follows:

1. Community Only-Individual – services provided by one staff to one participant at a time (1:1) within community settings.

**21.05 COVERED SERVICES** (cont.)

2. Community Only-Group – services provided by one staff to two participants at a time (1:2) within community settings

3. Community Center-Based – services provided by no less than one staff for three participants at all times (1:3) within or from a facility/center

A Member may not receive Community Support while enrolled in high school. Community Support cannot be provided in the Member’s 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.

 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 activity.

**21.05-6 Consultation Services** are services provided to persons responsible for developing or carrying out a Member’s PCSP. Consultation Services include**:**

1. Reviewing evaluations and assessments of the Member's present and potential level of psychological, physical, and social functioning made through professional assessment techniques; direct interviews with the Member and others involved in the PCSP; review and analysis of

previous reports and evaluations, and review of current treatment modalities and the particular applications to the individual Member;

B. Technical assistance to individuals primarily responsible for carrying out the Member's PCSP 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 PCSP Planning process, and training persons providing direct service in carrying out special habilitative strategies identified in the Member's PCSP;

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

E. Providing information and assistance to the Member and other persons responsible for developing the overall PCSP.

Consultation is available in the following specialties: Occupational Therapy (OT), Physical Therapy (PT), Speech Therapy, Behavioral and Psychological services. The provider of this service must be a Licensed Occupational Therapist (OT/L) for Occupational Therapy Consultation or a Registered Physical Therapist (RPT) for Physical Therapy Consultation or have a Certificate of Clinical Competence-Speech

**21.05 COVERED SERVICES** (cont.)

Pathology (CCC-SP) for Speech Therapy Consultation. For Psychological Consultation, the provider of this service must be a Licensed Psychological Examiner or Licensed Clinical Psychologist. For Behavioral Consultation, the provider of this service must be a Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC) or a Board Certified Behavior Analyst (BCBA). Reimbursement for Consultation Services may only be made to those providers not already reimbursed for consultation as part of another service. Personnel who provide services under Targeted Case Management, Section 13 of the *MaineCare Benefits Manual* may not be reimbursed for Consultation Services.

**21.05-7 Crisis Assessment** is a comprehensive clinical assessment of a Member who has required intervention by the DHHS Crisis Team on at least three occasions within a two-week period. The assessment includes: a clinical evaluation to identify causes or conditions that may precipitate the crisis, specific crisis prevention activities, and development of a plan for early intervention and stabilization in the event of a crisis. The required Members of a clinical team are a psychiatrist or licensed psychologist and a clinical liaison. Depending upon Member need, other team members may include a physician, occupational, physical or speech therapist.

**21.05-8 Crisis Intervention Services** are direct intensive supports provided to Members who are experiencing a psychological, behavioral, or emotional crisis. The scope, intensity, duration, intent and outcome of Crisis Intervention must be documented in the PCSP. Crisis Intervention is commonly provided on a short-term intermittent basis.

Emergency Crisis Intervention services must be authorized by a primary designated DHHS representative without the PCSP documentation this is permitted for a period of two weeks only. Outside of regular business hours, a secondary designated DHHS representative may authorize Crisis Intervention until the next business day only. Ongoing Crisis Intervention services must be recommended by the Planning Team and documented in the PCSP before the DHHS will authorize any further services for

reimbursement. For ongoing Crisis Intervention Services, the Planning Team must document the following:

• The nature of the ongoing crisis needs;

• Any recurring patterns, behaviors, or challenges that the service will address;

• The inability of currently- authorized habilitative services or direct support staffing to address the need;

• The expected duration and number of hours needed;

• How Crisis Intervention Services will be utilized; and

• A plan to remove the need for ongoing Crisis Intervention.

**21.05 COVERED SERVICES** (cont.)

Progress notes must indicate that Crisis Intervention Services were provided, even if the services are provided in conjunction with Home Support and/or Community Support Services.

Crisis Intervention Services may only be provided by staff employed or contracted by an approved provider enrolled in MaineCare.

**21.05-9 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; and (3) Employment Specialist Services for job development, if Vocational Rehabilitation denies services under the *Rehabilitation Act* and the Member is unable to benefit from Vocational Rehabilitation. If Employment Specialist Services are used for job development, current documentation of ineligibility from Vocational Rehabilitation is required.

 Employment Specialist Services are provided by an Employment Specialist, who may work either independently or under the auspices of a Supported Employment provider but must have completed the approved Employment Specialist training as outlined by DHHS in order to provide Employment Specialist Services. The need for continued Employment Specialist Services must be documented in a PCSP 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. The cost of transportation related to the provision of Employment Specialist Services is a component of the rate paid for the service.

On Behalf Of will continue as a component of Employment Specialist Services Support and is included in the established authorization and is not a separate billable activity.

Employment Specialist Services are provided on an intermittent basis with a maximum of ten (10) hours each month. Nothing in this rule prohibits a Member from working under a Special Minimum Wage Certificate issued by the Department

**21.05 COVERED SERVICES** (cont.)

of Labor under the *Fair Labor Standards Act*. Employment Specialist Services cannot be provided at the same time as Work Support-Group or Work Support-Individual.

**21.05-10 Home Accessibility Adaptations** are those physical adaptations to the private residence of the Member or the Member’s family required by the Member’s PCSP, that are necessary to ensure the health, welfare and safety of the Member or that enable the Member to function with greater independence in his or her home. These include adaptations that are not covered under other sections of the *MaineCare Benefits Manual* and are determined medically necessary as documented by a licensed physician or other appropriate professional and approved by DHHS.

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;
* Lexan windows (non-breakable for health and safety purposes);
* Specialized flooring (to improve mobility and sanitation).

Items not included above but which have been recommended in a Person-Centered Service Plan are subject to approval by DHHS for reimbursement. DHHS does not cover 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 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 is not allowable. General household repairs are not included in this benefit.

All services must be provided in accordance with applicable local, State or Federal building codes.

Home AccessibilityAdaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services. If the family is the paid provider, this service is not available.

**21.05-11 Home Support-Agency Per Diem** is individually tailored Direct Support that assists Members with acquiring, retaining, and/or improving skills related to living in the community. The agency owned or controlled setting is integrated in and facilitates the Member’s full access to the greater community including opportunities to seek

**21.05 COVERED SERVICES** (cont.)

 employment and work in competitive, integrated settings; engage in community life, control personal resources, and receive services in the community like individuals without disabilities. These supports include adaptive skill development, assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADL), community inclusion, transportation, and social and leisure skill development. These supports also include protective oversight and supervision. Services are developed in accordance with the needs of the Member and include supports to foster independence and encourage development of a full life in the community, based upon what is important to and for the Member, as documented in their Person-Centered Service Plan (PCSP). Individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact are optimized and not regimented. Individual choice regarding services and support, and who provides them, is facilitated.

 There must be at least one staff person in the same setting as Members receiving services at all times (24/7) that is able to respond immediately to the requests/needs for assistance from the Members in the setting. The Department reimburses for the delivery of a service to a Member and that assumes that the provider is awake.

 Members cannot be made to attend a day program (any other service or support other than Home Support) if they choose to stay home, would prefer to come home after a job or doctor’s appointment in the middle of the day, if they are ill, or otherwise choose to remain at home.

 Payments are not made for room and board, the cost of facility maintenance, upkeep, or improvement. The cost of transportation is included in the residential habilitation rate.

 **21.05-12 Home Support-Family-Centered Support**- is Direct Support provided to improve and maintain a Member’s ability to live as independently as possible in his or her home. Home Support may be provided in a licensed or unlicensed residential setting, or in any other residential setting where hours of support are routine or predictable. Home Support is Direct Support to a Member and includes habilitative training; assistance with ADLs and IADLs, development of safety skills and/or personal well-being. Within the scope of Home Support there may be activities that require that the service be carried over into the community. This is allowable as long as it does not duplicate community support services.

 Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. Cost of room and board is paid for separately by a combination of participant funds (e.g. SSI) and other state contracted funds.

**21.05 COVERED SERVICES** (cont.)

 Payment is not made directly or indirectly to Members of the participant's immediate family, except as provided 21.06-8 of this rule.

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

An increased level of support may be available for Members in Family Centered Support based on the documented needs of the Member as reviewed and approved by the CRT. The Member must require an increased level of staffing as documented in the Member’s Person-Centered Service Plan. Refer to Appendix I for more information.

**21.05-13** **Home Support-Quarter Hour** is an individually tailored Direct Support that assists Members with the acquisition, retention, or improvement in skills related to living in their own home (either owned or leased) within their community. Home Support – Quarter Hour is for Members who live independently or with others and who need less than 24-hour (1:1 in person) staff support per day. Support includes assistance with Activities of Daily Living, adaptive skill development, control of personal resources, transportation, and being prepared for opportunities to seek employment and to work in competitive, integrated settings. The Member’s health and safety needs and the support needed to meet them are documented in the Member’s Person-Centered Service Plan.

 Providers must develop methods, procedures, and activities to facilitate meaningful days and independent living choices about activities/services/staff for the Member.

 Procedures must be in place for individual(s) to access needed medical and other services to facilitate health and well-being.

 Home Support-Quarter Hour services include a combination of hands-on care, habilitative supports, skill development and assistance with Activities of Daily Living. Supports provided shall be aimed at teaching the person to increase his or her skills and self-reliance.

 Examples of support include:

 A. Self-help skills, including Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADL) and self-care;

 B. Cognitive and Communication Tasks Adaptive Skills;

 C. Replacement Behavior Components of Positive Behavior Support Plans, including those skills required to effectively address situations and antecedents of frequently occurring maladaptive or challenging behavior. In- Home Supports providers may work as directed by an assigned professional to assist the individual to

**21.05 COVERED SERVICES** (cont.)

develop skills necessary to reduce or eliminate episodes in which the individual becomes a danger to self or others.

 D. Prevocational/work related activities

 The Home Support-Quarter Hour service includes transportation furnished by the provider during the course of the service.

 Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

 Payment is not made directly, or indirectly, to Members of the Member's immediate family.

 **21.05-14** **Home Support-Remote Support** - This service provides real time, remote communication and support through a wide range of technological options including electronic sensors, video conferencing, environmental sensors (movement, doors, temperature, smoke, CO, etc.), video cameras, microphones and speakers, as wells as health monitoring equipment. This assistive technology links each Member’s residence to the Remote Support provider.

 If a Member chooses this service, the Member’s Person-Centered Service Plan must include a safety/risk plan that identifies that identifies emergency back-up arrangements.

 The use of this service is based upon the Member’s assessed needs and the resulting Person-Centered Service Plan. The PCSP reflects the Member’s consent and commitment to the plan elements including all assistive communication, environmental control and safety components. An Assistive Technology Assessment must be completed by a qualified provider. Prior to the finalization of the Person-Centered Service Plan the Case Manager and the Member with the assistance of the Planning Team will ensure the appropriateness of the identified assistive technology.

All Remote Support Services must be provided in real time. All electronic systems must have back-up power connections to ensure functionality in case of loss of electric power. Providers must comply with all federal, state and local regulations that apply to its business including but not limited to the “*Electronic*

*Communications Privacy Act of 1986*”. Any services that use networked services must comply with HIPAA requirements.

 There is no overlap between Assistive Technology and Home Support Remote Support. As set forth in §21.05-2, Assistive Technology may be used to provide for

**21.05 COVERED SERVICES** (cont.)

 assessments, equipment, and the cost of the monthly data transmission utility necessary to facilitate Home Support-Remote Support services. Home Support-Remote Support provides the staff that monitor the Member.

There are two types of Remote Support: Interactive Support and Monitor Only. Chapter III reflects the billing for each type. Interactive Support includes only the time that staff is actively engaging a Member in 1 to 1 direct support through the use of the Assistive Technology Device. Monitor Only is when Assistive Technology equipment is being used to monitor the Member without interacting.

**21.05-15** **Non-Medical Transportation Service** is offered in order to enable Members to gain access to Section 21 and other community services, activities and resources as specified by the Person-Centered Service 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 for Section 21 services are provided under the *MaineCare Benefits Manual*, Section 113 (Non-Emergency Medical Transportation Services).

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.

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

Relatives and Legal guardians may only be reimbursed by the broker if they indicate that they are unable to transport at no charge or there is no other viable option and there is a recommendation by the planning team.

**21.05-16 Non-Traditional Communication Assessments** determine the level of communication present via gesture, sign language or unique individual communication style. The assessment examines signed or gestured vocabulary for everyday objects or actions, as well as the ability to combine gestures and the ability to understand similar communication. Assessment recommendations are made to optimize communication to maximize social integration. The provider of this service must be approved by the Office of Aging and Disability Services.

 **21.05-17 Non-Traditional Communication Consultation** isprovided to Members and their direct support staff and others to assist them in order to maximize communication ability as determined from their assessment. The goal is to allow for greater participation in the service planning process and to enhance communication within the Member’s environment. The provider of this service must be a Visual Gestural Communicator approved by the Department or its Authorized Entity.

**21.05 COVERED SERVICES** (cont.)

**21.05-18 Occupational Therapy (Maintenance)** is a service that has maintenance of current abilities and functioning level as its goal. Evaluative and rehabilitative Occupational Therapy is included under other Sections of the *MaineCare Benefits Manual* and is not covered as a component of maintenance therapy under this Section. The provider of this service must be a Licensed Occupational Therapist, (OT/L) for Occupational Therapy Maintenance or a Licensed Occupational Therapy Assistant (OTA/L) under the supervision of a Licensed Occupational Therapist, .

**21.05-19** **Physical Therapy (Maintenance)** is a service that has maintenance of current abilities and functioning level as its goal. Evaluative and rehabilitative Physical Therapy is included under other Sections of the *MaineCare Benefits Manual* and is not covered as a component of maintenance therapy under this Section. The provider of this service must be a Registered Physical Therapist (RPT) for Physical Therapy Maintenance.

 The service may be provided to up to three (3) Members at once. When the service is provided to a group, the appropriate group rate must be billed.

**21.05-20** **Shared Living (Foster Care, Adult)-**is Direct Support and personal care (e.g., homemaker, chore, attendant care, companion) and medication oversight (to the extent permitted under State law) provided to a Member in a private home by a principal care provider (home provider) who lives in the home. Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with Activities of Daily Living, community inclusion, transportation, and social and leisure skill development that assist the Member to reside in the most integrated setting appropriate to their needs. The service facilitates the Member’s full access to the greater community, including opportunities to seek employment and work in competitive, integrated settings; engage in community life, control personal resources, and receive services in the community like individuals without disabilities. Residential habilitation also includes protective oversight and supervision. Services are provided according to the Member’s Person-Centered Service Plan. A provider may not have more than two people that they care for in one home.

 The Shared Living provider maintains a supportive home environment that promotes community inclusion with an appropriate level of support and supervision.

 The Shared Living Provider is required to maintain a clean and healthy living environment addressing any necessary Member-specific environmental or safety standards (see Appendix V).

 Additionally, the Shared Living Provider shall:

 A. Attend to the Member’s physical health and emotional well-being.

**21.05 COVERED SERVICES** (cont.)

 B. Participate as a part of the Member’s Person-Centered Service Planning Team and maintain open communication with the Case Manager, Administrative Oversight Agency, and guardian.

 C. Assist in transition, admission, or discharge plans.

 D. Include the Member in family and community life, assisting the Member to develop healthy relationships and increased community independence.

 E. Provide community access to services and activities desired by the Member including but not limited to; religious affiliation (if desired), physical activities, shopping, volunteering, etc.

 F. Maintain professional daily documentation in accordance with MaineCare requirements.

 G. Maintain daily documentation of all medication administered to the Member or by self-administration.

 H. Report any unusual incidents to the Member’s team (Case Manager, Administrative Oversight Agency and guardian) and, when required, through the Reportable Events Reporting System.

 I. Report to the Member’s team all changes in household members or legal status of household members.

 J. Maintain current homeowner’s or renter’s insurance at all times.

 K. Provide the transportation to appointments and activities.

 L. Maintain a valid Maine driver’s license and a properly registered, inspected, insured, and maintained vehicle.

 M. Enter into a contract for professional support with the Administrative Oversight Agency.

 The Administrative Oversight Agency supports the provider in fulfilling the requirements and obligations agreed upon by DHHS, the Administrative Oversight Agency, and the Member’s Planning Team as documented in the Member’s Person-Centered Service Plan.

 For this service, Respite is a component of the rate paid to the Administrative Oversight Agency and therefore is not a separately billable service. The record must accurately reflect the Member’s location during the receipt of Respite Services.

An increased level of support may be available for Members in Shared Living based on the documented needs of the Member, as reviewed and approved by the CRT. When the Member requires an increased level of staffing it must be documented in the Member’s Person-Centered Service Plan. The increased level of support is not to be used as respite or in place of the primary provider. See Appendix I for additional requirements.

 **21.05-21** **Specialized Medical Equipment and Supplies** include devices, controls, appliances, or necessary repairs to the same specified in the PCSP that enable Members to

**21.05 COVERED SERVICES** (cont.)

 increase their abilities to perform Activities of Daily Living, or to perceive, control, or communicate with the environment in which they live. This benefit also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and nondurable medical equipment not available under the *MaineCare Benefits Manual*. Items reimbursed under this waiver benefit are in addition to any medical equipment and supplies furnished under the *MaineCare Benefits Manual*. All items must meet applicable standards of manufacture, design and installation. If used in vehicle modification, this benefit applies to Member owned or a Member’s family owned vehicle only; it is not available in provider owned, leased or operated vehicles. All items shall be considered the property of the Member and must remain at the Member’s disposal at all times regardless of where the Member resides.

For Specialized Medical Equipment and Supplies costing more than five hundred dollars ($500), the Member must submit documentation to the Department from a physician or other appropriate professional such as an occupational, physical, or speech therapist assuring that the purchase is appropriate to meet the Member’s need and is medically necessary.

Specialized Medical Equipment and Supplies are limited to only Specialized Medical Equipment and Supplies that cannot be obtained as a covered service under other sections of the *MaineCare Benefits Manual*. Proof of attempts to obtain requested services under other MaineCare sections may be required for approval.

Examples of this benefit may include but are not limited to the following:

A. lifts such as van lifts/adaptations for vehicles used by Members who are unable to access transportation services covered in this Section or in Chapter II, Section 113, Transportation Services of the *MaineCare Benefits Manual*; lift devices, standing boards, frames, and standard wheelchairs, including those with removable arms and leg rests, pediatric "hemi" chairs, tilt-in-space and reclining wheelchairs;

B. control switches/pneumatic switches and devices such as sip and puff controls, and adaptive switches or devices that increase the Member’s ability to perform Activities of Daily Living;

C. environmental control units such as locks, electronic control units and safety restraints; and

D. other devices necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment that are not otherwise covered for reimbursement in the *MaineCare Benefits Manual*.

**21.05-22** **Speech Therapy (Maintenance)** is a service that has maintenance of current abilities and functioning level as its goal. Maintenance therapy provides for the

**21.05 COVERED SERVICES** (cont.)

 implementation of services that include direct therapy and consultation services to maintain the Member’s optimal level of functioning within the Member's current environment. The intent is to prevent regression, loss of movement, injury and medical complications that would result in a higher level of skilled care. Evaluative and rehabilitative Speech Therapy is included under other Sections of the *MaineCare Benefits Manual* and is not covered as a component of maintenance therapy under this Section. The provider of this service must have a Certificate of Clinical Competence-Speech Pathology (CCC-SP) for Speech Therapy Maintenance.

**21.05-23** **Work Support-Group** is Direct Support provided to improve a Member’s ability to independently maintain employment.

Work Support-Group is provided at the Member’s place of employment.

Work Support-Group comprises services and training activities that are provided in regular business, industry and community settings for groups of two to six Members. Mobile work crews and business-based workgroups (enclaves) employing small groups of workers in employment in the community are examples of the models allowed.

Work Support-Group must be provided in a manner that promotes the integration into the workplace and interaction between Members and

people without disabilities in those workplaces. The primary focus of the support is job related and also encompasses adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene and self-care.

To receive this service, a Member must have received an assessment and services under the *Americans with Disabilities Act*, and Section 504 of the *Rehabilitation Act,* and the need for on-going support must have been determined and documented in the Person-Centered Service Plan.

The outcome of this service must be sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which the Member is compensated at or above the minimum wage, and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Work Support-Group does not include vocational services provided in a facility-based work setting in specialized facilities that are not part of the general workforce. Documentation must be maintained in the file of each Member receiving this service that the service is not available under a program funded under section 110 of the

**21.05 COVERED SERVICES** (cont.)

*Rehabilitation Act* of 1973 or the *Individuals with Disabilities Education Act* (20 U.S.C. §1401 *et seq*.).

Work Support-Group does not include volunteer work.

Work Support-Group cannot be used to cover incentive payments, subsidies, or unrelated vocational training expenses such as the following:

* 1. incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program;
	2. payments that are passed through to users of supported employment programs; or
	3. payments for training that is not directly related to a Member’s supported employment program.

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

No more than six (6) Members at a time may be supervised by a Direct Support Professional. The appropriate group rate must be billed.

Information must be provided to the Member at least yearly that career planning and individual employment is available to the Member in order to make an informed decision regarding the services the Member receives.

The Ticket to Work Program (TTW) and Milestone payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided since payments are made for outcome, rather than for a Medicaid service rendered.

**21.05-24 Work Support-Individual** is Direct Support provided to improve a Member’s ability to independently maintain employment. Work Support-Individual is primarily provided in a Member’s place of employment, but may be provided in a Member’s home in preparation for work if it does not duplicate services already reimbursed as Home Support, Community Support or Employment Specialist Services. The primary focus of the support is job related and also encompasses adherence to workplace policies, safety, productivity, dress code, work schedule, building co-worker and supervisor relationships, hygiene, and self-care.

**21.05 COVERED SERVICES** (cont.)

Work Support-Individual must be provided to the Member in an integrated Employment Setting in the general workforce. The Member must be compensated at or above the minimum wage, and not less than the customary wage and level of

benefits paid by the employer for the same or similar work performed by individuals without disabilities.

This service is provided after the Member has received an assessment and services under the *Americans with Disabilities Act* and Section 504 of the *Rehabilitation Act* and need for on-going support has been determined and documented in the Person-Centered Service Plan, along with the Member’s health and safety needs within the work place.

Work Support-Individual may be provided to self-employed Members where the Member requires support operating his or her own business.

Support may be used for customized employment for Members with severe disabilities to include long term support to successfully maintain a job due to the ongoing nature of the Member’s support needs, changes in life situation, or evolving and changing job responsibilities.

Work Support-Individual does not include volunteer work.

Documentation must be in the file of each Member receiving this service that the service is not available under a program funded under section 110 of the *Rehabilitation Act of 1973* or the Individuals with *Disabilities Education Act* (20 U.S.C. 1401 *et seq*.).

Work Support-Individual cannot be used to cover incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program; 2) payments that are passed through to users of supported employment programs; or 3) payments for training that is not directly related to a Member’s supported employment program.

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

The Ticket to Work Program (TTW) and Milestone payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided since payments are made for outcome, rather than for a Medicaid service rendered.

**21.06 NON-COVERED SERVICES**

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

 **21.06.1 Duplicative Services** A Member receiving services under this Section 21, may not receive duplicative MaineCare services at the same time under any other sections of the *MaineCare Benefits Manual*, including: Section 2, Adult Family Care Services; Section 18, Home and Community-Based Services for Adults with Brain Injury; Section 19, Home and Community Benefits for the Elderly and for Adults with Disabilities; Section 20, Home and Community-Based Services for Adults with Other Related Conditions; Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations; Section 29, Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder; Section 45,Hospital Services; Section 46, Psychiatric Facility Services; Section 50, ICF/IID Services; Section 67, Nursing Facility Services, and Section 97, Private Non-Medical Institution Services, when the Member is receiving personal care services.

**21.06-2** Services not identified by the Person-Centered Service Plan;

**21.06-3** Services to any MaineCare Member who receives services under any other federally approved MaineCare Home and Community based waiver program;

**21.06-4** Services to any Member who is a nursing facility resident, state psychiatric hospital or ICF/IID resident;

**21.06-5** Services that are reimbursable under any other sections of the *MaineCare Benefits Manual*;

**21.06-6** 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;

**21.06-7** Room and board is not reimbursed by MaineCare. 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 or snacks 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;

**21.06-8** Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the Member’s parent, sibling or other biological family member. This rule will not be avoided by adult adoption. Persons appointed by a

**21.06 NON-COVERED SERVICES** (cont.)

probate court as legal guardian prior to and up to December 30, 2007, who are not biological family, and who are directly or indirectly reimbursed for services, may continue to receive reimbursement under this Section. Relatives who provide waiver services must meet the same standards as providers who are unrelated to the Member;

**21.06-9** Work Support-Individual, Work Support-Group or Employment Specialist Services when the Member is not engaged in employment; and

**21.06-10** Specialized Medical Equipment and Supplies, 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*.

**21.07 LIMITS**

**21.07-1** MaineCare Members can receive services under only one Home and Community Waiver Benefit at any one time.

**21.07-2** Effective January 1, 2021, when the Member receives Community Support services in addition to Work Support-Group and/or Work Support-Individual services, the combined cost of Community Support, Work Support-Individual and Work Support-Group may not exceed $39,875.32annually.

 **21.07-3** **Home Accessibility Adaptations** are limited to a ten thousand-dollar ($10,000.00) limit in a five (5) year period with an additional annual allowance up to three hundred dollars ($300.00) for repairs and replacement per year. Home Accessibility Adaptions that exceed five hundred dollars ($500) require documentation from a physician or other appropriate professional such as an OT, PT, or Speech Therapist, indicating that the purchase is appropriate to meet the Member’s need.

**21.07-4** **Specialized Medical Equipment and Supplies** are limited to only specialized medical equipment and supplies that cannot be obtained as a covered service under other sections of the *MaineCare Benefits Manual.*. Proof of attempts to obtain requested services under other MaineCare sections may be required for approval. These services are to be considered the property of the Member.

For purchases of Specialized Medical Equipment and Supplies costing more than five hundred dollars ($500), the Member must obtain documentation from a physician or other appropriate professional such as an occupational, physical, or speech therapist assuring that the purchase is appropriate to meet the Member’s need and is medically necessary.

**21.07 LIMITS** (cont.)

**21.07-5** **Communication Aids** costing more than five hundred dollars ($500), the Member must obtain documentation from a licensed speech-language pathologist, Licensed Audiologist or a Certified Assistive Technology Professional (ATP) 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.

**21.07-6** **Consultation Services** are limited to those providers not already reimbursed for consultation as part of another service. Personnel who provide services under targeted case management may not be reimbursed for Consultation Services. Consultation is limited to sixty-six (66) units or sixteen and a half (16.5) hours annually, per type of consultation (Occupational Therapy, Physical Therapy, Speech, Behavioral and Psychological).

**21.07-7** **Non-traditional Communication Consultation** is limited to sixty (60) hours annually.

**21.07-8** **Crisis Intervention Services** that have not been included on the Person-Centered Service Plan are limited to a period not to exceed two weeks and must be authorized by the DHHS or its Authorized Entity. Crisis Intervention Services may not extend past two (2) weeks without a recommendation from the Member’s Person-Centered Service Team and additional approval from DHHS.

**21.07-9** **Crisis Assessment Services** are limited to one (1) assessment in a three-year (3) period, with a maximum allowance of $2,250.00, and includes all related follow-up activities.

**21.07-10** **Occupational Therapy (Maintenance)** provided by an Occupational Therapist, Registered, Licensed (OTR/L) is limited to forty-eight (48) quarter hour units per year. Occupational Therapy (Maintenance) provided by an Occupational Therapist Assistant/Licensed (OTA/L) is limited to forty (40) quarter hour units per year. When a OTA/L is providing Occupational Therapy (Maintenance), it must be under the supervision of an OTR.

**21.07-11 Enrollment in High School** A Member may not receive Community Support while enrolled in high school.

**21.07-12** **Place of Employment** A Member may not receive Community Support or Home Support at his or her place of employment.

**21.07-13 Family-Centered Support Providers** No additional Family-Centered Support providers will be approved and enrolled after 12/20/2007.

**21.07 LIMITS** (cont.)

**21.07-14 Nursing Facility or Hospital** If a Member enters a nursing facility or a hospital, payment under Section 21 will be temporarily suspended. If the Member 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 DHHS to continue holding the funded opening.

 After six (6) continuous months in a nursing facility or hospital, if the Member does not resume services, the Member will be terminated from the waiver.

**21.07-15** **Work Support-Individual** services are limited to one DSP per Member at a time.

**21.07-16 Home Support- Agency Per Diem** as of December 24, 2012,Home Support- Agency Per Diem placements will only be approved at provider controlled homes where a minimum of two (2) Members reside.

**21.07-17 Home Support Quarter Hour** may not exceed three hundred and thirty-six (336) quarter hour units or eighty-four (84) hours a week. Units of service that were not provided to a Member in any week cannot be carried over into subsequent weeks.

**21.07-18** **Out of State Services** Authorizations for services to be provided out of state will not exceed sixty (60) days of service within a given fiscal year and not exceed sixty (60) days within any six (6) month period except as provided in 42 C.F.R. §431.52 (b).

**21.07-19** **Annual MaineCare Expenditures** for services under this waiver for an individual Member are limited to two hundred percent (200%) of the state-wide average annual cost of care for an individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by DHHS.

 **21.07-20 Assistive Technology Services** are not covered under this rule if they are available under another MaineCare rule.

The components above are subject to the following limits:

* + 1. Assistive Technology- Assessments are subject to a limit of 32 units, per state fiscal year.
		2. Assistive Technology- Devices and services are subject to a combined limit $6,000 annually, per state fiscal year.
		3. Assistive Technology- Transmission (Utility Services) are limited to $50.00 per month.

 **21.07-21 Career Planning** is limited to sixty (60) hours to be delivered in a six-month period. No two six-month periods may be provided consecutively.

**21.07 LIMITS** (cont.)

Career planning furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. §§ 1401(16), (17).

**21.07-22** **Employment Specialist Services** are provided on an intermittent basis with a maximum of ten hours each month.

**21.07-23 Home Support-Remote Support** is limited to forty-eight (48) units (12 hours) per day. This can be in addition to Home Support-Quarter Hour, as long as this is not duplicative.

**21.08 DURATION OF CARE**

**21.08-1** **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.

**21.08-2** **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 is determined to be financially or medically ineligible for this benefit or MaineCare;

B. The Member is determined to be a nursing facility resident, ICF/IID, psychiatric hospital, or hospital resident for six months;

C. The Member is 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 Person-Centered 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 Person-Centered Service Plan.

F. The Member has not received at least one waiver service in a thirty (30) day period; or

G. The annual cost of the Member’s services under this waiver exceeds two hundred percent (200%) of the state-wide average annual cost of care for an

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

 individual in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), as determined by the DHHS, unless the Member is authorized to exceed this limit pursuant to the Exceptions process in this rule and/or another ADA modification.

**21.08-3** **Termination from Participation as a MaineCare Provider:** Pursuant to Chapter I of the *MaineCare Benefits Manual*, the provider must notify the Department in writing of the intent to terminate its participation in the MaineCare program, at least thirty (30) days prior to the effective date of termination for non-emergency terminations and seven (7) days prior to emergency terminations. Additionally, providers shall notify all Members receiving Section 21 services from the provider in writing of the provider’s intent to terminate its MaineCare Provider status (and thus terminate all MaineCare services) following the same timeline for non-emergency and emergency terminations noted above.

**21.09 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:

**21.09-1** The Member's name, address, birth date, MaineCare identification number, guardian contacts, if applicable, and emergency contacts;

**21.09-2** The Member's social and medical history, including any allergies, and diagnoses;

**21.09-3** The Member’s Person-Centered Service Plan; and

**21.09-4** Written progress notes that identify actions related to the progress toward the achievement of the goals, activities and needs established by the Member’s Person-Centered Service Plan signed by the staff performing the service.

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.

All providers must document each service provided, the date of each service, the type of service, the activity, need or goal to which the service relates, the length of

time of the service, and the signature of the individual performing the service.

If services are provided by two (2) or more staff working different shifts, then each shift must be documented separately.

**21.09 MEMBER RECORDS** (cont.)

Example: A Member receives twenty-four hour (24) coverage from three (3) staff members working Monday through Friday in eight (8) hour shifts, and one (1) staff member that covers the weekend. The provider must have documentation for each eight (8) hour shift per day.

If Crisis Intervention is required, a separate progress note must be included in the Member's record. The documentation must describe the crisis services provided, the date in which the crisis service was provided, the length of the crisis service, and the signature of the individual performing the crisis service.

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS**

To provide services under this section a provider must be a Qualified Vendor as approved by OADS 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 OADS.

providers must ensure staff are trained in identifying risks, such as risk of abuse, neglect, or exploitation; 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. Any intervention must be consistent with the DHHS’s rule governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism (14-197 C.M.R. ch 5). It may also be necessary to seek emergency medical or safety assistance when needed and comply with reporting requirements outlined in DHHS’s Reportable Events System (14-197 C.M.R. ch 12) and/or Adult Protective Services System (10-149 C.M.R. ch 1).

**21.10-1** **Direct Support Professional (DSP)**

 The following requirements apply to DSPs:

A. DSPs must successfully complete the Direct Support Professional curriculum as adopted by DHHS**,** or demonstrated proficiency through DHHS’s approved Assessment of Prior Learning, or has successfully completed the Maine College of Direct Support within six (6) months of date of hire.

 a. Prior to providing services to a Member alone, a DSP must complete the following four modules from the College of Direct Support, including computer based and live sessions:

 1. Introduction to Developmental Disabilities

 2. Professionalism

 3. Individual Rights and Choice

 4. Maltreatment

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

b. Documentation of completion must be retained in the personnel record.

1. DSPs must complete the following Department-approved trainings, within the first six (6) months from date of hire and thereafter every thirty-six (36) months;

1. Reportable Events System (14-197 C.M.R. ch 12) and Adult Protective Services System (14-197 C.M.R. ch. 12)

2. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5)

3. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (34-B M.R.S. §5605).

4. DSPs, regardless of capacity and prior to provision of service to a Member, must be trained upon hire and annually thereafter on the Global HCBS Waiver Person Centered Planning and Settings Rule, *Maine Care Benefits Manual*, Chapter 1, Section 6;

1. DSPs must have a background check consistent with Section 21.10-10;
2. DSPs must have an adult protective and child protective record check;

E. DSPs must be at least eighteen (18) years of age;

F. DSPs must have graduated from high school or acquired a GED;

G. DSPs must have current CPR and First Aid Certification;

 H. 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 a Registered Nurse (RN), or otherwise has been trained to administer medications through a training program specifically for Family-Centered or Shared Living model homes and authorized, certified, or approved by DHHS;

 I. A DSP who also provides Work Support- Individual or Work Support-Group must have completed the additional employment modules in the Maine College of Direct Support in order to provide services;

J. A DSP who also provides Career Planning must successfully complete Maine's "Direct Support Professional Curriculum," or the "Maine College of Direct Support" program and additional employment modules, or the College of Employment Services Certificate, as follows:

a. Employment Specialist National (ACRE approved) Certification may be substituted for CDS and employment modules as it is a higher level of staff certification;

b. Additional 12 hours of Career Planning and Discovery provided through Maine’s Workforce Development System ([www.employmentformewds.org](http://www.employmentformewds.org)) for either the Direct Support Professional or the Employment Specialist;

c. An additional 6 hours annually of DHHS approved continuing education;

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

K. A DSP who provides Employment Specialist Services must hold a Certificate of completion of State of Maine Employment Curriculum for Employment Support Personnel and successfully complete Maine's "Direct Support Professional Curriculum" or the "Maine College of Direct Support" program and additional employment modules;

a. Employment Specialist National (ACRE approved) Certification may be substituted for CDS and employment modules as it is a higher level of staff certification;

L. A DSP who provides Crisis Intervention Services must have behavioral intervention training on approved behavioral interventions procedures (e.g., MANDT);

M. All new staff or subcontractors must complete the Maine College of Direct Support within six (6) months of actual employment, calculated from their date of hire. 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;

N. A person who provides Direct Support must be a DSP regardless of his or her status as an employee or subcontractor of an agency; and

O. A DSP can supervise another DSP.

 **21.10-2 Assistive Technology Assessment**: In order to provide an Assistive Technology Assessment, an enrolled provider must possess the following qualifications (Either A or B).

1. **License Requirements**
	1. Occupational Therapist or;
	2. Speech Pathologist

 Or

1. **Certificate Requirements**

A Direct Support Professional (DSP) must be certified as a:

* 1. Rehabilitation Engineering Technologist (RET) or;
	2. Assistive Technology Professional (ATP) from the Rehabilitation Engineering and Assistive Technology Society of North American (RESNA).

**21.10-3** A **Crisis Assessment Team** is a team of clinicians convened to provide Crisis Assessment Services. The team may include, but is not limited to, any or all of the following, if licensed or certified to practice within their profession:

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

1. Neuropsychiatrist or psychiatrist, who has worked with persons with developmental disabilities as a primary part of their practice;
2. Psychologist or behaviorist who has worked with persons with developmental disabilities as a primary part of their practice;
3. Clinic liaison person, having a bachelor’s degree or a nursing degree; direct experience with persons with developmental disabilities; and extensive experiences that provide a working knowledge of medical, psychiatric, and behavioral perspectives;
4. General medical practitioner;
5. Occupational therapist;
6. Physical therapist; or
7. Speech therapist.

 **21.10-4** An **Employment Specialist** is a person who provides Employment Services or Work Support and has:

1. Successfully completed an Employment Specialist Certification program as approved by DHHS within six months of date of hire; approved courses are listed at: <http://www.employmentforme.org/providers/crp-training.html>
2. Supervision during the first six months of hire from a Certified Employment Specialist;
3. Received certification as an Employment Specialist or completed the approved Direct Support Curriculum along with additional modules specific to employment;
4. Graduated from high school or acquired a GED;
5. Had a background check consistent with Section 21.10-10; and
6. Worked for a minimum of one (1) year with a person or persons having an Intellectual Disability or Autism Spectrum Disorder in a work setting.
7. An Employment Specialist who also provides Career Planning must have completed the additional twelve (12) hours of Career Planning and Discovery provided through Maine’s Workforce Development System and six (6) hours of Department approved continued education every twelve (12) months.

 **21.10-5 Phase-Out of Family-Centered Support**

DHHS is discontinuing the Family-Centered Support service. If a bed becomes vacant in a Family-Centered Support home, that vacancy may be filled.

Existing Family-Centered Support providers must meet all the requirements of a Direct Support Professional as set forth in these rules.

Effective with this rule, no new licenses or license transfers for Family-Centered Support homes will be approved.

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

Providers of Family-Centered Support shall not transfer, in whole or in part, ownership, management, or responsibility for day-to-day operations of the Family-Centered Support home to another individual or entity. DHHS will not authorize Family-Centered Support services under a new license.

 **21.10-6 Residential Vacancies in Two-Person Homes**

1. On the next business day, from the time of vacancy, the provider shall provide notice of the vacancy to the responsible OADS Resource Coordinator and the Case Managers for both the departing and remaining Members.
2. No later than three (3) business days from the time of vacancy, the provider shall submit a new proposed staffing pattern for the home that adjusts for the vacancy and is sufficient to maintain the remaining Member’s safety.
3. If the vacancy is the result of hospitalization, the provider may hold the vacant bed for the hospitalized Member for a period of thirty (30) calendar days. If, after thirty calendar days, there is no imminent plan for the

hospitalized Member to return to his or her home, the provider shall issue a thirty-day (30) discharge notice to the hospitalized Member, his or her guardian, and DHHS and proceed with the steps below.

1. If the provider determines that the remaining Member cannot be safely served in the current residence with a new housemate, the provider shall issue a thirty-day discharge notice to the remaining Member and DHHS within five (5) business days of the vacancy (or, where the

vacancy results from hospitalization, from the passage of thirty days from the time of hospitalization).

1. If the provider determines that the remaining Member can be safely served in the current residence with a new housemate, the provider and DHHS shall attempt to identify another Member to fill the vacancy.
2. **Ninety-Day Letter:** If no suitable candidate to fill the vacancy has been found after ninety calendar days from the date of vacancy (or, where the vacancy results from hospitalization, from the passage of thirty days from the time of hospitalization), the provider shall send a letter to the remaining Member and his or her guardian, where applicable, stating that no suitable housemate has been located and that the Member should consider looking for other residential options within or outside the provider agency. The letter shall state clearly that, should the provider be unable to fill the vacancy within thirty (30) days of the letter, the provider will issue a thirty-day discharge notice.
3. **Thirty-Day Discharge Notice:** If no suitable candidate to fill the vacancy has been found after thirty (30) calendar days from the mailing

2**1.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

of the ninety-day (90)letter, the provider shall issue a thirty-day (30) discharge notice to the Member, his or her guardian, where applicable, and DHHS. The provider shall cooperate with the Member’s planning team in developing a transition plan for the Member to move to other housing, whether permanent or interim, within thirty (30) days.

Should the provider fail to meet the obligations set forth above, DHHS may suspend reimbursement to the provider for the remaining Member’s Home Support.

 **21.10-7 Shared Living (Foster Care, Adult)**

 The Shared Living Provider must be a Certified Direct Support Professional (DSP) who has met all the requirements to provide this service. The Shared Living Provider must enter into a contractual relationship with the Administrative Oversight Agency in order to provide services to a Member. The agency supports the provider in fulfilling the requirements and obligations agreed upon by the DHHS, the Administrative Oversight Agency, and the Member’s Planning Team as documented in the Member’s Person-Centered Service Plan.

 **21.10-8 Additional Requirement of MaineCare Provider Participation**

All Section 21 Providers must comply with all applicable federal and state law, including applicable Maine licensing laws and regulations. Chapter I, Section 1 of the *MaineCare Benefits Manual* requires that MaineCare providers must maintain current licenses, as applicable, and must submit copies of license renewals to the OMS Provider Enrollment Unit.

 **21.10-9 Electronic Visit Verification (EVV)**

 Every provider of Home Support-Quarter Hour services must comply with Maine DHHS Electronic Visit Verification (“EVV”) system standards and requirements. In compliance with Section 12006 of the 21st Century CURES Act (P.L. 114-255), as codified in 42 U.S.C. §1396b(l)(1), visits conducted as part of such services must be electronically verified with respect to: the type of service performed; the individual receiving the service; the date of the service; the location of the service delivery; the individual providing the service; and the time the service begins and ends. Providers may utilize the Maine DHHS EVV system at no cost, or may procure and utilize their own EVV system, so long as data from their own or a third party EVV system can be accepted and integrated with the Maine DHHS EVV system.

 **21.10-10 Background Check Criteria**

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

 The provider must conduct background checks every two (2) years on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who maybe providing Direct Support Services under this Section. A background check is required for any adult who may be providing direct or indirect services where the Member receives Shared Living or Family-Centered Support. Background checks are required for any adult residing in a Family-Centered or Shared Living Home. 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;

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;

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

E. a habitual offender status under 29-A M.R.S. §2551-A.

 The provider shall contact child and adult protective services (including OADS and the Office of Child and Family 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. All staff and all adults residing with a Member must have all background checks completed. All background checks must be completed every twenty-four (24) months thereafter. Costs for background checks are the provider’s responsibility.

 **21.10-11 Emergency Intervention and Behavioral Treatment**

 A provider must follow DHHS’s rule governing emergency intervention and behavioral treatment for persons with Intellectual Disabilities (14-197 C.M.R. ch. 5), and training on approved behavioral interventions procedures (e.g., Mandt) if applicable and indicated as a need in the Member’s PCSP.

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

 **21.10-12 Informed Consent Policy**

 Providers must put in place and implement an informed consent policy approved by DHHS. For the purposes of this requirement, informed consent means consent obtained in writing from a person or the person's legally authorized representative for a specific treatment, intervention or service, following disclosure of information adequate to assist the person in making the consent. Such information may include the diagnosis, the nature and purpose of the procedure(s) or service(s) for which consent is sought, all material risks and consequences of the procedure(s) or service(s), an assessment of the likelihood that the procedure(s) or service(s) will accomplish the desired objective(s), any reasonably feasible alternatives for treatment, with the same supporting information as is required regarding the proposed procedure(s) or service(s), and the prognosis if no treatment is provided. At a minimum, a provider’s informed consent policy must ensure that Members served by the provider (and their guardians, where applicable) are informed of the risks and benefits of services and the right to refuse or change services or providers.

 **21.10-13 Rights, Reportable Events, and Behavioral Support Training**

 Providers shall comply with all terms and conditions as described in:

 a. Reportable Events System (14-197 C.M.R. ch. 12); and

 b. Adult Protective Services System (10-149 C.M.R. ch. 1); and

 c. Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine (14-197 C.M.R. ch. 5); and

d. Rights and Basic Protections of a Person with an Intellectual Disability or Autism (34-B M.R.S. §5605).

 As such, providers will ensure that staff members receive Department-sponsored training regarding all the regulations listed above (items a. through d.). Ideally, newly hired staff will receive training in advance of working with any Member or, at the latest, within six (6) months of being hired and every thirty-six (36) months thereafter. Providers will maintain documentation of all training within individual personnel files, regardless of the staff member’s length of employment.

**21.10-14 Plan of Corrective Action (POCA)**

A. Notice of Deficiency: The Department may issue a written notice of deficiency to a provider. The Notice of Deficiency will describe each deficiency with specificity, and will identify any regulation (including Ch. II, Sec. 21 Appendix V), policy, or statutory requirement with which the Department alleges the provider is not in compliance. The Notice of Deficiency may state that the provider is required to submit a Plan of Corrective Action to the Department, as described below.

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

B. Plan of Corrective Action (POCA): Within 30 days after receiving notification of any deficiency, including a deficiency with respect to the requirements of Appendix V, a provider must submit a Plan of Corrective Action (POCA) for approval by the Department. The Department will approve, reject, or suggest changes to, the POCA, in writing. If the Department rejects a POCA, the written notice of rejection will explain the reason(s) why the POCA is being rejected, and may suggest changes to the POCA.

C. The POCA must meet the following requirements:

(1) The POCA must be a specific plan which describes how the deficient circumstance(s) (event, incident, or risk) will be corrected, including the actions which will be taken to bring about correction.

(2) The POCA must address correction of the specific deficient circumstance(s) cited. In those instances where the deficiency resulted from a previously missed time frame, the plan must include an immediate correction of the deficient circumstance(s) even though the required time frame has been missed.

(3) The POCA must address all identified areas where the correction of all related deficient circumstances would be implemented as specific deficiencies cited may not represent all instances within the site/service where the practice is deficient. It is, therefore, the provider’s responsibility to identify and correct the deficiency throughout the site/service.

(4) The POCA must identify actions steps to prevent the deficient circumstance(s) from recurring/occurring. When monitoring systems are to be implemented, the plan will include the type of monitoring, detail for implementation, as well as the responsible party/entity.

(5) The POCA must clearly delineate the frequency each element of the plan is to occur. Such terms as “frequently,” “periodically,” “as needed” and “ongoing” lack the necessary specificity to be acceptable.

(6) The POCA must identify by title the individual(s) responsible for the implementation and monitoring of the plan. The individuals identified must be employed by the provider.

(7) The POCA must provide date(s), to run from the date of Department approval of the POCA, by which all components of the plan will be

**21.10 PROVIDER QUALIFICATIONS AND REQUIREMENTS** (cont.)

implemented, and the corrections completed. The length of time to correct the deficiency specified by the POCA must be as soon as possible.

(8) The POCA should not duplicate or closely parallel a previously submitted failed plan.

D. Notice of Corrections: When the provider has successfully completed and complied with the POCA, the agency will issue written notice to the Department. The Notice of Correction document will address each deficiency that was listed in the Notice of Deficiency, and explain, in writing, how the provider complied with the POCA to resolve each deficiency.

Provider Appeals: Providers can appeal a Notice of Deficiency within 60 days of receipt of the Notice.

**21.11 MEMBER APPEALS**

In accordance with Chapter I of the *MaineCare Benefits Manual*, Members have the right to appeal in writing or orally any decision made by DHHS to reduce, deny or terminate services provided under this benefit. In addition, Members have the right to appeal decisions made regarding priority level and waitlist determinations. 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: 711.

Office of Aging and Disability Services

 Department of Health and Human Services

 11 State House Station

 Augusta, ME 04333-0011

**21.12 REIMBURSEMENT**

A. Reimbursement methodology for covered services shall be the amount listed in Chapter III, Section 21, Allowances for Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder or the provider’s usual and customary charge, whichever is lower.

B. Compliance to the authorization is determined if the average of actual delivered services fall within the range established for that setting or Member. If the average falls within the range, then billing at the approved level is authorized. If the average falls below the pre-set level, then billing must reflect the lower level of service provided.

**21.12 REIMBURSEMENT** (cont.)

 C. In accordance with Chapter I, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing MaineCare. Therefore, a service provider under this benefit is expected to seek payment from sources other than MaineCare that may be available to the Member.

 D. Providers of Community Support Services and Work Support-Group services will not be reimbursed for any times the Member is away from the Provider’s setting, without being accompanied by a Provider staff member. The Provider must keep detailed and accurate accounting (by 15-minute increments) of when the Member is in the Provider setting, and receiving the service.

 E. Providers of Community Support Services and Work Support-Group will not charge additional reimbursement for any Visitors by the Member.

 F. 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.

**21.13 BILLING INSTRUCTIONS**

Providers must bill in accordance with DHHS's Billing Instructions.

**21.14 REQUESTS FOR EXCEPTIONS**

**21.14-1 General**

Members who receive services through this Benefit and Members applying to receive services through this Benefit may submit a Request for Exceptions. The purpose of submitting a Request for Exceptions is to ensure that Members receive adequate and appropriate services and supports in the most integrated setting appropriate to their needs, consistent with Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131-12134, and consistent with Section 21 health and safety requirements. To achieve that outcome, Members may submit a Request for Exceptions to seek services in excess of otherwise-applicable Section 21 waiver monetary and/or unit caps. Members or their Representatives may seek Exceptions by submitting a written request.

Filing a Request for Exceptions is neither a waiver of nor a substitute for the Member’s right to an administrative hearing on an appeal under Chapter I, Section 1; to file a grievance under 14-197 C.M.R. ch. 8; or to file a complaint pursuant to

34-B M.R.S. §5611.

**21.14 REQUESTS FOR EXCEPTIONS** (cont.)

**21.14-2 Applications**

A. Requests for Exceptions must be submitted in writing on a form provided by the Department by the Member, the Member’s Representative, or the Member’s Case Manager.

B. For those Members seeking an Exception when applying to receive Section 21 services, the Member, the Member’s Representative, or the Member’s Case Manager shall submit the Request for Exceptions with the materials required under the Section 21 regulation for a determination of the Member’s medical eligibility for Section 21 services. A Member must satisfy all Section 21 eligibility requirements, including wait list priorities, if applicable, and obtain a funded offer of Section 21 services prior to the Department’s consideration of a Request for Exceptions.

C. For those Members who have received a funded offer of Section 21 services or are already receiving Section 21 Services, Requests for Exceptions shall be submitted to the Department via email to HCBSwaiverexceptions.DHHS@maine.gov, or via US Mail to the Clinical Review Team at the Office of Aging and Disability Services, 11 State House Station, Augusta ME 04333. The Department will acknowledge receipt of a Request for Exceptions from a Section 21 Member within five (5) business days.

D. The Member bears the burden of establishing that the Member needs an Exception to: (i) ensure the Member receives adequate and appropriate services and supports in the most integrated setting appropriate to their needs and to avoid

an undue risk of segregation in an institution; and (ii) that natural supports are not available to meet the needs the Exceptions are intended to address.

E. A Request for Exceptions shall include the following information when known to the Member:

1. The name, address, telephone number, email address, and MaineCare number of the Member and the name, address, telephone number, and email address, of the person who submitted the Request for the Member, if applicable;

2. The specific provision(s) in MBM Chapters II or III, Section 21 from which an Exception is requested;

3. The specific Exception(s) requested, the proposed level of service that would result from approval of the Request for Exceptions, and the anticipated duration of the proposed Exception(s);

**21.14 REQUESTS FOR EXCEPTIONS** (cont.)

4. Any relevant facts;

5. A history of the Department’s action on the issue including prior communications with the Department on this issue, if applicable;

6. The name, address, and telephone number of any person inside or outside the Department with knowledge of the matter with respect to which the Exception is requested; and

7. Signed releases of information authorizing persons with relevant knowledge or records to furnish the Department with information pertaining to the request, if desired.

**21.14-3 Department Review and Decision**

A. The Department may ask for additional information from the Member. The Member has ten (10) business days from the date of the request to submit additional documents or information. The Department may deny a Request for Exceptions if the Member refuses or fails to provide documents or information requested by the Department.

B. The Department shall apply some or all of the Criteria set forth below in §21.14-4 and issue a written decision (“Decision”) on the Request for Exceptions within

sixty (60) days of receipt of all materials submitted by the Member or requested by the Department.

C. The Department may deny a Member’s Request for Exceptions if the Department

has previously denied a substantially similar Request for Exceptions from the Member, or if the Member has previously been denied a reasonable modification under the Americans with Disabilities Act for a substantially similar request, unless new information is available regarding the Member’s need for the requested Exception.

D. The Department’s Decision shall state:

1. The name of the Member on whose behalf the Request for Exceptions was made, and the Exceptions sought;

2. A list of documents reviewed, and a summary of other information obtained to review the Request for Exceptions;

3. Whether the Department has granted, granted in part, or denied the Request for Exceptions;

**21.14 REQUESTS FOR EXCEPTIONS** (cont.)

4. Alternative services or Exceptions offered to the Member;

5. The nature of any Exceptions granted to the Member, their duration, any conditions, and the reasons for the imposition of any limits on the duration of or conditions for the Exceptions;

6. The reasons for the Department’s Decision; and

7. Notice of the Member’s appeal rights.

E. All Exceptions are subject to Utilization Review.

F. All Exceptions must be written into the Member’s Person-Centered Service Plan.

**21.14-4 Criteria for Decisions**

A. The Department, or its Authorized Entity, can only approve a Request for Exceptions if the Member has demonstrated all of the below criteria:

1. The requested service is a Covered Service;

2. The Member reasonably requires the Exception to receive services in the

community, or failure to grant the Exception will place the Member at serious risk of institutionalization or segregation;

3. The Member lacks natural supports to meet the needs that the requested Exception is intended to address;

4. The need for Exception could not be met with other services or combination of services available in the *MaineCare Benefits Manual*; and

5. The Exception will ensure the Member’s needs will be met in the most integrated setting appropriate to their needs.

B. The Department may deny a Request for Exceptions (even if the Member demonstrates the Member needs the Exception to live in the most integrated setting appropriate to the Member’s needs) if the Department determines that any or all of the below applies:

1. The Member’s proposed community placement is not appropriate;

2. The Member’s health and safety cannot be assured in the community even if the Exception is granted; or

**21.14 REQUESTS FOR EXCEPTIONS** (cont.)

3. The Exception, if granted, would fundamentally alter this Benefit.

**21.14-5 Duration; Re-Assessment**

A. The Member’s Case Manager, the Member, or the Member’s Representative shall note approved Exception(s) and their duration in the Member’s Person-Centered Service Plan.

B. Exceptions granted to a Member under this section shall expire as set forth in the Decision.

C. At least sixty (60) days prior to the expiration of an Exception, if the Member wishes to renew the Exception, the Member, the Member’s Representative, or the Member’s Case Manager shall submit a request to renew the Exception in conformance with §21.11-2. The Department will evaluate the request to renew the Exception applying the criteria set forth in §21.11-4.

**21.14-6 Appeals**

A Member may appeal the Department's Decision on a Request for Exceptions, or a request to renew an Exception, through the Department's MaineCare appeals process pursuant to Chapter I, Section 1, within sixty (60) calendar days.

**21.15 APPENDIX I- Shared Living and Family-Centered Per Diem Criteria for increased level of support.**

 The Standard support level is an all-inclusive reimbursement for Services defined in 21.05. At times, a Member may require increased levels of staff support due to more intensive needs. Increased level of support is not to be used for respite or in substitute for the Shared Living Provider. It is to be used in addition to the Shared Living Provider to ensure the Member’s safety. DHHS may authorize an increased level of support for the purposes of additional staff for those Members who have current and documented challenging behavioral issues or high medical and safety needs. The Clinical Review Team (CRT) reviews all increased level of support requests. The CRT will use the following criteria to determine when this increased level of reimbursement to support the additional staff is utilized.

 To qualify for the increased level of support a Member must have an extraordinary need listed in at least one of the categories below

1) **Behavioral Issues**-Members with behavioral issues and/or behavioral health challenges that significantly raise health and safety concern may have increased levels of support authorized to assist with Behavioral issues. These may include high risk behavior such as a history of sexual offense, aggression to self or others, or criminal behavior. The planning team must identify a behavioral need that requires an increased level of support and is documented in the Member’s record. The Person-Centered Service Plan will outline specific activities and desired outcomes of the service being provided and those activities must be separately documented in the Member’s record.

2) **Medical Support**- Members that require support over and beyond routine services such as ventilators, nebulizers, diabetes management-insulin dependent, suctioning, seizure management-uncontrolled, chronic eating disorders, or persons with co-existing conditions that significantly affect physical movement and require near total physical assistance on a daily basis may have an increased level of support authorized to assist with medical issues. The Person-Centered Service Plan will outline specific activities and desired outcomes of the service being provided and those activities must be separately documented in the Member’s record.

 For Behavioral issues and Medical Support there must be a written recommendation, less than three months old, from a Physician, Physician Assistant, Psychologist or Psychiatrist which must specify:

1) The specific illness or condition to be addressed that requires increased support;

2) The manner in which increased support will be utilized;

3) The expected duration of the increased support. If the increased support is expected to be needed for an indefinite period of time then this expectation should be specified;

4) The anticipated frequency of the increased support on a daily, weekly, or monthly basis and

**21.15 APPENDIX I- Shared Living and Family-Centered Per Diem Criteria for increased level of support** (cont.)

5) Whether the setting where the Member is served is appropriate to carry out the physician’s recommended treatment or intervention.

 **Process of Application for the increased level of service**:

 The Provider must complete the Home Support Frequency tool provided by DHHS that will summarize the support needs of the Member and submit the tool along with identified materials to the Case Manager. The Home Support Frequency tool can found at this website,

 <https://www.maine.gov/dhhs/oads/providers/adults-with-intellectual-disability-and-autism>

 The Case Manager will be responsible for reviewing the information provided, verifying that the Person-Centered Service Plan and all other information is most current.

 The CRT will review the information submitted with the request, the PCSP, information in the electronic records, such as reportable events, crisis notes and case management notes as well as any applicable assessments or evaluations of the Member. Increased support that is anticipated to be needed for an extended or indefinite period of time must be reviewed and approved at least annually by the CRT.

 The CRT will issue a written decision within twenty (20) working days of receipt of all required documentation. If additional information is required, a written request will be issued to the Case Manager by the CRT. Upon receipt of the additional information, the CRT will approve or deny the request in writing within ten (10) working days.

**21.16 APPENDIX II- Guidelines for Approval of Medical Add-On in Maine Rate Setting**

The purpose of this Appendix is to detail guidelines for the Office of Aging and Disability Services 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 DHHS’ established published rate for Home Support, Community Support, Employment Specialist Services and Work Support Services-Individual.

The Clinical Review Team (CRT) is the entity within OADS that is responsible for review and approval, of all Medical Add-On rate increases for services under this section.

The rate supports Members with intermittent or longer duration medical conditions; changes or needs that may support Medical Add-On include but are not limited to: support over and beyond routine services such as ventilators, nebulizers, diabetes management-insulin dependent, suctioning, seizure management-uncontrolled, chronic eating disorders, or persons with co-existing conditions that significantly affect physical movement and require near total physical assistance on a daily basis. Conditions related to surgeries, procedures, injuries and other short-term conditions are also considered for the Medical Add-On rate increase.

The following standards and practices must be demonstrated in order for the CRT to approve a Medical Add-On:

A. **Physician Order**

 1. There must be a written physician’s or physician assistant order, less than three (3) months old, 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.

**21.16 APPENDIX II- Guidelines for Approval of Medical Add-On in Maine Rate Setting** (cont.)

B. **Planning Team**

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

a. To review and complete the request for Medical Add-On and any additional documentation required for submission to the CRT.

b. To determine whether the setting where the Member is served is appropriate to carry out the physician or physician assistant’s recommended treatment or intervention;

c. To determine how the Member’s needs shall be met and what the staffing requirements are

2. All of these determinations and recommendations must be noted in the plan.

C. **Provider Requirements**

1. The provider must be an enrolled MaineCare provider.

2. For any physician or physician assistant 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 CRT will review the information submitted with the request, the PCSP, information in the electronic record, such as reportable events, crisis notes, as well as any applicable assessments or evaluations in the Member’s record.

2. The CRT 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 the CRT will approve or deny the request within ten (10) working days.

3. Approvals will include a specification of the duration of the Medical Add-On, as well as authorized daily or weekly units of service which require the Medical Add-On.

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

**21.17 APPENDIX III- On Behalf Of** **Covered Activities**

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.

***Hours that may be claimed as being***

Examples of acceptable activities include:

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

Services, activities and time that are directly related to a Member that are associated with that Member’s Person-Centered Service Plan, medical plan or behavioral plan including in-service training specific to a Member’s plan of support, consultations with supervisors, therapist, clinicians, Member’s employer and or medical staff; activities relating to a Member’s parent, guardian or Maine Developmental Services Oversight and Advisory Board (MDSOAB) representative; documentation, reports and presentations to review committees.

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

Services, activities 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.

Documentation detail must clearly identify and support periods of such activity.

### On Behalf Of Non-Covered Activities

Services, activities and time that are related to group activities and/or services, activities or time that cannot be directly linked to Member’s Person-Centered Service Plan. For example, grocery shopping for a home.

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

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

**21.17 APPENDIX III - On Behalf Of** **Covered Activities** (cont.)

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

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

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

Services, activities 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.

**21.18 APPENDIX V- Additional Requirements for Section 21 Providers of Home Support Services, Shared Living, Community Support Services and Employment Specialist Services**

Providers must first be approved by OADS and subsequently enroll in MaineCare in order to provide services and be reimbursed under this Benefit.

Prior to approval and thereafter, the provider, any contractor or subcontractor of the provider, or other individuals compensated by the provider for assisting in the care of Member (s) shall be subjected to site visits and interviews to ensure compliance with federal and state laws and regulations and the operational, health, safety and environmental requirements set forth herein. The provider shall permit OADS representative(s) to visit the Member and the Member’s home and program as often as DHHS deems necessary to assure quality services, including unscheduled visits.

The provider must submit the following to the OADS District Resource Coordinator:

1. **Application Form**. Initial applications shall be submitted using DHHS forms to the OADS District Resource Coordinator. The initial application shall be signed and dated by the provider owner and the presiding officer of the Governing Body, if applicable.
2. The initial application shall be accompanied by documents described in this section of rule demonstrating compliance with requirements described in the following portions of these rules:
3. **Organizational Structure**
	1. **Ownership**
		1. **Authority**. The provider shall maintain documented evidence of its source(s) of authority to provide services. Such evidence will include articles of incorporation, corporate charter, or similar documents.
		2. **Records**. Corporations, partnerships, or associations shall maintain records of the contact information for officers, directors, charters, partnership agreements, constitutions, articles of association and/or by-laws, as applicable.
	2. **Capacity**
		1. **Professional Qualifications**. The provider shall have written job descriptions for all positions within the agency. The provider shall acquire and retain evidence to demonstrate that all persons engaged in the provision of services regulated by the State of Maine, other applicable government entities, professional associations or similar bodies are appropriately qualified, certified, and/or licensed.

**21.18 APPENDIX V- Additional Requirements for Section 21 Providers of Home Support Services, Shared Living, Community Support Services and Employment Specialist Services** (cont.)

* + - 1. The management shall have related experience demonstrating competency and experience in the health or human service setting and remain in good standing of licensure or certification
			2. Supervisors of Home Support Services, Employment Specialist Services, or Community Support Services shall be required to meet all of the requirements of the DSP position.
			3. Copies of contracts or service agreements. When the provider manages services delivered by another provider, a documented cooperative, affiliated service, or subcontracting agreement shall exist. This agreement shall be updated and renewed at least annually. The provider shall ensure that services provided through an affiliation agreement or subcontract complies with these rules and any contractual requirements.
	1. **Organization Chart**
		1. The provider will outline the business structure in an organizational chart, identifying management, staff and other individuals compensated by the provider for assisting in the care of Member (s) and illustrating the supervisory responsibilities; include credentials as required for the service delivery.
1. **Personnel Management**
	1. **General Orientation Program**. The provider shall have a written orientation program that is relevant to the organization as a whole and provided to all new employees, interns, and volunteers. This orientation shall include, but be not limited to:
		1. an overview of the service delivery system as a whole, including the availability of peer and family supports and other elements of services;
		2. the provider's mission, philosophy, clinical services, and therapeutic modalities, policies, and procedures
		3. Member’s right to privacy and confidentiality
		4. safety and emergency procedures general to the provider;
	2. **Position-Specific Orientation and Training**. The provider shall have personnel policies that include a description of the education, experience, and training required for Direct Support Professionals, Supervisors, and Program Directors.
		1. The policy shall address any provider requirement for a valid driver’s license, personal insurance limitations, computer proficiency, and any specific training specified by the provider and include a component specific to monitoring continued

**21.18 APPENDIX V- Additional Requirements for Section 21 Providers of Home Support Services, Shared Living, Community Support Services and Employment Specialist Services** (cont.)

compliance. The policy should note any requirement that the DSP will receive additional training specific to Member(s) needs as addressed in the Person-Centered Service Plan.

* + 1. The provider shall provide to all employees, interns, and volunteers, orientation specific to the duties and responsibility for which they were retained or accepted, and ensure

the appropriate certification and training requirements specified in this rule and applicable governing regulations which includes but is not limited to the following:

* + - 1. Medication Administration Training required for all DSPs who assist Members with over-the-counter and prescribed medication
			2. Cultural competence training relevant to the populations served, including: age, gender, race, religion, culture, and sexual orientation.
			3. MaineCare Global HCBS Waiver Person-Centered Planning and Settings Rule, *MaineCare Benefits Manual*, Chapter I, Section 6.
1. **Operational Policies and Procedures**
	1. **General Policies**. The provider shall maintain policies governing essential elements of service provision. Policies include and are not limited to:
2. **Behavioral Regulations**. The provider shall comply and ensure that all staff and other individuals compensated for assisting in the care of Member (s) comply with the DHHS’ Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine, (14-197 CMR Ch. 5.)
3. **Rights and Protection**. The provider shall comply and ensure that all staff and other individuals compensated for assisting in the care of Member (s) comply with 34-B M.R.S.A. §5605, Rights and Basic Protections of a Person with an Intellectual Disability or Autism.
4. **Reports of Abuse, Neglect or Exploitation**. The provider shall maintain a specific policy and procedure governing the reporting, recording and review of allegations of abuse, neglect, or exploitation of persons receiving services, in accordance with applicable laws, rules, and regulations, including but not necessarily limited to the Adult Protective Statute. The provider shall comply and shall ensure that all staff and other individuals compensated by the provider for assisting in the care of Member (s) comply with DHHS’ rule governing Behavioral Support, Modification and Management for people with intellectual disabilities or Autism. (14-197 CMR Ch. 12, Regulations Regarding Reportable Events, Adult Protective Investigations and Substantiation Hearings Regarding Persons with Intellectual Disabilities or Autism), and state law on reportable events and reports of abuse, neglect, and exploitation (22 MRSA §3477, Persons Mandated to Report Suspected Abuse, Neglect or Exploitation;

**21.18 APPENDIX V- Additional Requirements for Section 21 Providers of Home Support Services, Shared Living, Community Support Services and Employment Specialist Services** (cont.)

34-B M.R.S.A. §5604-A, Duty to Report Incidents; *Adult Protective* *Services Act and Rights Violations*; and 22 M.R.S.A. §3740, *et seq*., *Adult Protective Services Act*).

1. The provider shall maintain written policies and procedures and have reporting forms available at each site where Members are served to ensure compliance with the above mentioned laws and regulations governing Reportable Events, Rights and Basic Protections and Reporting of Abuse, Neglect and Exploitation.
2. **Duration of Care**. The provider shall maintain policies that outline the admission process, discharge procedures for planned or unplanned termination of services, the referral of individuals deemed inappropriate or not qualified for a particular program, to other programs to meet the individual's needs, and the mechanisms undertaken to eliminate wait lists or the justification for having no wait list.
3. **Medication Management**. The provider shall maintain specific policies and procedures ensuring that any staff and other individuals compensated for assisting in the care of Member (s) receive appropriate training in and comply with medication administration protocol that is in accordance with DHHS expectations.
4. **Quality Management**. The provider shall have written policies governing the development and maintenance of an effective quality management program to ensure quality service delivery consistent with federal and state laws and regulations. The program shall:
	1. identify areas determined by the provider to be critical to quality service provision.
	2. describe goals set by the provider to improve services or service delivery and shall describe indicators to measure achievement of the goals.
	3. include ongoing, year-round, regular activities to measure goal achievement.
	4. include a component describing the system to monitor compliance with federal and state laws and regulation
		1. **Evaluation**. The findings of the quality management process shall be reviewed at least annually by the provider.
		2. **Plan of Correction**. A finding of deficiency in violation of federal or state laws or regulations shall be reported to DHHS within a 30-day period and be accompanied by a Plan of Correction to be deemed acceptable by the DHHS.
5. **Financial Management**
	1. The provider shall make available to DHHS upon request, a federal income tax return for the year in question, a statement of finances including income statement, balance sheet, cash flow statement, operations and program budget, and profit projection.

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1. **Environment**
	1. **Fire and Safety Inspections**. Upon receipt of the completed application, fire and safety inspections may be conducted by authorized representatives of organized fire departments, by the State Fire Marshall's office and code enforcement officers.
		1. Fire drills shall be conducted and documented at least four times per year
		2. Emergency Management Plan shall address the event of loss of essential services such as electricity, water, and heat
2. **Insurance**. The provider shall insure and maintain a record of all homes in which Home Support Services are provided and have adequate homeowner/rental liability insurance and all vehicle and driver comply with all applicable Maine law including valid driver’s license, auto registration, inspection and automobile insurance coverage.
3. **Structures**. The provider shall meet current requirements of the *Americans with Disabilities Act of 1990*, the *Rehabilitation Act of 1973*, and the *Maine Human Rights Act*. New construction, renovation, remodeling or repair shall be in full compliance with the *Americans with Disabilities Act of 1990*, the *Rehabilitation Act of 1973*, and the *Maine Human Rights Act*. All structures used in the delivery of waiver services shall be maintained in good repair, free from danger to the Member’s health or safety and shall be appropriate to the services provided. The provider shall ensure that:
	* 1. furnishings and equipment are appropriate to the Member’s age and physical conditions,
		2. rooms and areas are clean, appropriately lit, and adequately heated and ventilated based on the needs of the Members,
		3. the square footage of rooms (i.e. bathrooms, bedroom, dining areas) are appropriate and adequate for the level of privacy, purpose of the space and to accommodate users,
		4. utilities are maintained in good repair and in a manner consistent with applicable codes,
		5. a storage area that shall provide secure space used for the proper storage of potentially harmful materials (i.e. chemicals, medications, and firearms).
4. **Integrated Settings**. The setting in which residential, Community Supports, and Employment Specialist Services are provided shall be integrated in and support full access to the greater community to the fullest extent and:

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* + 1. be one of choice and based on the needs of the individual as indicated in the Member’s Person-Centered Service Plan;
		2. ensure a Member’s rights of privacy, dignity and respect and freedom from coercion and restraint;
		3. support opportunities to promote competitive, integrated employment,
		4. support opportunities to seek employment in competitive integrated settings, engage in community life, control and optimize autonomy; and support their choice in activities and schedules, facilitate choice of services and providers, and access to services in the community.