

**10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER II**

**HOME AND COMMUNITY BENEFITS FOR MEMBERS
WITH MENTAL RETARDATION OR AUTISTIC DISORDER**

SECTION 21

**ESTABLISHED 11/1/83
LAST UPDATED 10/1/2008**

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21.01 INTRODUCTION

The Home and Community Based Benefit (HCB or Benefit) for members with Mental Retardation or Autistic Disorders 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 Persons with Mental Retardation (ICF/MR). The Benefit supplements, rather than replaces supportive, natural personal, family, work, and community relationships and complements. It does not duplicate other MaineCare services. This Home and Community Benefit for members with Mental Retardation or Autistic Disorder is not intended to replace Section 29, Community Support Benefits for members with Mental Retardation and Autistic Disorder.

The HCB Benefit is 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.

To be eligible for this Benefit, members must meet medical eligibility requirements and there must be a funded opening. In addition, the planning process includes identifying and documenting the member's needs in a Personal Plan. The Personal Plan describes certain habilitative, 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 it will provide the benefit to 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 those sections of Maine statute, regulation, DHHS policy or the community consent decree governing the person centered planning process including the process for identifying and addressing needs and desires of the member.

21.02 DEFINITIONS

- 21.02-1 Abuse/Neglect/Exploitation** 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.
- 21.02-2 Agency Home Support** means a facility that routinely employs direct care staff to provide direct support services in an agency operated facility.
- 21.02-3 Autistic Disorder** means the member has received a diagnosis that falls within the category of Pervasive Developmental Disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric

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21.02 DEFINITIONS (Cont.)

Association), and manifested during the developmental period, in accordance with the definition of autism codified in 34-B MRSA § 6002 and accompanying rules.

- 21.02-4 Behavioral Add On** is a component of Home Support, Community Support, Employment Specialist Services and Work Support 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. Documentation must clearly identify and support periods of such activity. Refer to Appendix I for more information.
- 21.02-5 Correspondent** is a person designated by the DHHS Consumer Advisory Board to act as an ally to a person who has no actively involved family or private guardian, as described in the Community Consent Decree.
- 21.02-6 Designated Representative** means the DHHS staff authorized by DHHS to perform specified functions.
- 21.02-7 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. Direct support activities are provided as Home Support, Community Support, Employment Specialist Services or Work Support. 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 performance of guiding, directing, or overseeing the performance of self-care and self-management of activities.

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

Self-management includes assistance with managing safe and responsible behavior; exercising judgment with respect to the member's health and well-being;

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

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

21.02-8 Employment Setting The following criteria determine whether an employment site is integrated. The job must be one that is available to a non-disabled employee with the same expectations for the member's job performance and attendance. The member works under similar work conditions as others without disabilities in similar positions; including access to lunchrooms, restrooms, and breaks. The member performs work duties with ongoing interaction with other workers without disabilities, and has contact with customers, suppliers and the public to the same degree as workers without disabilities in the same or comparable occupations. The member cannot be excluded from participation in company-wide events such as holiday parties, outings and social activities. The member must be on the employer's payroll. Members may receive additional employment supports from a provider agency. A member must be supervised in a manner identical to other employees. It is permissible, on a case by case basis to have the support agency offer and provide this supervision as long as the above conditions are met.

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- 21.02-9 Family-Centered Support** is a model designed to provide enhanced 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. Additionally, Family-Centered Support has an intensive model when the provider requires the assistance of other trained and approved staff to assist in habilitation and support offered to the member. No more Family Centered Support will be approved after this rule has been adopted.
- 21.02-10 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.
- 21.02-11 Individual Support Coordinator (ISC)** is a person responsible for assuring the timely convening of the service planning team, developing the Personal Plan, monitoring the planned services received by the member, and for insuring that those services meet the requirements set forth in the member's Personal Plan. This person may also be referred to as a case manager.
- 21.02-12 Medical Add On** is a component of Home Support, Community Support, Employment Specialist Services and Work Support 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. Documentation must clearly identify and support periods of such activity. Refer to Appendix II for more information.
- 21.02-13 Member** is a person determined to be eligible for MaineCare benefits by the Office of Integrated Access and Support (OIAS) in accordance with the eligibility standards published by the OIAS in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.
- 21.02-14 Mental Retardation** is a condition/disability that is manifested by: 1) significant sub-average intellectual functioning as measured on a standardized intelligence test; 2) significant deficits in adaptive behavior/functioning (e.g., daily living, communication and social skills); and 3) on-set during the developmental period of life (prior to age eighteen (18)).
- 21.02-15 On behalf Of** is 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

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21.02 DEFINITIONS (Cont.)

activity. Documentation detail must clearly identify and support periods of such activity. Refer to Appendix III for more information.

- 21.02-16 Personal Plan** is a member's plan developed at least annually that lists the services offered under the waiver benefit. The Personal Plan may also include services not covered by the waiver but identified by the member. Only services included on the Personal Plan are reimbursable. The Personal Plan may also be known as a person centered plan, a service plan, an individual support plan, or an individual education plan, as long as the requirements of Section 21.04-2 are met.
- 21.02-17 Qualified Mental Retardation Professional (QMRP)** is a person who has at least one year of experience working directly with persons with mental retardation 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 42 Code of Federal Regulations (CFR) 483.430, paragraph B5.
- 21.02-18 Qualified Vendor** is a provider approved by DHHS to provide waiver services to eligible members receiving services under this Section. DHHS requires agencies to provide high quality services that, at a minimum, meet the expectations of the members who utilize those services. DHHS may authorize agencies to provide services under this Section after an application, along with supporting documentation, has been submitted to a Designated Representative for review and approval. The Designated Representative will authorize only agencies that meet DHHS expectations in the areas of organization and operation, operation of individual programs or services, personnel administration, environment and safety, and quality management. Only Qualified Vendors will receive DHHS referrals and authorizations for reimbursement.
- 21.02-19 Shared Living** is a model in which Home Support services are provided to a member by a person who meets all of the requirements of a Direct Support Professional with whom that member also shares a home. The home may belong to the provider or the member, but the provider must enter into a contractual relationship with an agency in order to provide Home Support services under this model. Only one member may receive Home Support services in any one Shared Living arrangement at the same time, unless a relationship is established prior to the service arrangement and approved by DHHS. In such case, no more than two members may be served in any one Shared Living arrangement concurrently.

DHHS refers a member to an agency for the provision of Home Support in a Shared Living arrangement when that need is identified in the Personal Plan. The Direct Support Professional must enter into a contractual relationship with the agency in order to provide Home Support services in a Shared Living arrangement. The agency supports the provider in fulfilling the requirements and obligations agreed upon by the DHHS, the agency and the Personal Plan.

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21.02 DEFINITIONS (Cont.)

21.02-20 Shared Living Provider is a provider who subcontracts with an agency to provide direct support to a member, with whom they share a home.

21.02-21 Summary of Authorized Services (SAS) is a list of the medically necessary services identified through the planning process that the parties signing the Personal Plan have agreed will meet the habilitation needs of the member. The SAS shall identify the nature and timing of the services as identified in the member's Personal Plan, including the MaineCare rates for each service. A DHHS Designated Representative shall sign (electronic or original) and date the SAS as a means to authorize payment for services provided. The Personal Plan may contain service needs that the member may pursue, but which are not covered by MaineCare, and are, therefore, not reflected on the SAS for HCB services. The SAS is a component of the Personal Plan. The SAS was formerly known as the CHECKLIST.

21.03 INITIAL CLASSIFICATION

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

21.03-1 Funded Opening

The number of MaineCare members that can receive services under this Section is limited to the number, or "funded openings," approved by the Centers for Medicare and Medicaid Services (CMS). Persons who would otherwise be eligible for services under this Section are not eligible to receive services if all of the funded openings are filled.

21.03-2 Reserved Capacity

The DHHS reserves a portion of the participant capacity of the waiver for specified purposes subject to CMS review and approval 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/MR or other institutional setting.

The number reserved associated with Section 21.03-2 above is an average based on the DHHS's data for those in need of adult protective services in recent years. The number reserved for ICF/MR or other institutional residents is based on currently known referrals.

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21.03 INITIAL CLASSIFICATION (Cont.)

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 (members younger than age 18 and already receiving services under this Section as of the effective date of this rule may continue to receive benefits under this Section); and
- B. Has Mental Retardation or Autistic Disorder; and
- C. Meets the medical eligibility criteria for admission to an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) as set forth under the MaineCare Benefits Manual, Chapter II, Section 50; and
- D. Does not receive services under any other federally approved MaineCare home and community based waiver program; and
- E. Meets all MaineCare eligibility requirements as set forth in the MaineCare Eligibility Manual.

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 referral form (BMS99); and
- B. A copy of the member's Personal Plan approved and signed by the member or guardian and the case manager and any other relevant material indicating the member's service needs.

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

DHHS shall notify each member or the member's guardian in writing of any decision regarding the member's medical eligibility, and the availability of benefit openings under this Section. The notice will include information about the member's right to appeal any of these decisions. Rights for notice and appeal are further described in Chapter I of the MaineCare Benefits Manual.

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21.03 INITIAL CLASSIFICATION (Cont.)

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

21.03-5 Priority

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

- A. **Priority 1:** Any member on the waiting list shall be identified as Priority 1 if the member has been determined by DHHS to be in need of adult protective services in accordance with 22 M.R.S.A. §3473 *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.

- B. **Priority 2:** Any member on the waiting list shall be identified as Priority 2 if the member has been determined to be at risk for abuse 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:
 - 1. a member whose parents have reached age sixty (60) and are 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 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;

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21.03 INITIAL CLASSIFICATION (Cont.)

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.

21.03-6 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, a planning team meeting for each member shall be held to redetermine that member's current services needs and to redevelop a current member service plan that incorporates a signed services agreement. Upon receipt of information from DHHS concerning all members within the same priority group who continue to meet financial and medical eligibility criteria and for whom current service plans have been redeveloped, DHHS shall determine which members to serve. The determination will be based on a comparison of the members' known needs, the availability of capable service providers who can adequately meet those needs, and the comparative degree of risk of abuse that each member will likely experience in the absence of the provision of the benefit.

21.03-7 Waiting List

DHHS will maintain a waiting list of eligible MaineCare members who cannot get 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.

21.03-8 Reclassification

For reclassification purposes, the case manager will submit an updated Assessment Referral Form (BMS 99) to DHHS twelve (12) months from the date of initial approval, and every twelve (12) months thereafter. The Summary of Authorized Services will be updated annually during reclassification, when the assessment referral form is submitted. If the updated Assessment Referral Form is received after the due date, reimbursement for services will resume upon receipt of the assessment form. Whenever significant changes occur that alters level of care, the case manager will submit an updated Assessment Referral Form to DHHS.

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21.04 PERSONAL PLAN

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

21.04-1 Authorization for Reimbursable Services

Medically necessary services and units of services must be identified in the Personal Plan. Requests for services must be submitted to DHHS. Requests will be reviewed and negotiated by DHHS, and may be examined and evaluated by DHHS, before units of service are authorized and entered on the SAS. 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.

21.04-2 Plan Requirements

The ISC will ensure that the Planning Team is convened to initiate development of the Personal Plan prior to services being initiated. The plan must be less than six (6) months old. If older than six (6) months, supporting documentation must accompany the plan that discusses the current services being provided under this section, subject to ISC approval. The Personal Plan must describe at a minimum:

- A. All MaineCare Home and Community waiver benefit services determined medically necessary by the team including all other services that may not be covered under this section but the member identifies and may pursue;
- B. The frequency of provision of the services;
- C. How services contribute to the member's health and well-being and the member's ability to reside in a community setting;
- D. The member's goals for strengthening and cultivating personal, community, family, and professional relationships;
- E. The role and responsibility of the Direct Support Professional, the Employment Specialist and the member's other service providers in supporting the member's goals, including goals for strengthening natural and supportive personal, family, community and professional relationships; and

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21.04 PERSONAL PLAN (Cont.)

- F. Signatures of the participants, in order for the Plan to be authorized the Plan must include signatures of the member, guardian, if applicable, and case manager.

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

21.04-3 Planning Team Composition

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

- A. Plan facilitator;
- B. case manager or Individual Support Coordinator;
- C. The member;
- D. The member's parent, guardian or Correspondent;
- E. The member's advocate or friend or any additional individual invited by the member;
- F. Operator of the member's home or a Direct Support Professional providing services to the member;
- G. Staff from the member's Community Support, Work Support or Employment Specialist Services Provider; and
- H. Any professionals involved or likely to be involved with the member's Personal Plan.

21.04-4 Updating the Personal Plan

The member's Personal Plan must be reviewed, revised and updated at least annually, when there is a revision or update to the member's SAS, or when other significant changes occur relating to the member's physical, social, or psychological needs, or the member's significant progress toward his or her goals. The ISC will reconvene

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21.04 PERSONAL PLAN (Cont.)

the Planning Team to revise and update the Personal Plan. Planning meetings shall be held both prior to and subsequent to the planned move of a member to a new residence in order to coordinate supports and services and to evaluate the member's satisfaction with the change.

21.05 COVERED SERVICES

Members receiving Home and Community Benefits may receive the following services, as specified in the SAS, as long as they are not available under another section of the MaineCare Benefits Manual and the services are medically necessary.

21.05-1 Home Support is direct support provided by a Direct Support Professional to improve and maintain a member's ability to live as independently as possible in his or her home. Home Support is direct support to a member and includes primarily habilitative training and/or personal assistance (self-care, self management), development and personal well-being.

There are different models of home support. Home Support may be provided by an Agency (Agency ¼ hour and Agency per diem), in a Shared Living arrangement, or in a Family Centered-Support Model. Home Support may be provided as either a regularly scheduled "round the clock" service or as individual hours, or blocks of hours, of service.

Within the scope of Home Support, there may be activities that require that the service be carried over into the community. Nothing in this rule is intended to prohibit community inclusion as a reimbursable service accompanied by documentation on the Personal Plan provided that the service has a therapeutic outcome. An example is shopping for food, which may later be prepared in the home. This is allowable as long as it does not duplicate Community Support.

On Behalf Of is a component of Home Support and is included in the established authorization and is not a separate billable activity.

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

21.05-2 Community Support is Direct Support provided by a Direct Support Professional in order to increase or maintain a member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well being. This is a habilitative service with a focus on community inclusion, personal development, and support in areas of daily living skills if necessary. Community Support is intended to be flexible, responsive and provided to members consistent with his or her personal plan.

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The location of the service and staffing level may vary, allowing for a mix of individualized and group services. The average staff to member ratio for Community Support for each program location must not exceed 1:3.

Within the scope of Community Support, there may be activities that require that the service be provided in the member's home; most commonly, this will involve the origination or termination of a period of the service. This is allowable as long as it does not duplicate Home Support.

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

A member may not receive Community Support while enrolled in high school. Community Support is not 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.

The maximum annual allowance for Community Support is thirteen hundred (1,300) hours per year.

- 21.05-3 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. An Employment Specialist may work either independently or under the auspices of a Supported Employment agency but must have completed Maine's Employment Curriculum for Employment Support Personnel in order to provide Employment Specialist Services. The need for continued Employment Specialist Services must be documented in a Personal Plan as necessary to maintain employment over time. Employment Specialist Services are provided at work locations where non-disabled individuals are employed as well as in entrepreneurial situations. The cost of transportation related to the provision of Employment Specialist Services is a component of the rate paid for the service.

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21.05 COVERED SERVICES (Cont.)

On Behalf Of is a component of Employment Specialist Services Support and is included in the established authorization and is not a separate billable activity. Employment Services are provided on an intermittent basis with a maximum of 10 (ten) hours each month. There is a maximum annual allowance for the combination of Employment Specialist and Work Support Services of six hundred (600) hours. Nothing in this rule prohibits a provider from operating under a fair labor standards certificate program.

21.05-4 Work Support is Direct Support provided by a Direct Support Professional or an Employment Specialist to improve a member's ability to independently maintain productivity and employment. This service is commonly provided after a period of stabilization and encompasses adherence to workplace policies and productivity. It may also include hygiene, self-care, dress code, work schedule and related issues. Work Support is usually 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. The cost of transportation related to the provision of Work Support is a component of the rate paid for the service. On Behalf Of is a component of Work Support and is included in the established authorization, and is not a separate billable activity. The maximum annual allowance for the combination of Work Support and Employment Specialist Services is six hundred (600) hours. Nothing in this rule prohibits a provider from operating under a fair labor standards certificate program.

21.05-5 Home Accessibility Adaptations are those physical adaptations to the private residence of the member or the member's family required by the member's service plan, that are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home. 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 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 & safety purposes);
- Specialized flooring (to improve mobility and sanitation).

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21.05 COVERED SERVICES (Cont.)

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.

This service applies to member owned or a member's family owned home only; it is not available in agency owned or operated homes. Home Accessibility Adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

The limit for adaptations is ten thousand dollars (\$10,000) in a five (5) year period, with an additional annual allowance up to three hundred dollars (\$300) for repairs and replacement per year. All items in excess of five hundred dollars (\$500) require documentation from a physician or other appropriate professionals such as OT, PT or Speech therapists that the purchase is appropriate and medically necessary to meet the member's need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this section if they meet all requirements of this Section.

- 21.05-6 Specialized medical equipment and supplies** include devices, controls, or appliances specified in the plan of care that enable members to 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 may be provided 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. This benefit applies to member owned or a member's family owned vehicle only; it is not available in agency 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

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21.05 COVERED SERVICES (Cont.)

All items in excess of five hundred dollars (\$500) require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the member's need. Medically necessary adaptive aids that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this section if they meet all the requirements of this Section.

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.

21.05-7 Communication Aids are devices or services necessary to assist individuals with hearing, speech or vision impairments to effectively communicate with service providers, family, friends, and other community members. 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;

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21.05 COVERED SERVICES (Cont.)

- C. Facilitated communication. Providers must submit a written plan for DHHS's approval defining the facilitated communication services that will be offered to the member. The provider of this service must have a Certificate of Clinical Competence-Speech Pathology (CCC-SP).

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 assuring the medical necessity of the devices or services.

21.05-8 Non-Traditional Communication Consultation is provided to members and their direct support staff and others to assist them in order to maximize communication ability as determined from 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 DHHS.

21.05-9 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 every day 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 DHHS Office of Multi-Cultural Affairs.

21.05-10 Consultation Services are services provided to persons responsible for developing or carrying out a member's Personal Plan. Consultation Services include:

- A. 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 Personal Plan; 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 Personal Plan in the member's home, or in other community sites as appropriate;

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- C. Assisting in the design and integration of individual development objectives as part of the overall Personal Planning process, and training persons providing direct service in carrying out special habilitative strategies identified in the member's Personal Plan;
- D. Monitoring progress of a member in accordance with his or her Personal Plan and assisting individuals primarily responsible for carrying out the member's Personal Plan 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 Personal Plan.

Consultation is available in the following specialties: Occupational Therapy, Physical Therapy, Speech Therapy and Psychological services. The provider of this service must be an Occupational Therapist, Registered (OTR) for Occupational Therapy Consultation or a Registered Physical Therapist (RPT) for Physical Therapy consultation or have a Certificate of Clinical Competence-Speech Pathology (CCC-SP) for Speech Therapy Consultation. The provider of this service must be a Licensed Psychological Examiner or Licensed Clinical Psychologist for Psychological Consultation. 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.

21.05-11 Counseling is a direct service to assist the member in the resolution of the member's behavioral, social, mental health, and alcohol or drug abuse issues. Counseling services, as recommended in the Personal Plan, must be approved by DHHS. The provider of this service must be a Licensed Clinical Social Worker (LCSW) or a Licensed Clinical Professional Counselor (LCPC).

21.05-12 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 Personal Plan. Crisis Intervention is commonly provided on a short-term intermittent basis.

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21.05 COVERED SERVICES (Cont.)

Emergency Crisis Intervention services may be authorized by a primary designated DHHS representative without Personal Plan documentation 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 Personal Plan before the Department will authorize any further services for reimbursement.

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 by an approved agency enrolled in MaineCare.

- 21.05-13 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 to develop 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 client need, other team members may include a physician, occupational, physical or speech therapist.

The maximum allowance for this service is limited to one (1) assessment in a three-year (3) period. This cost includes all related follow-up activities.

- 21.05-14 Transportation Service** may be provided in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the Personal Plan. This is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services in the MaineCare Benefits Manual, defined at 42 CFR §440.170 (a) (if applicable), and does not replace them. Transportation services under this waiver are offered in accordance with the member's Personal Plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized.

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

Relatives and legal guardians may only be reimbursed for transportation if they indicate that they are unable to transport at no charge, there is no other viable option, and there is a recommendation by the planning team to reimburse the transportation.

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21.05 COVERED SERVICES (Cont.)

- 21.05-15 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 an Occupational Therapist, Registered (OTR) for Occupational Therapy Maintenance.
- 21.05-16 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.
- 21.05-17 Speech Therapy (Maintenance)** is a service that has maintenance of current abilities and functioning level as its goal. 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.

21.06 NON-COVERED SERVICES

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

- 21.06-1** Services not identified by the Personal Plan;
- 21.06-2** Services to any MaineCare member who receives services under any other federally approved MaineCare Home and Community based waiver program;
- 21.06-3** Services to any member who is a nursing facility resident, or ICF/MR resident;
- 21.06-4** Services that are reimbursable under any other sections of the MaineCare Benefits Manual;
- 21.06-5.1** 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;

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21.06 NON-COVERED SERVICES (Cont.)

- 21.06-6** Room and board; The term “room” means shelter type expenses, including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term “board” means three meals a day or any other full nutritional regimen. Board does not include the provision of a meal at an adult day health or similar facility outside the member’s home. Board also does not include the delivery of a single meal to a participant at his/her own home through a meals-on-wheels service;
- 21.06-7** Services provided directly or indirectly by the legal guardian will not be reimbursed unless the legal guardian is the member’s spouse, parent, sibling or other biological family member. This rule will not be avoided by adult adoption. Current guardians, who are not biological family, and who are directly or indirectly reimbursed for services, may continue to receive reimbursement for up to one year after the adoption of this rule, during which time the guardian shall plan for alternative guardian or alternative reimbursement;
- 21.06-8** Work Support or Employment Services when the member is not engaged in employment. Employment means traditional employment or telecommuting that is compensated at a competitive wage; or self employment or business ownership. A competitive wage is a wage at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by an employee without a disability. Employment does not include work in a setting in which the member has little or no interaction with customers or other employees not having a disability, unless the member is telecommuting, self-employed, or owns his or her own business;
- 21.06-9** 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** Employment Specialist Services and Work Support Services are limited to a combination of six hundred (600) hours per year. Members who receive Community Support Services **and** Work Support and Employment Specialist Services are limited to a combination of thirteen hundred (1300) hours per year. Both limits apply. The maximum annual allowance for Community Support is thirteen hundred (1,300) hours per year.

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21.07 LIMITS (Cont.)

- 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.
- 21.07-4** All items in excess of five hundred dollars (\$500) require documentation from physician or other appropriate professional such as OT, PT or Speech therapist that purchase is appropriate to meet the member's need. Medically necessary home modifications that cannot be obtained as a covered service under any other MaineCare benefit may be reimbursed under this section only if they meet all requirements of this Section. This benefit applies to personal homes only; it is not available in agency owned or operated homes.
- 21.07-5** For 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 OT, PT 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 will be reimbursed under this Section. These services are to be considered the property of the member.
- 21.07-6** For communication aids costing more than five hundred dollars (\$500), the member must obtain documentation from a licensed speech-language pathologist assuring that the purchase is appropriate to meet the member's need and assures 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.
- 21.07-7** 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.
- 21.07-8** Crisis Intervention Services that have not been included on the Personal Plan are limited to a period not to exceed two weeks and must be authorized by the DHHS. Crisis Intervention Services may not extend past two (2) weeks without a recommendation from the member's Person Centered Team and additional approval from DHHS.
- 21.07-9** Crisis Assessment Services are limited to one (1) assessment in a three-year (3) period and includes all related follow-up activities.
- 21.07-10** A member may not receive Community Support, Employment Specialist Services or

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21.07 LIMITS (Cont.)

Work Support while enrolled in high school. A member may have services authorized while still enrolled in high school; however, the start date of the service may only begin after the date of graduation or termination of enrollment.

- 21.07-11** A member may not receive Community Support at his or her place of employment.
- 21.07-12** No more Family Centered Support will be approved after this rule has been adopted.
- 21.07-13** If a current waiver recipient enters a nursing facility or a hospital, payment under the waiver will be temporarily suspended. If the waiver recipient remains in the nursing facility or hospital for more than thirty (30) consecutive days, enrollment in this waiver will be terminated unless there is a written request to the Department to continue holding the funded opening.

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 has been determined to be financially or medically ineligible for this benefit;
 - B. The member has been determined to be a nursing facility resident or ICF/MR resident without an approved Personal Plan to return to his or her home;
 - C. The member has been determined to be receiving MaineCare services from another Home and Community Based Waiver benefit;
 - D. The member is no longer a resident of the State of Maine;
 - E. The health and welfare of the member can no longer be assured because:
 - 1. The member or immediate family, guardian or caregiver refuses to abide by the Personal Plan or other benefit policies;
 - 2. The home or home environment of the member becomes unsafe to the extent that benefit services cannot be provided without risk of

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21.08 DURATION OF CARE (Cont.)

harm or injury to the member or to individuals providing covered services to the member; or

3. There is no approved Personal Plan.

21.08-3 Provider termination from the MaineCare Program- The provider must provide the member and DHHS thirty (30) days written notice prior to the effective date of termination.

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, and MaineCare identification number;

21.09-2 The member's social and medical history, and diagnoses;

21.09-3 The member's Personal Plan.

21.09-4 The Summary of Authorized Services; and

21.09-5 Written progress notes that identify any progress toward the achievement of the goals, activities and needs established by the member's Personal Plan signed by the staff performing the service.

21.10 PROVIDER QUALIFICATIONS

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

21.10-1 **Direct Support Professional (DSP)** is a person who provides Home Support, Work Support, Community Support, or Crisis Intervention and:

- A. Has successfully completed the Direct Support Professional curriculum as adopted by DHHS, or demonstrated proficiency through DHHS's approved Assessment of Prior Learning;
- B. Has a background check consistent with Section 21.10-5;
- C. Has an adult protective and child protective record check;

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21.10 PROVIDER QUALIFICATIONS (Cont.)

- D. Be at least 18 years of age; and
- E. Has graduated from high school or acquired a GED; Persons without a high school diploma or a GED and currently providing the services as of the effective date of this rule must request a written exemption from DHHS within six (6) months.

As of the effective date of this rule, staff or subcontractors currently providing this service must obtain the DSP certification or demonstrate proficiency through DHHS's approved Assessment of Prior Learning within one (1) year (2080 hours, two thousand and eighty) of actual employment from date of hire, or three (3) calendar years, whichever is less.

All new staff or subcontractors shall have one (1) year (2080 hours, two thousand and eighty) of actual employment from date of hire, or three (3) calendar years, whichever is less, to obtain DSP certification or demonstrate proficiency through DHHS's approved Assessment of Prior Learning. Evidence of date of hire and enrollment in the training must be documented in writing in the employee's personnel file or a file for the subcontractor. Services provided during this time are reimbursable as long as the documentation exists in the personnel file.

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

A DSP can supervise another DSP.

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

As of the effective date of this rule, DSPs who currently assist with the administration of medication must obtain the Certified Nursing Assistant-Medications (CNA-M); or a Certified Residential Medication Aide (CRMA); or otherwise be trained to administer medications through a training program authorized, certified, or approved by DHHS within one (1) calendar year.

All new DSPs who assist with the administration of medication shall have one (1) calendar year from date of hire to obtain the Certified Nursing Assistant-Medications (CNA-M); or a Certified Residential Medication Aide (CRMA); or otherwise be trained to administer medications through a training program authorized, certified, or approved by DHHS certification.

21.10-2 An **Employment Specialist** is a person who provides Employment Services or Work Support and has:

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21.10 PROVIDER QUALIFICATIONS (Cont.)

- A. Successfully completed Maine’s “Employment Curriculum for Employment Support Personnel,” as approved by DHHS;
- B. Graduated from high school or acquired a GED; Persons without a high school diploma or a GED and currently providing the services as of the effective date of this rule shall have three years to obtain the minimum educational requirements.
- C. Has a background check consistent with Section 21.10-5; and
- D. Worked for a minimum of one (1) year with a person or persons having a disability in a work setting.

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:

- A. Neuropsychiatrist or psychiatrist, who has worked with persons with developmental disabilities as a primary part of their practice;
- B. Psychologist or behaviorist who has worked with persons with developmental disabilities as a primary part of their practice;
- C. 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;
- D. General medical practitioner;
- E. Occupational therapist;
- F. Physical therapist; or
- G. Speech therapist.

21.10-4 A provider must follow DHHS’s rule governing emergency intervention and behavioral treatment for persons with Mental Retardation (14-197 CMR Chapter 5), and training on approved behavioral interventions procedures (e.g., Mandt) if applicable and indicated as a need in the member’s Personal Plan.

21.10-5 Background Check criteria-The provider must conduct background checks on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide direct support services under this Section. Background checks on persons professionally licensed by the State of

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21.10 PROVIDER QUALIFICATIONS (Cont.)

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

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

21.11 APPEALS

In accordance with Chapter I of the MaineCare Benefits Manual, members have the right to appeal in writing or verbally any decision made by DHHS to reduce, deny or terminate services provided under this benefit.

21.12 REIMBURSEMENT

Reimbursement methodology for covered services shall be the amount listed in Chapter III, Section 21, Allowances for Home and Community Benefits for members with Mental Retardation or Autistic Disorder or the provider's usual and customary charge, whichever is lower.

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21.12 REIMBURSEMENT (Cont.)

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.

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

The provider must document each service provided, the date of each service, the type of service, 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. Services requiring a 2:1 ratio staffing may be documented by 1 (one) staff member, but both staff must sign the progress note. If services are provided by two (2) or more staff working different shifts, then each shift must be documented separately.

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 week end. The provider must have documentation for each eight (8) hour shift per day and one (1) progress note to cover the week-end shift. If crisis intervention is required, a separate progress note must be included in the member's chart. 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.

21.13 BILLING INSTRUCTIONS

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

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21.14 APPENDIX I-Guidelines for Approval of Behavioral Add On in Maine Rate Setting

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

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

A. Planning Team

The Planning Team must:

1. Include a written plan that articulates the desired outcome of the behavioral treatment intervention(s) in the member's planning process. The planning team must approve this plan. The approval process must include an outline of the process in place for the team to monitor progress and or identify barriers.
2. The planning team must always include the member and the guardian, if applicable. The team must also include a caseworker or Designated Representative, who must coordinate the inclusion of any other relevant planning team members. The planning team must include representatives of every site at which the behavioral intervention procedure is implemented.
3. The team must develop a transition plan that identifies key objectives which would trigger the removal of the Behavioral Add Ons from the Personal Plan.

B. The written behavioral intervention plan and approach must be developed, reviewed, and/or approved by a licensed psychologist or psychiatrist. A planning team recommendation for consideration of a Behavioral Add On will not be accepted without this review and approval from a psychologist or psychiatrist. The clinicians must:

1. Meet with the member and the member's support staff.
2. Confer with the member's family, if involved, and guardian, if one has been appointed.
3. Develop or approve the written plan and the monitoring system.
4. Agree to monitor the implementation and the effectiveness of the plan at least quarterly and more frequent if regulation requires.

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- C. Provider Requirements
1. The provider must assure that there are policies in place that provide guidance to staff in regards to Behavioral Services in their agency. This must include guidance in regards to agency and state regulation, the process for developing behavioral plans, gathering of data, and monitoring.
 2. Service providers must assure that plans that are developed by other than a licensed psychologist or psychiatrist are done by professionals meeting the QMRP level of qualifications. (Note: these plans must be approved by a licensed psychologist or psychiatrist).
 3. Service providers must ensure that all individual staff members who work with the member are trained in all sites where the member interacts. This training should be reviewed and approved by the agency QMRP, QA or similar agency delegate.
 4. Service providers must compile reports to the team and clinicians at least quarterly and have a review by the team at minimum semi annually or more frequently if required by regulation.
- D. Approval Process-DHHS will complete the following process in reviewing and approving Behavioral Add Ons for the rate setting process:
1. Members for whom a Behavioral Add On is being requested must have been on the home and community based waiver benefit for a minimum of six (6) months. An exception may be requested for members entering the system through Adult or Child Protective Services if adequate documentation exists to support an exception. An exception can also be requested for members with pending adult or child protective cases whether they are adjudicated or not.
 2. The following documentation must be submitted by the provider:
 - a. Copies of behavioral services policies. (These will be maintained in the regional office and only need to be provided the first time a request is made or at any time the policies are updated or changed.)
 - b. A copy of the member's Personal Plan and attendance sheet with documented approval of the member, guardian and team.
 - c. A copy of the behavioral plan(s) signed by the appropriate clinician.
 - d. Quarterly reports.

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3. DHHS will issue a written decision for the Behavioral Add On, within twenty (20) working days of receipt of all required documentation. If DHHS requires further clarification, a written request will be issued. Upon receipt of the additional information DHHS will approve or deny the request within five (5) working days.

Documents will be reviewed by a designated representative.

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

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

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

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

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

A. Physician Order

1. There must be a written physician's order for the member. This order must specify:
 - a. The specific illness or condition to be addressed;
 - b. The specific procedure(s) that will be utilized;
 - c. The time span over which the treatment or intervention is expected to be needed. If the treatment or intervention is expected to be needed for an indefinite period of time then this expectation should be specified;
 - d. The anticipated frequency of treatment or intervention on a daily, weekly, or monthly basis;
 - e. Where applicable and possible:
 1. The approximate length of time required for each episode of the treatment or intervention and
 2. The degree of licensure or certification required for those who carry out the treatment, and those who provide training and oversight relative to its application.

B. Planning Team

1. The team must meet or otherwise confer for the following purposes:
 - a. To determine whether the setting where the member is served is appropriate to carry out the physician's recommended treatment or intervention;
 - b. To determine how the member's needs shall be met and what the staffing requirements are.

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

C. Provider Requirements

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

D. Approval Process

1. The DHHS will issue a written decision for the Medical Add On, within twenty (20) working days of receipt of all required documentation. If additional information is required, a written request will be issued. Upon receipt of the additional information DHHS will approve or deny the request within five (5) working days.
2. Documents will be reviewed by a designated representative.
3. Approvals will include a specification of the authorized daily or weekly units of service which require the Medical Add On. Approval may be retroactive to the date of application of the Add On based on documentation.
4. Treatments or interventions that are anticipated to be needed for an extended or indefinite period of time must be reviewed at minimum, annually by the team. Verification of this continued need must be provided to the DHHS within a year of the original approval, in order for the Medical Add On to continue.

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21.06 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.

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 Personal Plan, medical plan or behavioral plan including in-service training specific to a member's plan of support, consultations with supervisors, therapist, clinicians and or medical staff; activities relating to a member's parent, guardian or CAB 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 their parents, guardian, or friends home for visits, returning a member to their home, and any time spent during such a visit such as attending a family function with the member.

Services, 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.

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 Personal 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.

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.

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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.